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MINDING THE BODY:

QUESTIONS OF EMBODIMENT AND THE PRACTICE OF PSYCHOANALYTIC PSYCHOTHERAPY

VOLUME I: THESIS

By: Karen Louise Gubb

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology at the University of the Witwatersrand

DECLARATION

I declare that this is my own unaided work. It is being submitted for the degree of PhD in Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.

_____

Karen Louise Gubb

_____*Day of* _____*, 2013*

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ABSTRACT

It is well understood that psychoanalysis began with Freud's encounter with hysteria and his work with illnesses of the mind which manifested in bodily terms. However, despite its close connection to the body and the understanding that psychoanalytic theory and practice develop hand-in-hand, psychological conflict that expresses itself in physical terms and more especially the role of the two bodies in the therapy room has received relatively little attention. The topic of this research project is captured in its title: "Minding the Body", and the four journal articles it presents interrogate the relationship between the mind and body of both the patient and therapist. The thesis begins with two published papers which focus on the body of the patient, rehearsing and extending the psychoanalytic theory of bodily psychopathology and the implications that the different understandings of the relationship between body and mind in different forms of psychosoma have for clinical interventions. The second two papers examine what the analyst's interpretation of her somatic responses to the patient, and the patient's engagement with the analyst's body, can reveal about the dynamics of the therapeutic dyad. The project concludes with a discussion of the clinical implications of a greater focus on the two bodies in the room, suggesting that the techniques developed to make sense of the patient's physical symptoms can be usefully applied to decode the somatic countertransference as it manifests in a particular therapeutic dyad. That process, coupled with an awareness of the patient's engagement with the therapist's body, can create conditions under which the analyst's body may become an analytic object and this can add significantly to the analytic repertoire.

CHAPTER 1: INTRODUCTION TO THE PROJECT

Psychoanalysis was born through Freud's search for ways to explain the physical symptoms he observed presenting in hysterical patients which appeared to have no biological cause, and thus the foundational moment of psychoanalysis was in relation to the body. A key underpinning principle of the field of psychoanalysis was thus the idea that an illness that is purely psychological can express itself in physical terms; and consequently a theory was built that distinguished human suffering that is physical from that which is mental (Breuer & Freud, 1893; Freud, 1912d, 1917a). This idea that the mind expresses itself through the body is anticipated in Freud's much quoted statement that "The ego ... is first and foremost a body-ego" (Freud, 1923a). It is in his early encounters with hysteria that Freud developed psychoanalysis as a theory of psychopathology accompanied by practice, and it is in these founding principles that the key ingredients of this research project emerge.

The practice that emerged following Freud's work with hysteria is essentially the verbal interpretation of symptoms and their meaning, which is intimately connected with the notion of psychoanalysis being a 'talking cure'. The practice is therefore located in language, both as a site of the production of meaning and as the instrument by means of which the cure is effected. The curative practice of psychoanalysis is therefore not only closely connected to speech but is also based on an understanding that the very idea of the kind of meaning that this interpretive practice uncovers is one in the register of language and talking (Sirois, 2012).

While speech may be emitted from the mouth of one individual and be intended for the ear of another, it is necessary for it to be structured by language in order to communicate a message. Doing so conveys large amounts about the culture, history, and society of the speaker. Consequently, speech and language may be produced by a body, but they exist more widely and independently than the bodies that create and convey them. At the core of the psychoanalytic endeavour is the wish to understand the processes by which the embodied self comes to create and be created by language (Lichtenstein, 2012).

However, while the practice of psychoanalysis is in the domain of language, the understandings of the nature of the pathology have to do with the relationship between psychic objects which the patient is conscious of and can give meaning to, and principles and forces that are still in the patient's unconscious mind.

Psychoanalysis has at its foundation an underlying drive theory which proposes that humans have biological and psychological needs which they are driven to meet. If these needs are not met, the individual will experience discomfort, tension and sometimes internal conflict. An individual's task is to balance these internal needs with their own internal value system as well as behaviour deemed appropriate by society (Freud, 1923a). Symptoms may manifest in the body as a result of the interaction of these bodily and 'non-bodily' phenomena. The very reason that these symptoms present in this physical way is because it is not yet possible for the patient to make psychic sense of them and to put them into words. What can be concluded is that that both practically and conceptually, the relationship between questions of the body and questions of practice and technique in treating the psychopathology of the body, are going to be complex – precisely because the practice is in the domain of language, while bodily symptoms occur in an altogether different domain.

One of the ways in which psychopathology with an explicitly bodily dimension is connected to the core metapsychological theory of symptom formation is through the concept of mentalization, which is defined as the process of making meaning and expressing conflicts and experiences in language (Allen, Fonagy, & Bateman, 2008; Fonagy, Gergley, Jurist, & Target, 2004). The issue of mentalization is fundamental to psychoanalysis, and remains central to both the theory and the practice of psychoanalysis and is based on the relationship between the body (i.e. drives, instincts and affects) and that which it is possible to mentalize. Mentalization is therefore a process that unites implicitly psychoanalytic psychopathology as a theory and that which is a goal for clinical practice, and is consequently vital to the project of 'minding the body'.

Unsurprisingly, the body that was the focus in early psychology was the body of the patient. More recently however, contemporary writings have highlighted the influence that the person of the analyst has on the therapy. This theoretical development consequently brings another body into focus: the body of the analyst. The body of the analyst and the role that it plays in a treatment has received relatively little attention. However, the analyst's physical response to the patient can be a source of useful information about therapeutic dynamics. Similarly, how the patient engages with and refers to the analyst's body provides valuable insights into the transference-countertransference forces at work.

The specific and primary focus of this research is to draw attention to the benefits of paying attention to, and in that way 'minding', the fact that both members of the therapeutic couple are in fact embodied beings. With this in mind, attention can be paid to how those bodies convey valuable information about internal conflicts, psychopathology and transference-countertransference dynamics.

The secondary focus of the project is to describe the mechanisms involved in bodily pathology and bodily responses and then to describe ways in which these can be worked with and mentalized in order that they might become available to language and in that way made use of in the therapeutic encounter.

This thesis arose out of my work as a psychoanalytically-informed clinical psychotherapist with a special interest in body-mind link and disorders of the body. In the course of my work I became aware that in contemporary psychoanalytic writing there is a tendency to consider the body metaphorically, rather than a concrete, physical presence (Barratt, 2010). It seemed to me that this tendency resulted in a loss of remarkably useful and revealing information, and the idea for this project began to evolve.

RATIONALE FOR THE PROJECT

The history of concentrated focus on the body in psychoanalytic thought and practice is a complex one. Over the years, even though it was where psychoanalysis began, the body has come to occupy less and less of a central role in psychoanalysis. In more modern psychoanalysis where the object-relations school has increased in influence, references to the body are often understood as being metaphorical and thus the body's physicality seems to holds decreasing importance. There is also diminishing focus on the Freudian theory of the body and its drives (Paniagua, 2004). The history of psychoanalysis has shown alternating trends (Swartz, 2000) from explicit concerns with the body expressed in the original drive theories, to a preoccupation with other the elements and ingredients of the so-called talking cure such as the patient's inner world or the relationship between patient and therapist.

Yet, even in those psychoanalytic schools of thought where the body does not receive direct focus, most psychoanalytic theories are still concerned with the regulation, dissociation, and integration of affective states, which are in fact theories of an embodied self as these states are all registered, recorded, and sustained in some form of bodily inscription. Thus, even if contemporary

psychoanalytic theories privilege the social or interpersonal side of the psychotherapeutic work, the subject remains an embodied being and therefore the bodily element of psychotherapeutic processes cannot be ignored if the therapy is to be successful (Lichtenstein, 2012).

There does appear to be a renewed interest in the body in psychoanalysis (Gubb, 2013a; Paniagua, 2004). However, where the body has been included in clinical practice, the focus has usually emphasised the body of the patient. What is emerging strongly more recently though, is the understanding that there needs to be concentration on the bodies of both the patient and the therapist, as well as on the need to foster the ability of both of these individuals to mentalize their somatic experiences.

This study consists of two parts which reflect the dyad of the analytic couple. The first part of the study focuses on the body of the patient, while the second part concentrates on the body of the therapist. The thesis was conceived of in this format in order to emphasise the presence of two bodies in the room and to highlight the fact that they both contribute and 'speak' during the therapy process.

This PhD including publication and its prerequisite four papers presented an ideal opportunity to discuss various aspects of 'minding the body' in detail. Each of the four papers focuses on a different aspect of what psychological dynamics can be revealed (and hidden) by the body. By making use of individual cases it is possible to explore and contrast processes and mechanisms in depth, and this allows for a deeper understanding of not only the processes involved in somatisation, but also the therapeutic interventions required to access and transform these into mental elements.

The aims of this research enterprise then are to advocate for minding the body, emphasise the two bodies in the room, and explicate the role of mentalization in psychoanalytic practice and how this aids in transforming somatic manifestations of psychological origin into mental objects which can be processed and worked through by means of the talking cure. The quest to 'mind' the body is not a new quest, but an old one that is worth revisiting. What this research project aims to contribute to that quest is an understanding of the mechanisms behind conflicts or psychological responses that take a somatic route, and a clinical application of how to make use of these in the therapy room.

THEORETICAL ORIENTATION

This research is located within the broad psychoanalytic paradigm which offers a theoretical understanding of human behaviour that emphasises unconscious motives, anxieties and conflicts. The focus of the research is related to psychoanalytic psychopathology and the clinical interventions characteristic of an analysis or a psychodynamic psychotherapy.

Psychoanalysis is a theory of human development and psychopathology as well as a treatment technique for patients suffering from psychological disorders. The psychoanalytic theories of personality development which are of significance to this research are those found in Freud's work (1910a, 1912b, 1912d, 1915c). Equally important is the work done on attachment by, amongst others, Bowlby (1969) and Fonagy (Fonagy, et al., 2004; Fonagy & Target, 2007). Attachment theories emphasise the impact of the caregiver on an infant's developing sense of themselves and their relation to their own body. Most importantly for this project, however, is the work done by these attachment theorists on the concept of mentalization and what role this plays in the individual's ability to translate physical sensations into psychological objects with meaning (Allen, et al., 2008; Fonagy, et al., 2004; Fonagy & Target, 2007).

Fundamental to psychoanalytic psychopathology, and to this thesis in particular, is the understanding that symptomatology which is essentially mental in origin may take a route to the body and may manifest in physical terms. This idea originates from the very early understandings of psychoanalytic psychopathology, particularly the concept of hysteria which emphasises somatic symptoms and the mechanisms involved when mental suffering is expressed in bodily terms. The most important of these mechanisms is that of the repression of unconscious fantasies and wishes (Breuer & Freud, 1893; Freud, 1912d, 1917a). In addition, the early work on hysteria involved another concept that is of significance to this project, and that is the idea that the form that the patient's physical symptom takes, has significance and is essential to understanding the psychic conflicts which were at work in the development of that symptom (Freud, 1912d).

As stated above, psychoanalysis is also a treatment modality for psychological difficulties. It is a 'talking cure' that emphasises the interpretation of the patient's unconscious material. In classical psychoanalytic treatment patients are encouraged to say whatever comes into their mind in the order in which it comes to

them. This process is known as free association and it is believed that this will reveal the unconscious conflicts which lie beneath the patients' symptoms and character problems (Freud, 1910a, 1917a). The analyst then interprets any underlying conflicts revealed by the material to the patient in order for the patient to understand the meanings behind their symptoms. Developing such an insight around their conflicts allows for the repression of the associated wishes to be lifted and the symptoms to resolve (Freud, 1914).

Further important and fundamental psychoanalytic concepts which are relevant to this project are those of 'transference' and 'countertransference'. Transference is the redirection of the patient's feelings about a significant person from the patient's past onto the therapist (Freud, 1912a; Klein, 1952). The manner in which the transference is expressed by the patient must be analysed in order to reveal the unresolved conflicts the patient has with figures from their childhood, and other parts of their life. Equally important is the idea of 'countertransference' which are the feelings that the analyst has towards the patient. These countertransference feelings can give the analyst valuable insight into the relationship between themselves and the patient (Heimann, 1950; Lemma, 2003).

AIMS OF THE PROJECT

The overriding aim of the study was to argue for, and substantiate the need for working with, and focusing on, the physical body in psychoanalytic psychotherapy, and to give meaning and to mentalize the symptoms and reactions that occur in the physical dimension, whether it be the body of the patient or the body of the therapist. Against this background, and in light of the literature discussed in the following chapter, the study aimed to highlight the advantages of attending to both the bodies in the room.

As suggested by the title, the main aim, therefore, is to argue for the benefits of 'minding of the body' in psychoanalysis, and there are four specific dimensions, divided into two parts, which are explored:

1. The first half of the thesis concentrates on the symptomatic body of the patient

    - The study reflects on the most widely accepted theories explaining how the patient's body manifests psychopathology (e.g. conversion hysteria and psychosomatic illness) and provides a comparative overview of this body of theory in psychoanalytic literature with the aim of paying particular

attention to how each of these pathologies is linked to a particular type of failure of mentalization.

- The study further aims to explore one particular form of bodily psychopathology (i.e. psychosomatic illness) in more detail and to compare and contrast existing and emerging schools of thought about psychosomatosis through a focus on the underlying difficulties in mentalization that the particular illness demonstrates.

2. The second half of the thesis concentrates on the body of the therapist

- The third aim of the study is to demonstrate the usefulness of paying attention to the second body in the room: that of the analyst. The analyst may have a number of physical responses to the patient, and the aim here is to explore how attending to, and understanding and mentalizing around these physical responses might give the therapist insight into the therapeutic dynamics at work in a particular therapy.

- The final aim of the study is to give attention to moments when the patient observes and comments on physical aspects of the therapist during a psychotherapy in order to gain insight into what such moments might reveal about the transference-countertransference dynamics occurring between the psychoanalytic couple.

RESEARCH QUESTIONS

The research questions that the study addresses include:

THE PATIENT'S SYMPTOMATIC BODY

- What are the different ways in which psychoanalytic theory has understood the patient's symptomatic body?
- Which psychological anxieties and conflicts can be seen to underpin the main theories of the symptomatic body of the patient in psychoanalysis?
- How are failures of mentalization conceptually linked to physical symptoms in psychoanalysis?
- What implications do different understandings of the process of somatisation have for treatment of psychosomatic illnesses?

THE THERAPIST'S BODY

- What information about the therapeutic dynamics are revealed by the therapist's physical response to the patient, and how can this be used in the treatment?
- What might the patient's references to the therapist's body reveal about the therapeutic dyad, and how can this information be used therapeutically?

THE EMBODIED ANALYTIC PAIR

- What are the potential benefits of paying particular attention to the embodiedness of both members of the therapeutic pair?

STRUCTURE OF THE THESIS

The thesis is presented in two volumes. The first of these is the thesis proper which contains the papers which are presented as chapters as well as a linking and uniting overall argument. The second volume contains the three papers which have already been published, in their published formats.

VOLUME I: THESIS

The study is made up of two parts which reflect the dyad of the analytic couple. The first half of the study focuses on the body of the patient while the second half focuses on the body of the therapist.

The structure of this PhD thesis including publication following this introductory chapter is as follows:

CHAPTER 2: LOCATING THE RESEARCH IN THE LITERATURE

The first two published papers included in this thesis are in themselves reviews of the historical and more contemporary literature which is relevant to the overall topic. The second two papers also include selected literature which is reviewed in order to place the argument presented in each paper in context. In order to avoid repetition only a few crucial points are highlighted in this chapter which is a brief orientation to the literature which is relevant to the thesis.

CHAPTER 3: RESEARCH METHODOLOGY AND ETHICAL CONSIDERATIONS

In this chapter the data collection and analysis methods which were used in the study are described. Any relevant ethical issues are discussed, as well as the steps taken to address these.

The next four chapters of the thesis take the form of the four journal articles which were a requirement for the degree to be conferred. All four of the stand-alone papers were submitted to peer-reviewed psychoanalytic journals. Three of the manuscripts have been published, and the fourth has been provisional accepted pending some minor changes which are being processed. Submission of the thesis with three accepted papers and one which has been submitted is in accordance with the guidelines of the Faculty of Humanities of the University of the Witwatersrand PhD programme. Each article was written to conform to the specific requirements of the journal to which it was submitted. In order to contextualise the papers and to make the relationships between the papers more explicit each of these chapters includes a brief introductory section. These additional sections highlight the argument being presented by the thesis as a whole and identify the research questions being addressed by each paper.

The first two papers discuss the subject of psychosoma in the patient, but with a specific emphasis on clinical implications.

CHAPTER 4: THE QUESTION OF PSYCHOSOMA

The paper included in this chapter is entitled “The Sense of Bodily Symptoms” and was published in *Psycho-Analytic Psychotherapy in South Africa* in 2011. The paper explores the relationship between psychological illness and physical symptoms. It reviews the concepts of conversion and somatisation and compares and contrasts their genesis, the possible meanings that the form of the symptoms might reveal, and the therapeutic task related to the treatment of each type of symptom. The two types of pathology are contrasted in terms of the patient’s mentalizing capacity.

CHAPTER 5: PSYCHOSOMATIC ILLNESS

A brief introduction links this paper to the previous one.

The paper then follows and is entitled “Psychosomatics Today: A Review of Contemporary Theory and Practice” and was published in *The Psychoanalytic Review* in March 2013. This paper is a review of recent literature on the topic of psychosomatic illness. It suggests that there are two theoretical approaches in the literature: the first is the well-defined French school of psychosomatics, and the second which the paper proposes: the Attachment approach. The paper explores in detail how each of these approaches understands the concept of mentalization and how this in turn informs the theorisation of the mechanisms involved in

psychosomatic illness and consequently its treatment. The paper ends with some comments about the clinical implications resulting from the different theoretical approaches.

When this paper was published, the editors called for comments on the paper, and those which are relevant are included in the Discussion chapter of the thesis.

The focus of the second half of the thesis shifts to the other body in the room: that of the therapist.

CHAPTER 6: THE THERAPIST'S PHYSICAL RESPONSE TO THE PATIENT

The chapter will begin with some introductory comments which link it to the previous papers.

The paper in this chapter was submitted to *The British Journal of Psychotherapy* in May 2013 and is entitled "Craving Interpretation: A Case of Somatic Countertransference". The paper argues that it is the unique details of each therapeutic relationship which are of interest when an analyst experiences a somatic countertransference reaction. It suggests that in order to make sense of the rich information that this unique response provides, the therapist must mentalize and make meaning of her particular somatic experience as this somatic reaction is in response to unspoken material in the room, and the form that it takes can be used very productively in the therapy if it is mentalized, analysed and interpreted by the therapist.

The moment you start returning focus to the two bodies to the room, questions arise about the patient's relation to the therapist's body.

CHAPTER 7: THE TWO BODIES IN THE ROOM

The chapter begins with a brief introductory section.

This paper included in the chapter was published by Psychoanalytic Psychotherapy in South Africa in June 2013 and was entitled *"Re-embodying the Analyst"*. The paper focuses on comments patients make about the body of the analyst in therapeutic exchanges, and which are characterised by a theoretically based asymmetry between analyst and patient. Having explored the nature of this asymmetry and its theoretical foundations in psychoanalysis, the question is posed as to whether considering some of the specific features of the form and timing of the references to the analyst's body in light of this asymmetry, may help therapists to understand the dynamics of particular therapeutic dyads. The paper concludes

with some thoughts on how comments of this kind can be made use of to illuminate aspects of the particular patient's transference-countertransference and thus the dynamics of any particular therapy more widely, as well as how they affects levels and kinds of disclosure by the therapist.

CHAPTER 8: DISCUSSION

The contributions made by, and the relationship between, the four papers is clarified in this chapter which also synthesises the previous chapters and demonstrates how together they add to the body of knowledge in the field. It reflects on the research process and any noteworthy limitations. The implications of the research for theory and practice are considered, and limitations of the study as well as recommendations for further research are discussed.

CONCLUDING REFLECTIONS

This chapter is a personal reflection and offers some concluding thoughts.

REFERENCE LIST

A comprehensive list of all the references used in the study is included in this section.

APPENDICES

This section includes:

i. The consent forms sent to subjects of the study
ii. The ethical clearance certificate from the University of the Witwatersrand

VOLUME II: PUBLISHED PAPERS[1]

The three papers of this thesis which have already been published are included in their published form in this volume.

[1] During the time that the thesis was being examined, the final paper was published and the published version of the article is now included in the second volume.

CHAPTER 2: LOCATING THE RESEARCH IN THE LITERATURE

This project is closely connected to, and informed by, literature which gives an account of the fundamental features of psychoanalytic psychopathology, particularly the early psychoanalytic concept of pathology that is expressed in, or is related to, the physical body. This chapter briefly reviews some of the earliest Freudian concepts of bodily psychopathology and then goes on to examine how various aspects of Freud's work have been expanded and developed by different theorists. Since the project has both a theoretical and a clinical focus, literature that informs psychoanalytic practice related to questions of the body is also included.

PSYCHOANALYTIC PSYCHOPATHOLOGY

The way in which physical symptoms are conceived of and worked with in this project has its foundations in the very earliest psychoanalytic theorisations, and for that reason it is useful to rehearse some of those concepts here.

A central tenet of the first of the four papers making up the body of the thesis is the intimate connection between the notion of psychosoma and the fundamentals of psychoanalytic thought. The first paper of the thesis, "A Sense of Bodily Symptoms", outlines in detail the history of psychoanalysis which is relevant to this research, and the ideas explored in that paper then form the foundations of the rest of the project. The paper makes the point that the way in which Freud 'minded the body' in his pioneering work with hysterics marked the beginnings of psychoanalytic theory and practice. It was while working with hysterical patients who presented with physical complaints that did not seem to have an underlying biological origin, that Freud began to map the mechanisms involved in such psychopathology (Breuer & Freud, 1893; Freud, 1912d, 1917a; Swartz, 2000). The physical body of the patient has therefore always occupied a crucial place in psychoanalytic theory and practice.

However, although hysteria may have been the initial understanding of how psychopathology might manifest physically, it is now a part of a wider conceptualisation of pathology in psychoanalysis which is based on one of the key foundational concepts of psychoanalysis: the unconscious. The notion of the unconscious was developed by Freud (1912b) during his experiences of the psychoanalytic treatment of patients in which he came to see that not all the

contents of the psyche are conscious, and that certain psychic material only becomes available to the conscious mind when resistances to that material are removed by means of psychoanalytic treatment. It was though his interactions with patients that he observed that the mind holds many ideas which are active yet at the same time are not known to the individual. He proposed that it was from these unknown, unconscious yet active ideas that symptoms arise.

Freud (1917a) further theorised that patients who present with hysterical symptoms are in fact experiencing *intrapsychic* conflicts even though they might be presenting with bodily symptoms, and that these conflicts are the result of previous traumatic experiences during which their sense of self was threatened, and where they had consequently experienced unpleasant emotions such as shame or guilt. He suggested that the memories of these events and the associated emotions were so unbearable that the hysterical patient would attempt to manage their discomfort by means of a process of active forgetting or 'repression' which would push the event and its related feelings and thoughts into their unconscious.

Freud (1926) understood repression as a psychological activity in which an individual endeavours to fend off thoughts or feeling which are connected to a biological instinct, and repel these into the unconscious. Repression is a form of defence which an individual may use in order to manage the situation that arises when there is a desire to satisfy an instinctual drive which takes the form of a wish (and which will be experienced as pleasurable) but which will at the same cause the individual intense unpleasure because of other (usually superego) psychic requirements. While repression is particularly manifest in hysteria, it is in fact a universal mental process and is what separates the unconscious domain from the rest of the psyche (Freud, 1926; Laplanche & Pontalis, 2006).

In summary, the Freudian understanding of the connection between psychopathology and repression can be described in the following way: A patient will experience an internal conflict in which they desire or wish for an object or experience. This desire often develops following a trauma in which they become aware that their wish is in fact not acceptable to themself. Freud did not use the word 'trauma' here in the usual way to mean an actual bodily or physical event, but rather as the experience of unacceptable thoughts and feelings (Freud, 1917a). An internal conflict develops between the part of the individual's psyche that desires that which is unacceptable and the part of the psyche which is appalled by the desire. In order to manage the conflict, the patient will repress the wish so that

the conscious part of their mind does not need to know about the desire (Freud, 1926). However, repression is imperfect and never completely holds the desire at bay. As Freud (Freud, 1915b) explains, this is because the contents of the unconscious are indestructible and have a tendency to re-emerge into consciousness if the instinctual pressure increases (e.g. in puberty) or if events in the present re-awaken the repressed material. Symptoms form when the repressed material returns (Freud, 1915b) and when the individual attempts to strike a compromise between those unacceptable id-driven ideas which were repressed and those super-ego ideas that prompted the repression (Freud, 1896). The symptom is this compromise made manifest and is a way for the patient to satisfy their desire while at the same time allowing themselves to believe that they are not doing so. In order to achieve the compromise, the symptom will satisfy the underlying wish in a disguised form which enables the patient to not consciously 'know' that they are in fact satisfying their unacceptable wish. This disguised, compromised version of the wish can never fully satisfy it and so the symptom is sustained as the patient repeats it over and over in order to achieve as much satisfaction as possible (Freud, 1915b).

Fundamental to the Freudian concept of symptoms is the understanding that the form that a symptom takes has an important, unique and personal meaning to the patient. The manifestation of the symptoms and its link to the repressed wish or original trauma is a symbolic one, and psychoanalytic treatment emphasises interpreting how the symptom relates to the patient's personal experience (Breuer & Freud, 1893). The original, repressed wish was originally formulated in language and was understandable to the patient consciously in language prior to the act of repression. It would not have been necessary to repress the wish unless the individual understood it on the level of the ego, and was ashamed of it via superego sanctions (Freud, 1915b). The unique symbolic meaning of a patient's symptom needs to be unravelled during the psychoanalytic treatment (Freud, 1893b).

Freud developed the psychoanalytic method as the treatment for hysterical symptoms and his treatment practice closely followed his theoretical understanding of the symptoms and their genesis. This treatment occurred through language and aimed to reveal the meaning of the form that the symptom took. The patient was asked to free associate (Freud, 1900a, 1900b) and in that way say whatever came to their mind, and the analyst's response took the form of interpretations which were intended to reverse and lift both the repression of the memories of the trauma

and the transformation of these and their related wishes into symptoms, and in that way bring these back into consciousness. In other words, the treatment aimed to make the meaning of the symptom mental. The free association of the patient reveals to the analyst what the symptom disguises, and the analyst then interprets that latent, disguised meaning back to the patient with the aim of identifying the repressed wish behind the symptom. The analyst's task is thus to decipher how the symptoms disguised the wish from the patient while at the same time fulfilling the very same wish (Freud, 1893b, 1900a, 1900b, 1905).

The psychoanalytic method therefore aims to aid the patient to develop an insight into the symptom and the meaning behind its form, which was once known and conscious but which has been repressed into the unconscious (Freud, 1905; Sirois, 2012). Once the patient has developed this insight they are able to work through the symptom, and through that process, overcome the resistance to the idea or wish which was originally so unpalatable to them and which they had needed to repress. The working through of a symptom frees the patient from the need to partially satisfy the wish by repeating the symptom (Freud, 1914).

The Freudian conceptualisations of the unconscious, repression, symptom formation and the meaning of symptoms are all very important themes which are referred to in this research. The connection between unconscious anxieties and physical symptoms also remains a central topic in the contemporary psychoanalytic understandings of bodily symptoms and underpins all the papers included in this thesis.

PSYCHOANALYSIS AND PSYCHOSOMA

Having reviewed some fundamental psychoanalytic psychopathology concepts and theories more generally, attention will now be turned to bodily symptoms in particular.

Current psychoanalytic thought continues to have a sustained interest in, and preoccupation with, questions around the body. This reflects the origins of psychoanalysis which was built on Freud's drive theory and work on hysteria.

Recent work in psychoanalysis concerned with the body includes, in particular, the field of neuropsychoanalysis which addresses the biological bases of mental life. It is a discipline interested in psychopathology and how that relates the functioning of the brain (see for example Kaplan-Solms & Solms, 2000).

There have also been advances in other areas of psychoanalysis which pay attention, in one form or another, to the physical body. These include concerns with sexuality and gender (Dimen, 2011a, 2011b), race (Dalal, 2006; Harris, 2011; Swartz, 2012) and questions of affect regulation (Schore, 2011, 2013). Further areas of psychoanalytic research which include a focus on the body are the work done on dissociation (Bromberg, 1996, 2001, 2003a, 2003b), the impact of trauma (see for example Benjamin, 2011, 2013) and the relational and intersubjective engagement with the physical body in psychoanalytic treatment (Aron, 1996, 1998).

However, as the focus of this study is on psychosoma in particular, an area which has not received as much attention of late, and the physical body that is of interest in this study is specifically the *symptomatic* body, literature which discusses the body more generally has not been included. There are points in the study where some of these ideas are included where appropriate, such as dissociation in the third paper and relational ideas in the final paper, but they are not covered in any great detail.

Of particular interest in this project is the manner in which the early understandings of physical symptoms with a psychological origin have been developed and how these theoretical advances implicate the treatment of these symptoms by means of the 'talking cure' and the interpretive nature of psychoanalytic practice.

THE FREUDIAN UNDERSTANDINGS OF PSYCHOSOMA

While Freud described various forms of hysteria, each having symptoms that manifest in different ways, he proposed that patients suffering from conversion hysterias in particular satisfied their unpalatable desires and wishes in indirect and disguised ways in the form of physical symptoms rather than psychological ones (Freud, 1893b). In other words, patients with hysterical conversions were suffering from an illness of the mind, but were presenting with symptoms of illness in their body. This early work in psychoanalysis therefore emphasised a strong link between the mind and the body. The concept of the link between body and mind has been very important for the ideas presented in this thesis, and is also an idea which was expanded on by later theorists working with the concept of mentalization – another key notion in this project which is discussed below.

Freud understood hysterical conversions in economic terms, and described how conversion symptoms develop when the libido is detached from an idea during

repression, and how this libidinal energy is consequently transformed into a somatic symptom (Freud, 1894b, 1909; Laplanche & Pontalis, 2006). The physical conversion symptom that develops during this process is the compromise formation which patients use to satisfy their unacceptable desires, while at the same time allowing themselves to believe that they were in fact not doing so (Freud, 1912d, 1917a).

As with all hysterical symptoms, the physical symptoms of a conversion hysteria have a particular meaning in that the symptom is an indirect and figurative representation of an unconscious idea, conflict or wish (Freud, 1893b, 1909, 1926; Laplanche & Pontalis, 2006). The implication of the physical symptom having an individual meaning is that the manner in which the symptom manifests (e.g. pain or anaesthesia) as well as the bodily location in which it presents, is not arbitrary but has a unique and specific meaning to the patient and their underlying conflict, and which is linked to the nature of the traumatic event and the associated repressed memories at the origin of the pathology.

The psychic meaning of the physical symptoms of hysterical conversions is related to the way in which the body is often mapped in the mode of language according to its external or functional form, and in that way the body can be understood to be 'signing' the mind (Breuer & Freud, 1893). The symbolic mapping of the mind onto the body is what allows for the symptoms to take a disguised form, but despite being hidden, the connection between the physical symptom and the traumatic experience will remain a close and symbolic one. Comprehending the concealed meaning behind the form in which the symptom manifests holds the key to unravelling the unconscious conflict behind the symptom (Freud, 1893b).

Freud differentiated between the physical presentations of patients with hysterical conversions from those with other psychosomatic symptoms. He identified an alternative set of symptoms which he defined as 'actual' neuroses and which he proposed included the intense physical symptoms that accompany or conceal fear such as paralysing attacks of anxiety. He hypothesised that actual neuroses are a direct outcome of absent or inadequate sexual satisfaction (Freud, 1894a) and he distinguished these from psychoneuroses in which the physical symptoms are symbolic, have meaning in their form and have their source in an original trauma. It was his view that the aetiology of the actual neurosis is somatic rather than psychical and that for this reason these symptoms of actual neuroses do not have a meaning that can be elucidated by means of psychoanalysis and the task of

interpretation that is central to it (Freud, 1905; Laplanche & Pontalis, 2006; Sirois, 2012). Since the physical sensations of the actual neuroses do not originate in the mind, the form that the symptom of an actual neurosis takes has no symbolic meaning (Freud, 1894a) and therefore interpretations about the symptom's form (which was fundamental to psychoanalytic practice) would not be therapeutically helpful. Freud concluded therefore that the physical symptoms of actual neuroses are beyond the scope of psychoanalysis (Freud, 1894a, 1912d).

This question which was first posed by Freud in his work with actual neuroses about which somatic ailments were and were not treatable by means of the psychoanalytic talking cure was picked up by theorists who followed Freud, and who worked in the area of 'psychosomatic illness'.

PSYCHOSOMA AFTER FREUD

As described in the previous section, during the earliest moments of psychoanalysis the understanding of psychopathology was fundamentally constituted at a bodily level. Freud's work with conversion had initially established an understanding of psychosoma that is predicated on the principle of the physical symptoms being the disguised expression of unfulfilled psychological wishes. Theorists working in the field of psychosoma after Freud expanded on this idea and proposed new understandings of psychosoma by focusing on different aspects of Freud's work and by following various theoretical trajectories. The first paper "The Sense of Bodily Symptoms" tracks the development of the concept of psychosoma in psychoanalysis in detail but a few important points are highlighted here.

Freud's work on conversion was expanded by theorists such as Rangel (1959), Engel (1968), Sperling (1973) and Fox (1959) who posed questions that Freud had not considered, such as what level of psychological development patients manifesting with conversion symptoms had achieved and whether or not internal organs could also be objects of conversion. These thinkers understood both conversions and actual neuroses differently from Freud and began to question his hypotheses about the close relationship between the form of the symptom and its specific unconscious, personal meaning. Their extension of Freud's ideas paved the way for the development of the theory and practice of another form of psychologically related physical symptom: psychosomatic illness.

Work concentrating specifically on psychosomatic illness was begun by theorists such as Sándor Ferenczi (1928), Felix Deutsch (1939), Georg Groddeck (1977), and Helen Flanders Dunbar (1938, 1943), and the development of this work is discussed in more detail in the paper in Chapter Five: "Psychosomatics Today". The particular elements of the theory of psychosomatic illness that are of particular interest to this research are the mechanisms at work that determine which type of physical symptoms an individual will present with, as well as the idea that in patients suffering from psychosomatic illness the functioning of the mind is bypassed and the illness is thus played out in the body instead.

This research explores two specific schools of thought about the origin, genesis and treatment of psychosomatic illness. The first of these is the well-established Paris School of Psychosomatics, and the second is an emerging school which is identified, named and argued for in the paper in Chapter Five: "Psychosomatics Today" and is named the 'Attachment approach' in this project. Both of these paradigms have foundations in, and are compatible with, Freudian understandings of metapsychology and psychopathology.

The theorisation of psychosomatic illness represented by the Paris School is based upon a biological understanding of the nature of the relationship between the body and mind. This approach appears to be an extension of Freud's concept of the actual neuroses since it is theorised that the form in which the physical symptoms manifest in a psychosomatic illness has no unique and specific meaning and does not need to be interpreted in treatment (Aisenstein, 2006; Aisenstein & Smadja, 2010).

I would make the argument that the French understanding of psychosomatic illness is still, however, fundamentally in accordance with Freudian metapsychological principles. This approach maintains the basic Freudian economic understandings in that it is concerned with the preservation and discharge of libidinal energy. However, the Paris School of Psychosomatics does not pay attention to the dynamic or topographical elements which are present in Freud's explication of hysteria i.e. it does not focus on different parts of the psyche setting up conflicting demands which need to then be managed by the ego by means of repression.

In contrast, the Attachment approach, which generally accepts the notion that there is a specific meaning behind the form in which the physical symptoms manifest, is closer to Freud's understanding of conversion hysteria than it is to that of the actual neuroses. It could be argued therefore that this school retains the Freudian

topographical principles in so far as there is an interest in the relationship between the psychic agencies and an understanding of how the unconscious works in opposition to the ego at the bidding of the superego, even if these ideas are phrased in different terms by the writers who form part of this approach.

Another useful theorisation of psychosomatic illness, but one which is not covered in detail in this project, comes from the more recent work on dissociation. With this work's specific focus on how trauma impacts affect regulation, it appears to have some common understandings with the French School's theoretical foundations concerning psychosoma and how an individual may hold the self and emotions in mind.

Bromberg's (1996) work on dissociation in particular, has proposed new ways of understanding hysteria and hysterical symptoms. Bromberg (1996) proposes that the human psyche is shaped by traumatic experiences, and that dissociation is a defence against these traumas, and in this is also a way to maintain personal continuity, coherence and integrity of the self. This view is based on the idea that one's early experience of the self originates in relatively unlinked self-states, each of which is coherent in its own right, and that the experience of a unitary self is an acquired, developmentally adaptive illusion. Dissociation as a defence becomes pathological when it begins to limit and foreclose on an individual's ability to hold and reflect on all the different states of mind that occur within a single experience. Bromberg (1996, 2001) concluded that although a hysteric may appear to be dramatising their feelings in what appears to be a performance or 'act', they are in fact telling the 'whole' truth of their dissociated reality.

It is Bromberg's (1996) view that when Freud wrote that pains might be determined either organically or by the memories of past psychic pains, that he was anticipating the work of later authors who suggest that, following trauma, a dissociative split occurs between the psyche and the soma which forces the body to store sensory experiences physically, and these are revealed as symptoms. In such a dissociation, the psyche is disconnected from the body in order to protect an individual's illusion of a unitary and cohered selfhood from an event which is potentially so threatening that it cannot be processed cognitively. Thus, dissociation can result in a form of psychosomatic illness, where the relationship between body and mind is disturbed, and then suffering is enacted rather than thought, understood or cognised.

As in both the Attachment approach and the French School, those working in the field of dissociation see the task of therapy as helping the patient to mentalize their physically suffering (Bromberg, 1996) and thereby develop the capacity to symbolise previously and unconscious mental states in oneself as well as in others.

Pierre Marty (1968), who was one of the founding members of the Paris School of Psychosomatics, coined the term 'mentalization' following his work with somatising patients during which he observed that these patients often show a lack of psychic representations and psychic processing, and presented as though their minds were empty. His theory of mentalization had its foundations in the Freudian principle that thought exists between the instinctual demands of the body and the actions taken to satisfy those bodily demands. Based on this Freudian foundation, Marty (1968) understood mentalization as a process of working mentally to interpret and respond to the body's demands. It is now generally accepted that the problem of psychosoma is related to a failure of the mental apparatus to work over or bind somatic excitations, and the result is that phenomena that are unmentalized remain unconscious and are expressed by the language of the body rather than the language of the mind (Gottlieb, 2013).

The term 'mentalization' is also used extensively in the area of attachment theory where it is conceived of as an interpersonal mental process in which an individual perceives and interprets their own and others' behaviour (Fonagy, et al., 2004). Attachment theorists place particular emphasis on early infancy and the caregiver's ability to foster in the child the capacity to endure and make sense of their affects and other internal states. Of particular importance here is the general understanding that mentalizing is dependent not only on resonance and imitation of the states of others, but also on the knowledge of one's own body. Indeed, most theorists working in the field of mentalization emphasise that mentalization begins in the body at the point when an individual begins to engage with, and understand, their drives and affects (Allen, et al., 2008; Fonagy, et al., 2004; Fonagy & Target, 2007). For an individual to be able to mentalize at a sophisticated level, they are required to recognise that not everyone shares the same desires, emotions, and thoughts that they do, and to be able to interpret and understand the similarities and differences between their own mental and bodily states and those of the other (Sletvold, 2012).

Despite the differences in the understandings of the origins of mentalization, the concept is now commonly used in contemporary psychoanalysis to denote the process of understanding and giving meaning to affects and experiences which were previously outside of the language of the mind. Mentalization is therefore the mind's attempt to grapple with, organise, modify and bind all energies that it is confronted with (Gottlieb, 2013).

Mentalization is one of the uniting concepts that runs through the four papers of this thesis and is explored thoroughly at various points. A model of levels of mentalization based on Freudian topographics is discussed in depth in the paper "The Sense of Bodily Symptoms", and the second paper "Psychosomatic Today" then tracks the genesis of mentalization according to the two different schools of thought of psychosomatic illness described above. Both papers make the point that should the ability to mentalize be compromised, it is likely that higher order mental processes might also fail and psychosomatic processes may thus develop. Further, it is argued that the level of mentalization achieved by a patient will influence the form of the psychopathological symptom, and nature of the therapeutic task.

Various definitions of the concept are discussed in the papers "A Sense of Bodily Symptoms" and "Psychosomatics Today", but in this project the term is specifically understood as the process of verbalising and/or making meaning of somatic experiences in particular so that they might move from the body and enter into the realm of the mental. The process of mentalization therefore aids an individual to achieve control over intense affects, particularly those of a bodily origin. The idea has its roots in Freud's concepts of binding, linking and other secondary processes where there is an emphasis on building connections between instinctual or bodily drives and mental processes (Freud, 1915c). In other words the act of mentalization moves that which begins in the body, or which manifests in bodily terms, back to the mind. This understanding of the concept of mentalization highlights the intimate connection between the diagnostic and clinical aspects of the treatment of physical symptoms in psychoanalytic practice.

PSYCHOANALYTIC PRACTICE

A previous section highlighted how the theory of psychoanalytic psychopathology, and in particular symptom formation, is intimately connected with the psychoanalytic task as a whole i.e. the interpretation of that which is repressed based on the understanding that symptoms are manifestations of unconscious

material. Consequently the psychoanalytic method or 'talking cure' aims to make the unconscious conscious through the use of free association and interpretation.

There are further aspects of psychoanalytic practice which are referred to, and made extensive use of, in this research project and which are therefore introduced here.

The psychoanalytic method aims to make repressed, unconscious material mental, thereby bringing it into language and giving it meaning. In this thesis this is conceived of as the analyst facilitating the process of 'mentalization' based on the assumption that symptoms (especially physical ones) may be psychic objects which are not yet in the realm of the mental. In psychoanalysis, speech is used as both the bearer of messages and the tool which performs the therapeutic task. An interpretation which is mutative gives evidence to the analyst's witnessing of the analysand as well as capturing the patient's state of mind in words and giving it a functional meaning (Sirois, 2012). It is speech then, which enables symbolization and mentalization in psychoanalysis.

In order to provide a setting in which effective interpretations can be made, the prerequisite for a successful psychoanalytic treatment is related to an adherence to the psychoanalytic frame and the attendant roles of analyst and analysand. The term 'analytic frame' refers to the place and time at which therapy occurs. This is consistent and unchanging with the sessions beginning and ending on time and for which the analysand pays an agreed upon, set fee. The purpose of the analytic frame is to create an environment which will encourage the development of the transference (Freud, 1917a).

The requirement of the patient within the analytic setting is that they submit to the 'fundamental rule' (Freud, 1910b) of psychoanalysis and reveal the contents of their free associations spontaneously. This method was designed to reveal unconscious aspects of the patient's psyche which are then interpreted by the analyst.

The equivalent and counterbalancing requirement of the analyst is that she engages in the therapy from a position of analytic neutrality which means that she should be neutral in terms of religious, ethical and social values and must not direct the treatment according to any of her own ideals. It was Freud's (1913) view that the establishment of a successful transference was dependent on this analytic neutrality and, further, that the most important aspect which the analyst must be

neutral is in regards to the form that the transference takes (Aragno, 2008; Laplanche & Pontalis, 2006; Renik, 2007). Analytic neutrality is an important concept in the paper presented in Chapter Seven: “Re-Embodying the Analyst”.

Closely associated with the idea of analytic neutrality is the psychoanalytic concept of ‘evenly suspended attention’ (Freud, 1900a, 1900b). This is the manner in which the analyst should listen to the analysand’s material and requires that the analyst should not pay particular attention to specific parts of the patient’s discourse, or read particular meanings into it. She should, instead, allow her own unconscious to operate freely and suspend the motives which would usually direct her attention. This way of listening to the patient is the complement of the rule of free association. Freud suggested that making use of this way of listening allows the analyst to discover unconscious connections in the patient’s material, and his goal in suggesting its use appeared to be direct communication between the unconscious of the patient and the unconscious of the analyst (Bollas, 2001; Freud, 1923c; Laplanche & Pontalis, 2006).

The concept of evenly suspended attention was expanded by Bion (1962) who suggested the idea of analytic ‘reverie’. This idea was then further elucidated by Ogden (1994b, 1997a, 1997b, 2004a), and in this more modern conceptualisation of reverie, emphasis is placed on a more active engagement with the contents of the analyst’s mind and, importantly for this thesis, also includes a focus on somatic responses. While the analyst’s reverie is broadly a part of the literature on technique, I am proposing that it is also an instrument of mentalization. In other words, reverie is the instrument and mentalization is the outcome. These ideas are explored in detail below, as well as in the in the paper in Chapter Six: “Craving Interpretation: A Case of Somatic Countertransference”.

The notions of free association and evenly suspended attention are particularly important in this project as they underpin the interpretive work required to move somatic experiences into the domain of the mental and thus give them meaning. This is the beginning of the process of mentalization, which is a crucial integrating theme in this research and which makes it possible to apply psychoanalytic principles to somatic experiences and in this way hold the body in mind. Remembering that an important aim of this research project is to draw attention to the fact that there are *two* people (and thus two bodies) in the therapy room during a treatment, the thesis seeks to mind both of these bodies.

Contemporary object relations literature and its focus on countertransference has already done significant work in bringing awareness to the presence of the figure of the analyst in the room. Much of this literature prefigures what is now known as the intersubjective paradigm. Intersubjective ideas have always been implicit in psychoanalysis, but the term 'intersubjectivity' was introduced to the psychoanalytic lexicon by Jacques Lacan in 1953. It was, however, only introduced to American psychoanalysis in 1978 by Robert Stolorow (Schwartz, 2012). The roots of explicit intersubjective thought can be found in the expansion of the understanding and use of countertransference by Kleinian theorists. Research on the development of infants and the observation that communication between mothers and infants is bi-directional also focused on and expanded ideas about the important effects of interpersonal interaction. This work has been assisted and facilitated by work done by attachment theorists such as Fonagy on the process of mentalization (Schwartz, 2012).

The emphasis of this research is on the therapeutic dyad but *not* the intersubjective exchange as it is in the established intersubjective paradigm. In this study the term 'intersubjectivity' is used in the descriptive or interpersonal sense rather than to mean the method of practice or school of thought it has come to denote in which the patient is no longer the only object of observation, and instead the co-created occurrences in the here-and-now become the focus of the therapeutic exchange. This research's focus remains on the more classical elements of the exchange and on the transference-countertransference dynamics.

The position on the nature of the dyadic exchange taken in this research most closely resembles that of Christopher Bollas (2001) who suggests that Freud offered his clearest explication of the psychoanalytic method when he stated that psychoanalysis took place when the two functions of the analysand's free associations and the psychoanalyst's evenly suspended attentiveness were linked (1923c). Bollas terms this level of interaction the "Freudian Pair" (2001), and goes on to explain that the Freudian analyst's presence is not without influence or contribution, but does afford an energy and influence which simultaneously actively assists the analysand to explore their mind and its internal objects while at the same time allowing them to do so freely.

It is Bollas's view that in the Freudian Pair the mutative aspects of the interpersonal interaction are located in the transference-countertransference dynamics and how these are both formed and transformed by the patient and the psychoanalyst in

turn. He emphasises not only the importance of what each member of the Freudian pair says, but also the manner in which it is said, and concludes that Freud's vision was to create an environment which encouraged and interpreted unconscious communication (Bollas, 2001). The particular form of unconscious communication that is of interest in this thesis is somatic communication originating in either the body of the patient or the body of the therapist.

Throughout the history and development of psychoanalysis there has been a tension around whether focus should be placed on the internal or the external, on the drive or the object, on the intrapsychic or on the therapeutic relationship (Schwartz, 2012). Writers such as Ogden (1994a) with his concept of the analytic third, have highlighted the importance of maintaining the patient's psyche as an integral part of the work (Schwartz, 2012). Ogden conceived of the analytic third as being formed by the transference-countertransference relationship of an analysis. It is a space which is created by the unique combination of the two members of the therapeutic dyad. Importantly for this research, Ogden was of the opinion that it can only be accessed through the analyst's reverie or physical sensations. In Reis's (1999) paper about Ogden's theoretical development, he links Ogden's work with that of the philosopher Merleau-Ponty, as they both suggest that the individual begins in an interpersonal world and then develops an individual subjectivity. Both these theorists pay particular attention to the idea that this original subjectivity is seated in the body rather than the mind. These ideas highlight the importance of paying attention to the body and the information it holds, and are at the heart of this study.

In order to make use of what bodily communications are revealed through the interpersonal interaction, Ogden expanded on Bion's (1962) concept of reverie and explained that reverie occurs when the analyst becomes aware of the other (i.e. the patient). Ogden's reverie takes the form of "a motley collection of psychological states that seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, daydreaming, sexual fantasying, and so on" (Ogden, 1994b, p. 74). In his clinical work, Ogden (1994b) attends to what are at times barely perceptible experiences in both mind and body to access a level of functioning he calls "being-in-sensation" (p. 174). In Ogden's view, the analyst's reverie represents unthought and unfelt experiences of the patient which are sensation-based but which eventually take form in the space between the patient and the analyst, or what he called the 'analytic third' (Reis, 1999). This thesis locates itself clinically in the space of the analytic third and with those unthought experiences (especially those

of the body) and has the objective of exploring, interpreting and eventually revealing their meaning.

In order to interpret those unthought experiences, Bollas (1987) suggests that the analyst should remain with her countertransference for extended periods before it can be properly processed and the unconscious communications within it made sense of. He is opposed to the analyst reporting their undigested experiences to the patient (Gerhardt & Sweetnam, 2001) which is in accordance with Ogden's (1997a, 1997b, 1999, 2004a, 2004b) suggestion that analysts should first engage with and interpret their reverie before bringing any of the contents thereof into the therapy. In this study I argue that while attending to any intersubjective aspects which might arise is fundamental, these do also raise the key issue of the extent to which the therapist's understanding of the multiple dimensions of the practice of psychoanalysis require that these understandings should be shared by the analyst with the patient and in that way made explicit.

This issue of the extent and nature of the patient's involvement in the interpretive process has emerged since the beginning of psychoanalysis, since Freud first proposed that the best interpretation is enabled by the therapist but made by the patient (Freud, 1914). The ideas are linked to questions of how to interpret a countertransference response and what of it should be revealed to the patient, and are explored further in the paper entitled "Craving Interpretation: A Case of Somatic Countertransference".

PSYCHOANALYTIC PRACTICE AND MINDING THE BODY

It is argued here that fundamental to, and providing the coherence between, the two parts of the thesis as a whole (i.e. the first concerned with the body of the patient and the second concerned with the body of the analyst) are, at the most basic level, the contemporary contributions made by two particular bodies of literature: the literature on countertransference, and the literature on mentalization. Changes in the understanding of the notion of countertransference and an increased emphasis on the role of mentalization have had practical consequences for psychoanalytic practice, and particularly on the central topic of this research: minding the body.

COUNTERTRANSFERENCE: CONCEPTUAL CHANGES

Gabbard (1995) proposed that a point of commonality and convergence between different paradigms in contemporary psychoanalytic thought has emerged through the understanding of the concept of countertransference.

A quote by Ogden (1994b) clearly expresses the now widely accepted interconnectivity of the analyst and the analysand, an idea that underpins this study:

> "There is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand." (p. 63)

Ogden's quote emphasises how the pair are inextricably linked in every way. While the particular focus here is on the *bodies* of the two players in the psychoanalytic relationship, the important point for the work here is that the intrapsychic and interpersonal aspects are equally important in an analysis.

Contemporary writings on countertransference bring the presence of analyst firmly into the room, and the analyst is no longer the *tabula rasa* of old. This demonstrates how the understanding and use of the term 'countertransference' has changed significantly since it was first introduced by Freud in 1910 to denote the analyst's *transference* to the patient's *transference*, originating in the analyst's own unconscious material, and therefore as an obstacle which analysts must work to overcome (Freud, 1910b).

Following the work of theorists including Winnicott (1958), Little (1951), Racker (1957, 1968) and Heimann (1950) the countertransference is now seen as a tool which can be used to gain a better understanding of the patient (Epstein & Feiner, 1979; Zachrisson, 2009).

I propose that yet another shift can be seen in the concept of countertransference in that the more contemporary intersubjective view of countertransference does not look for the origin of a countertransference in either the therapist or the patient alone, but instead understands that it is the unique material that develops in that particular therapeutic dyad which results in the specific countertransference manifestation. Gabbard explains the intersubjective understanding of countertransference by suggesting that the patient draws the therapist into playing a role that reflects the patient's internal world, but that the specific dimensions of

that role are coloured by the therapist's own personality and life history (Gabbard, 1995, 2001).

Gabbard (1995) further describes the interplay between the analytic couple as the analyst being pulled into the patient's world through a succession of enactments which serve to displace the analyst from the blank screen aimed for in traditional psychoanalysis. During these enactments the patient arouses particular responses in the analyst, while the analyst's own psychic constitution determines how that countertransference response will eventually manifest.

Ogden (1992) sees this interplay slightly differently by saying that the dialectic created by the patient and analyst entering into a relationship is one in which they are at the same time separate while also being 'at one' with each other. What these ideas have in common is that they emphasise that the results of a psychoanalytic psychotherapy are a product of the two individuals which constitute the analytic pair and the work that they do together in making sense of and mentalizing the unconscious material that arises.

It can be argued that countertransference's new status is a precondition for an enquiry into psychoanalytic practice and into psychosoma in particular. These changes and developments in the concept of countertransference are important for this study in two ways. The first of these is that they bring the analyst firmly into the room and pose questions about the relatively different roles of the participants of the dyad. This move opens the door for a focus on the physicality of the analyst which is the object of attention in the second half of the study. The second important point is that these new understandings implicate practice (Swartz, 2000) and these implications are also explored in the second two papers – "Craving Interpretation: A Case of Somatic Countertransference" and "Re-Embodying the Analyst".

MENTALIZATION IN PSYCHOANALYTIC PRACTICE

An important way in which the mentalization literature plays an integrative and linking role here is that it unites psychopathology to the practice of psychotherapy and underscores that the therapist's role is to assist the patient to mentalize when those things represented by the patient's body are still unavailable to the patient's mind.

In practice, what it means to help a patient to mentalize is, amongst other things, to put them in a new relation to that which is of the body. To make something 'mental'

is to make something conscious, and to make something conscious is to make it meaningful. If the psychic material remains unmentalized it cannot be processed and made sense of and may therefore manifest in symptomatic ways (Gottlieb, 2013). There is an element of the body-to-mind relationship which is fundamental to being human, and mentalization is thus a phenomenon which has a metapsychological status, an implication for pathology, and an implication for cure. This view is consistent with the founding principles of psychoanalysis which state that once something is brought into the realm of the mental and given meaning it can be processed and worked through, and in that way its pathological grip is loosened. An important question which is raised by this study is how an enquiry into the body in psychoanalysis raises debates about mentalization. The response is that mentalization allows individuals to verbalise and express those things which are not yet mental such as unconscious material, affects and bodily experience, and in doing so move the experiences from the arena of the unconscious to the sphere of the conscious, and should therefore be a goal of treatment (Swartz, 2000). As explained previously, in individuals with poorly mentalized structures it is likely that one might see a meaningless discharge of psychic energy in the form of senseless actions or into the somatic field rather than into thought. This idea is discussed further in the paper “Psychosomatics Today” which describes two specific understandings of psychosoma and how these are related to different conceptualisations of mentalization.

This project aims to extend the clinical use of the concept of mentalization by proposing the idea that somatic phenomena as experienced by the analyst, and the role and presence of his or her body in the therapeutic endeavour, could also be understood in terms of mentalization, and to argue that the process of mentalization should also be applied by the analyst to him- or herself. The approach argued for in this study opens up the capacity for the analyst to think about, and through, their own body as seen by the patient. By applying an understanding of the original principles of psychosoma and relating these to the interpretation of somatic countertransference, an analyst may be able to develop a deeper understanding of the transference-countertransference dynamics of the dyad. This idea is then further developed when it is proposed that the analyst should think about their own body not only as an object of their own free-floating attention or reverie, but also as a potential object of meaning making and transferential sense-making in the eyes of the patient as suggested in the paper “Re-embodying the Analyst”.

CHAPTER 3: RESEARCH METHODOLOGY AND ETHICAL CONSIDERATIONS

RESEARCH METHODS

This research project makes use of qualitative research methods and is broadly located within the critical, interpretive tradition in combination with clinically based material.

Qualitative research focuses on and interprets human and social experiences and processes, and is particularly interested in how meaning is made of these. This broad research approach usually investigates experiences and processes in their natural settings (as opposed to experimental ones), and this may mean that the researcher plays a role in shaping the research - a role that is acknowledged in research practice (Edwards, 2007). The kind of material that is obtained in qualitative research is gathered with the aim of *understanding* the subject matter in a complex, nuanced and rich manner and generally does not report on trends or statistics. Qualitative research data may hold multiple, and perhaps even contradictory, meanings and these are commonly seen to add to the depth and richness of the material rather than rendering it meaningless (Kelly, 1999; Mertens, 2005). It is commonly acknowledged that there are problems with the generalisability of qualitative research in general, but it is equally important to state that generalisable results are not an aim of qualitative research (Darlington & Scott, 2002), but instead there is an interest in what a particular phenomenon might reveal about both itself and something wider than itself. In response to the criticism that qualitative research methods lack objectivity and generalisability (Willig & Stainton-Rogers, 2008), the point is made that this particular qualitative research study aims to investigate specific cases in an in-depth manner rather than the general population, and to understand each particular and unique case through psychoanalytic theory.

Three of the study's four published papers were developed out of research methods which draw on aspects of the case study method and were based on material derived from psychoanalytic clinical practice. The specific clinical material included in the study was chosen as it served to illustrate the points being made about clinical practice. This is in accordance with the psychoanalytic tradition, which is distinct from other kinds of qualitative analyses seen in the social

sciences, such as narrative or discourse analysis. The fourth paper took the form of theoretical research in the psychoanalytic tradition.

The clinical material that was used to ground and illustrate this research was selected in order to reinforce and provide evidence for the overall argument or point of view. A distinctive feature of practice-based clinical research relates to the fact that the data itself is not generated for research purposes, but is instead mined, investigated and selected in the interests of providing material which reflects on both theory and practice. This is in line with the longstanding psychoanalytic tradition (Greenwood & Loewenthal, 2005; Hinshelwood, 2010; Midgley, 2006).

In the case of research that makes use of clinical material such as in this project, the 'epistemological' and the ethical are intimately connected, in that the pressing ethical demands of confidentiality and protecting of the patient may require that the data be presented in a way which may raise epistemological concerns. Psychoanalytic practice places the ethical treatment of clinical material at the centre of practice, and it therefore follows that research in the psychoanalytic tradition would do the same. The manner in which the clinical material was selected, interpreted, disguised and presented as well as the researcher reflecting on her own clinical practice and the extent to which the clinical material colleagues was made use of, all reflect an emphasis on ethics and confidentiality. This first section describes how these ethical questions were integrated with the research methods used. A section is included below, addressing further ethical concerns.

As is customary in research of this kind, the project draws on a number of research instruments. Since most of the data was derived from psychoanalytic clinical practice and is in the form of clinical material from the treatment of particular patients, the methodology used here is what would be referred to by writers in the field of qualitative methods as clinical case study research.

THE USE OF CLINICAL CASE MATERIAL

Case study methodology is a specific form of qualitative research design that examines cases as they occur naturally (Edwards, 2007). Case studies are in-depth, usually long-term, examinations of a single instance phenomena and are typically used for descriptive purposes (Whitley, 2002). Case study research generally makes use of relatively few cases, instances or subjects, but explores each of these in a very detailed manner (Yin, 1993), using qualitative methods to

analyse the data with the aim of maintaining the holistic and meaningful character of the real-life information (Mertens, 2005). This methodology does not aim to prove or disprove hypotheses, but the rich and in-depth data is rather used to test theories, or to make new discoveries (Bromley, 1986). In this research methodology, it is precisely the uniqueness of the data rather than its generalisibility that is of interest (Mertens, 2005). A researcher may choose to make use of the case study method when they are interested in studying a particular phenomenon in context, and based on the understanding that a well-motivated choice of example may also reveal information about the class of phenomenon to which the example belongs (Bromley, 1986; George & Bennett, 2005; Midgley, 2006; Yin, 1993).

Research using case studies is considered an appropriate method of inquiry within the social sciences as it allows the researcher to understand rather than control the material, and is the research method best suited to investigating particularly complex social and psychological phenomena (Hancock & Algozzine, 2006; Whitley, 2002). The use of case material was selected as a research method for this study as it is the method that reflects most closely how the material presented occurred in the therapeutic setting and in line with Yin's (1993) assertion that this form of research is the method of choice when it is not possible to distinguish the phenomenon being studied from its context. The information gathered was interpreted within existing psychoanalytic theory and conclusions were drawn about how what was observed relates to that theory, with a focus on the material and theory related to the particular aims of the study.

Clinical case studies in particular, have been used to explore particular therapeutic processes in any of a number of clinical settings outside of medicine, such as their wide use in the development of psychoanalytic theory and clinical psychology practice (Bromley, 1986). Although this research method has been criticised for not being sufficiently 'scientific', it is still the basic unit of applied psychological practice and is the best bridge of the gap between theory and practice in certain areas of clinical psychology especially, as it is in the therapeutic setting that these two mutually influencing aspects come together (Edwards, 2007). Each therapeutic dyad could in fact be thought of as representing an experiment where hypotheses are continually tested. Describing cases echoes the in-session process of hypothesis testing and allows for greater rigour and care in elaborating and exploring such clinical hypotheses.

Since the time of Freud who generated his psychoanalytic theories from what he observed during clinical practice (Greenwood & Loewenthal, 2005; Midgley, 2006), clinical case studies have been the main method of presenting, discussing and exploring psychoanalytic clinical material in particular. This research method contributed to Freud's ground-breaking discoveries of the unconscious and the Oedipus complex (Bromley, 1986), and continues to be used widely by psychoanalysts. Psychoanalytic knowledge has evolved to a large extent through the development of a meta-theory predicated largely on the practice of examining case studies, as this method allows for both depth and specificity. Consequently psychoanalytic clinical case studies have historically been employed to cast light on diagnostic and psychopathological phenomena and to enrich both theory and technique (Bromley, 1986).

A psychoanalytic clinical case study highlights the interaction between the clinical view (i.e. what happens in the room), and the theory of what people do, think and feel. The psychoanalytic account of a case must fit with the accepted theory and practice of psychoanalysis. Examining a single case can thus help a therapist to think through other cases, as well as to develop both clinical and conceptual understandings of specific psychoanalytic phenomena. These observations and thoughts can then be applied more widely in psychoanalytic clinical practice (Eells, 2007). The case study method does not attempt to identify causal relationships, but is rather used to explore therapeutic practice using reflection and observation, identifying themes and patterns, and in this way develops theory and practice (Edwards, 2007). Psychoanalytic case studies aim to understand the meaning of the described phenomena rather than determining their cause (Edelson, 1985).

A psychoanalytic case study usually includes relevant patient history and may include some session material (Bromley, 1986). It pays specific attention to unconscious communication as well as to the role of the transference and countertransference, and through the examination of these elements, inferences are drawn about the dynamics of the case and therapeutic work. A psychoanalytic psychotherapist plays a significant role in the generation and analysis of therapeutic data, and therefore in psychoanalytic research it is important that this role is processed and understood appropriately. This type of self-reflexivity is part of the fabric of psychoanalysis, and a therapist's countertransference is in fact a fundamental tool. This research study was extremely cognisant of the role played by the therapist, and this is borne out by the dedication of an entire chapter to the

subject (Chapter Six: The Therapist's Physical Response to the Patient), as well as the focus throughout the project on the interactions of the therapeutic dyad.

Since its inception, psychoanalysis has received criticism for not reaching the requirements identified by Popper (1959) of a scientific epistemology and for therefore being unfalsifiable and unscientific. The practice of psychoanalytic data collection has also been criticised for being so tied to theory that it renders the data unable to prove or disprove theory (Miliora & Ulman, 1996).

Traditionally psychoanalytic research has made use of the clinical case study method (Greenwood & Loewenthal, 2005). However, in response to criticisms of this kind, there is currently much debate in the psychoanalytic literature regarding the type of research method that is most suitable for the examination of psychoanalytic hypotheses. There are two main methods proposed as best suited to researching psychoanalytic concepts. The first of these is the traditional case study (as introduced by Freud) which focuses on meaning, interpretation, and narration of phenomena arising in the treatment room. The second is a standpoint more interested in 'hard facts' and statististical statements, and which makes use of experimental and quasi-experimental methods (Luyten, Blatt, & Corveleyn, 2006).

In recent years psychoanalytic theories and concepts have been increasingly tested using empirical studies. These have shown not only that the quasi-experimental study of psychoanalytic hypotheses is possible, but that there is also solid evidence which supports many psychoanalytic assumptions (Luyten, et al., 2006). However, it is often suggested that creative psychoanalytic thought arises primarily through the analyst-patient interaction in the traditional psychoanalytic session, and the case method of presenting these ideas continues to play an important role in theory-building (Luyten, et al., 2006).

In addition to a debate about the most appropriate research methodology, the focus of psychoanalytic research and theory-building has also experienced a shift in focus over the years. Even though Freud (1912d, 1917a) stressed that symptoms are overdetermined, psychoanalysis initially followed a model which emphasised cause and effect in the development of symptoms (Chrzanowski, 1987). It is often argues that contemporary psychoanalysis no longer follows such a model, but instead refocuses on the crucial role of the overdetermination of symptoms and underscores a complex interaction between the causations, motive

and meaning of symptoms, with a particular emphasis on meaning (Gabbard, 2007).

The empirical data used in this study have much in common with the psychoanalytic case study as outlined above, however it is important to point out that none of the published papers are based on a sustained case study in the traditional form, but are rather in the form of clinical case vignettes which are shorter versions of a clinical case studies.

A clinical case vignette is a very brief case report which is used to illustrate the type of case being referred to, and describes just the kernel of the case (Bromley, 1986). Clinical case vignettes do not usually include a detailed history of the subject, and neither do they include word-for-word case material or a sustained account of the unfolding of a treatment. This methodology was selected for this project for ethical reasons and in order to protect the patient's confidentiality as less intimate, personal material is revealed in vignettes than in full case studies. The clinical material in the form of vignettes was used to explore and examine how the two bodies in the therapeutic room express, reinforce, and communicate the interactive dynamics at work in any particular psychoanalytic psychotherapy. It was intended to contribute to an understanding of these phenomena in such a way that a more general appreciation of this aspect of clinical presentation and communication in psychoanalytic psychotherapy could be developed. More specifically, the research was conducted on the assumption that learning something about how the body is used by a particular patient might lead to a deeper psychoanalytic understanding of how it is used more generally in psychopathology and in psychotherapy.

THE USE OF THE CLINICAL MATERIAL OF COLLEAGUES

Unlike traditional case material research, this research project takes the form of a combination of material based on the researcher's own clinical practice as well as that of other clinicians. There were two reasons why this research required the interviewing of other clinicians. The first was to source more clinical data on the topics under discussion and to gain an understanding of how this material was being worked with and understood by other professionals and in that way checking and validating the ideas being put forward. The second reason was to create an extra layer of anonymity over the sensitive case material in order to protect the identity of patients even further and thus to maintain ethical standards. This technique provides another layer of separation between the researcher and the

patient in question. The identities of these patients were not revealed to the researcher by the treating clinician, and the use of 'thick disguise' (Gabbard, 2000) was also used. This was done in conjunction with the treating therapist to ensure that any disguise used did not distort the nature of the case.

The data from the other clinicians was derived from something approximating a face-to-face 'expert interview' but more precisely resembling an interview-like discussion conducted with a single professional in a collegial structure. The primary emphasis here was to explore clinical material and practice-based data.

THE USE OF EXPERT INTERVIEWS / DISCUSSIONS

Interviews as a research method allow a researcher to collect data, explore that data with the interviewee and also to determine the acceptability of the research (Whitley, 2002) all at the same time. The advantages of using interviews to collect data is that the immediacy and relational quality of the process creates significant flexibility both in terms of areas explored and the theoretical direction that the data collection takes (Darlington & Scott, 2002). Interviewing experts also allows the researcher to check some of her hypotheses and conclusions and in that way validate the empirical data to some extent. The use of interview-based data collection allows the researcher to get a wide range and depth of material. It also allows for a relationship between the researcher and the participant to develop that supports data collection (Mertens, 2005).

In this project, the other clinicians interviewed were five psychoanalytic psychotherapists in good standing and with many years of experience. They were all engaged in academic activities and work in private psychoanalytic psychotherapy practice.

DATA COLLECTION METHODS

The data collection of the clinical material used in this study occurred in two steps: Firstly the particular cases to be examined were selected, and secondly the material from within each of those cases that was relevant for the study was decided upon.

CASE SELECTION

The case material selected for the research was from patients who presented for psychoanalytic psychotherapy treatment to the researcher's or her colleagues' private practices. The selection of cases was classically purposive (Fossey,

Harvey, McDermott, & Davidson, 2002) in that it was chosen from a range of clinical work on the grounds of its relevance and appropriateness to the research topic and was illustrative of what the research was trying to argue. Specifically, clinical material that paid particular attention to, reflected upon and appropriately provided greater insight into both the understanding of, and clinical practice associated with, symptomatology related to the body was drawn on. Cases were selected if they raised questions, were of interest to, or were related to, questions around bodily symptoms in clinical practice, be they those of the patient or the therapist, even if the material had not yet been completely interpreted and understood.

The selection of the clinical case material was an area where ethics and epistemology were closely intertwined. Ethical issues were borne in mind throughout the process of choosing case material which was relevant to the research topic: Material was chosen from patients who were ethically eligible in terms of age and stage of therapy and only singular moments or very small parts of the treatment were used.

All the participants in the study were over the age of eighteen years, and no patients who were currently in therapy with myself or my colleagues were approached to be in the study. This decision was made based on the knowledge that such a request may contaminate the therapy, which was something that I was determined to avoid. One patient who had terminated therapy but who remained in touch with me as she made the transition to life in another country was approached, and the project was explained to her. She perused and considered the information contained in the Information and Consent form (See Appendix 1), and then agreed to participate in the study. It is her case material that is discussed in the paper in Chapter Six: “Craving Interpretation: A Case of Somatic Countertransference”.

Patients who were identified as being appropriate for the study but whose therapy had been terminated were not contacted as it is well known that this might be harmful and distressing, especially since they no longer have the space to process the feelings that such a request might provoke. (See the Ethical Considerations section below for further details). Case material was therefore only used from patients who had terminated therapy more than six years previously.

When using the clinical material of the other five psychoanalytic psychotherapists, the aims of the study were outlined to them, and the clinicians were then asked if

any of their cases (which met the ethical criteria describe above) came to mind. If so, semi-structured interviews were used to collect data pertaining to research questions. Careful notes were taken during the interviews.

Once the cases were sampled in the method just described, the material within each case was sampled so as to select the most relevant patient-therapist interactions.

SELECTION OF CASE VIGNETTE DATA

In the clinical case study research method, the researcher is the instrument for collection of the data (Mertens, 2005) and this remains true in this project. The clinical material used for the study was the recollections and clinical observations of the therapist and her colleagues, as well as the case notes that were kept during the therapy. These notes were made within twenty-four hours of each therapy session and were between one and two typed pages in length. These notes included information such as:

- the verbal content of the session as verbatim as possible
- observations that were made about the patient's presentation, tone of voice, emotional state
- observations about the patient's physical behaviour in the session
- any of the therapist's relevant thoughts, reflections or fantasies
- countertransferential responses (both physical and psychological).

During the process of therapy, the therapist alternates between being thoroughly immersed in a session, and having a more distanced view while reflecting on the material and thinking their own thoughts. This process is added to when the session notes are written up, and the therapy session thought about and processed at a more abstracted level.

Patient material of the researcher's own cases was discussed in clinical supervision which allowed for a 'third eye' to help to evaluate the more difficult aspects of the countertransference. In the case of the vignettes of the researcher's colleague's patients, it was the discussion with both their own supervisors and the researcher herself which allowed for this evaluative process to occur. Notes that were generated by the researcher during supervision sessions incorporated the supervisors' thoughts on how to formulate the case, her theoretical understanding of the case, as well as any transferential or countertransferential enactments that

she observed might be occurring and these were included as part of the 'data' for the research.

There have been suggestions that the most accurate way to collect data is through audio or video recording, but the negative therapeutic effects of this are well documented (Lincoln & Guba, 1985; Stajner-Popvic, 2001; Tuckett, 1993), and for this reason, no recording of therapy sessions was undertaken. While it could be argued that recordings would have produced more data than the therapist's recollections, it is extremely likely that it would have contaminated the therapeutic process. Data collection was therefore restricted to case and process notes.

From these notes, only specific moments were chosen to be included in the research. From the methodological point of view, these moments were selected as they were illustrative of a point under discussion or an argument being made, but this form of data selection also has an ethical dimension, in that small moments from an entire therapy do not reveal too much about the individual patient involved. This protects the patients' identity and ensures that they will not be recognised by anyone who may know them. This technique will also further reduce any potential harm to the patient in the unlikely event of them reading the papers. In fact, due to the use of the method of 'thick disguise' (Gabbard, 2000) discussed below, it is likely that many of the patients may not even recognise themselves, especially where the focus of the research is on the therapist's response to the patient, and this will mitigate against them feeling exposed.

The clinical data extracted in this way became the object of the research process and was then analysed and interpreted.

DATA ANALYSIS AND INTERPRETATION

As stated above, the clinical material investigated in the study was analysed and interpreted within a psychoanalytic framework. This paradigm explores unconscious dynamics, anxieties and conflicts as they are demonstrated in the therapy room by observing what is manifested in the patient's verbal material, behaviour, appearance and physical presentation as well as the therapist's psychological and physical responses to the patient's communications (Lemma, 2003).

In my primary role as therapist, I was initially and continuously analysing the data as it manifested in the therapy room using psychoanalytic principles. In a

psychoanalytic treatment everything the patient does in their world is understood to have a (usually unconscious) meaning, so even while the data was being gathered, due to the very nature of the psychoanalytic technique, meaning was looked for in the patient's affect and levels of arousal, verbal material that was included or excluded by the patient, the nature of the interaction between the therapist and patient, any observed shifts in countertransference or transference, the effect of psychoanalytic clinical interpretations on the patient and any relevant observable behaviours or physical presentations (Rustin, 2003).

This case material was then analysed using a number of different theories which were relevant to the overarching aims of the study, including classical Freudian drive theory, the object relations theory of both the Kleinian and Independent schools, as well as more contemporary attachment theories. This is part of common practice due to the fact that psychoanalytically informed clinicians make use of an interpretive rather than purely descriptive approach as they attempt to understand material as it is revealed in the therapy room.

While data analysis began as the material was generated, it continued at a second level following the therapeutic session when the information (including session material, the researcher's reflections, countertransference responses, thoughts, feelings, observations and reverie that manifested during the session) were written up, organised and developed. I then reflected on ways in which bodily pathology manifested in the therapeutic encounters as it has been described in the literature, or as my own body entered the therapy (either implicitly by means of a somatic countertransference or explicitly via the patient's comments). Other psychodynamics demonstrated by the patient were also recorded. This process of analysis was not rigid, but was rather systematic and comprehensive. What this demonstrates is that a reflective process is part of psychoanalytic therapy and is therefore a fundamental part of the analysis of psychoanalytic research data.

An essential part of clinical psychoanalytic practice is the clinician's engagement with a clinical supervisor (Watkins, 2011). This knowledgeable and experienced practitioner will think through the dynamics of practice with the treating therapist. The supervisor assists the therapist to check their interpretations of the patients' material during practice. This built-in check reflects on the process of interpretation in practice and assists to maintain the authenticity of the clinical material.

During the period of research the clinical data was discussed with three clinical supervisors who were all experienced psychoanalysts, and this provided a further

level of analysis to the ones described above. This process is part of good clinical practice and aids the understanding and interpretation of the data while still maintaining its authenticity. Clinical supervisors do not, however, clarify the material epistemologically, because, as stated previously, the data generated from practice is not generated for the purposes of research. However, as the idea for this project began to develop, some of the clinical material jumped out as being research-worthy. As I became intrigued by some of the material – driven by an interest in the research topic – I began to establish links with psychoanalytic theory and previous data from earlier experiences with the patient or from other cases.

Data was then selected for the research according to the process described in the previous section. The selected material was then read through, discussed and reflected upon for the nature of the research project. The patient's history, session notes and supervision notes were read through a number of times, and notes were made of any associations or thoughts that arose. In some situations the contributing clinicians returned to their notes and completed this phase, and a second interview was then held. The focus at this point in the research was to move from reading the data as a whole to breaking it down into smaller and more meaningful units. The data analysis was inductive in that the research questions were used to guide the analysis, but additional themes were allowed to emerge as the data was reviewed and discussed. The material that arose was constantly analysed theoretically and notes were made about where it conformed with and intersected the existing literature. My research supervisor had an important part to play in ensuring that at this level of analysis attention was paid to upholding the veracity and legitimacy of the material.

In addition to input from my research supervisor, this PhD programme also involved regular seminars with other PhD candidates (all experienced clinicians) and a faculty of five professors (all predominantly clinically informed practitioners) during which all research was reviewed, analysed and discussed.

Yet another level of critique, analysis and review of the material occurred in the peer review process after the papers were submitted to the journals for consideration for publication.

EVALUATION OF THE QUALITY OF THE RESEARCH

Qualitative research methods were appropriate for this study as they allowed for the investigation of the psychotherapeutic process in a way that was as close to the real setting as possible. These methods also make it possible for the complex, multifaceted and sometimes conflicting themes relating to aspects of clinical work to be depicted and explored in a detailed and thorough manner, and for these to then be elaborated in terms of psychoanalytic theory (Hancock & Algozzine, 2006).

It would not be true to the principles and tenets of qualitative research to try to evaluate it by means of positivist, scientific measures. Instead, qualitative research needs to be assessed by more appropriate methods which ensure that the results reflect a version of reality that is trustworthy, credible, coherent and reflexive (Midgley, 2004). It is generally accepted that the procedures used by a researcher should be transparent and accountable, and that readers should be able to track how theory is used, and illustrations are chosen, in order for arguments to be made (Guba & Lincoln, 1989).

This research project has attempted to maintain the credibility, validity, viability, appropriateness and authenticity of its data selection and interpretation processes in a number of ways.

Firstly, Guba and Lincoln (1989) propose that the concept of credibility is in fact a measure of the plausibility of the research findings and data interpretations, and suggest that there are three steps involved in establishing credibility:

i. The researcher must engage with each of the subjects (i.e. psychotherapy patients) for an adequate time. *Almost all of the subjects included in the study were in treatment for over a year. Mr C described in the paper included in Chapter Seven: "Re-embodying the Analyst", was a fairly new patient, but the behaviour described occurred consistently in more than eight sessions. The study therefore fulfilled the requirement that the researcher engages with each subject for an adequate time.*

ii. Each subject must be sufficiently observed. This involves prolonged consideration of each subject and their material. *Since all of the subjects were in weekly (or in some cases, twice-weekly) therapy, it can be agreed that all subjects were observed regularly.*

iii. Member checks refer to the process of checking with the patient that they feel adequately understood by the therapist and her interpretations and comments. *This is in fact an integral part of psychoanalytic psychotherapy which consists of a constant interaction between the therapist and the patient. Psychoanalytic psychotherapy can be considered to be an on-going process of the therapist presenting hypotheses to the patient in order to check them, and then the patient and therapist working together to develop those ideas.* 'Triangulation' is the process of verifying the data with different investigators who provide alternative viewpoints to be considered. *In this study the researcher made use of a number of senior analysts and clinicians as clinical supervisors. All the other clinicians whose material was made use of, were similarly in clinical supervision. An added layer of this form of examination occurred when other clinicians' material was discussed by the researcher and the treating clinician and all hypotheses debated and checked, and again with the professors who were the faculty of the PhD programme. A further significant way in which 'member checks' occurred was in the peer review process during the consideration of the papers for publication.*

Criticisms which are levelled against the use of the qualitative case study method in particular include the claim that it makes use of argument by authority, it often presents an incomplete presentation of evidence, the narrative is designed to persuade the reader (who is also often excluded from the process of analysing the research data) (APA guidelines cited in Midgley, 2004) and finally that it makes use of anecdotes (Edwards, 2007). In other words, this research method is sometimes criticised for being vulnerable to what is called researcher bias (Whitley, 2002) with the claim that this contaminates the data and affects the objectivity of the study. This critique may be particularly relevant when case vignettes are used as the researcher chooses to reveal only parts of the material.

This challenge is responded to here by the proposition that in using the clinical case material in a research project, the researcher's subjectivity in fact becomes a valuable tool – just as it is in the therapy room. However, it is important that there is transparency and self-reflection about the researcher's investment in the study (Willig & Stainton-Rogers, 2008). This point received significant attention, and in fact, one entire paper ("Craving Interpreting: A Case of Somatic Countertransference") was dedicated to the subject of the therapist's role in the process and outcome of a treatment.

The problem of researcher bias fundamental to qualitative research is probably more appropriately described in this study as a concern around the integrity and authenticity of the data used. Maintaining the strength and appropriateness of the data was in tension with some of the ethical concerns relevant to clinical material, and can be seen to have been checked by a number of procedures which were a part of the way in which the research data was selected and interpreted as well as the way in which the PhD programme functioned:

1. The project grounded its arguments and methods in psychoanalysis, and this is in line with the suggestion that grounding the research in a specific theoretical framework can help to avoid researcher bias (Guba & Lincoln, 1989).
2. In order to protect the identity and confidentiality of the patient, use was not made of a sustained case history, and relatively little of the case's clinical data was used. This meant that the clinical data is presented in the form of vignettes consisting of data that was selected for the extent to which it would provide credible and useful information for the discussion without revealing identifying facts about the patient.
3. In order to maintain some sense of the authenticity of the data and the integrity of the interpretation, discussions were held between the researcher and her clinical supervisor. The cases were all clinically supervised, the research process was supervised, and all the research (i.e. the case studies and the thematic analysis) was subjected to a peer review during the publication process which also mitigated against the potential bias of the researcher.
4. Since the integrity and authenticity of the data were so intimately connected with ethical considerations, a certain level of disguise of the data was required. Those patient details that were revealed were partially disguised in ways which were believed not to vitiate their authenticity. It is clear that the integrity of the data could potentially have been at risk because it required some level of disguise, but in this case the particular built-in checks related to the research being carefully supervised by a clinical supervisor who would discuss the integrity of the material, discussion of some of the material with the group of clinicians that formed part of the PhD programme itself, as well as with individual members of that group who shared their own case material would have mitigated this risk by ensuring that the changes made did not have a material impact. Perhaps even more importantly though, the ingredients of the case that were changed were in fact of the kind that were in the interests of

protecting personal identification (such as the age or profession of the patient) rather than the description of the psychodynamics of the case or the nature of the interaction that occurred in the examples (Kantrowitz, 2004).

5. Once the papers were written, the contributing clinician read the paper and confirmed that the description of the case material was accurate and that any conclusions drawn were plausible and a fair reflection of the unfolding of the case. The examples provided by these clinicians were compared with the researcher's own data to check that the theory was consistently applied.
6. Yin (1989) has commented that the greatest concern about the use of case material in research is the lack of rigour applied. A good practice in order to reduce the effects of a lack of rigour and potential bias is to discuss the case material with a colleague. As already stated, the case material in this study was discussed with clinical supervisors, the colleagues who were interviewed for the study and the five professors on the faculty of the PhD and the requirement of rigour was therefore satisfied in this project. Guba and Lincoln (1989) suggest that if a qualitative research study is deemed reliable and authentic by professional and competent peers who have appropriate knowledge of the subject, then it is considered to be 'confirmable'. The use of a number of other qualified and experienced psychologists and psychoanalysts to triangulate the data in this study have served to confirm the results achieved and the conclusions drawn. Additionally, and similarly to the point made above, all the papers presented the in chapters went through a stringent peer review process before being accepted for publication. This would also have served to further confirm the results.

These methods are appropriate and sufficient as quality control in qualitative clinical case studies.

ETHICAL CONSIDERATIONS

Further to the ethical considerations and safeguards already discussed a few additional reflections are included here.

Research participants have the right to privacy, and researchers must protect that right by keeping information provided confidential – especially when the information is personal and potentially embarrassing, as in the case of material discussed in therapy. Writing up psychotherapy case material almost by definition involves some degree of confidentiality breach (Whitley, 2002). There is therefore

somewhat of a philosophical impasse when a clinician publishes clinical material even if it is in the interest of education. On the one hand, as the patient's treating clinician, it is incumbent on the therapist-researcher to protect the patient's privacy and confidentiality. On the other hand, sharing some of what occurred with that patient in the therapy room serves to illustrate concepts and add to existing knowledge (Stajner-Popvic, 2001)

With respect to the clinical subjects (i.e. patients), confidentiality is a core ethic in psychoanalytic psychotherapy and is a requirement for ethical research. In order to minimise the effects of any such breach in confidentiality, permission (i.e. informed consent) to include their material in the study was requested from case study participants where appropriate. For consent to be regarded as informed, the subject must be given sufficient information about the study in a way that is deemed appropriate for that particular subject (HPCSA, 2008a). In this instance, the patient who formed the primary focus of the paper in Chapter Six: "Craving Interpretation: A Case of Somatic Countertransference" was approached and asked for her consent. It was eventually decided by the researcher that despite having permission to write about the patient, in order to protect her identity as much as possible, the aspect of the treatment focused on would be the therapist's reaction to the patient, thereby revealing more about the researcher than the patient.

Even when informed consent is received, the researcher still has further ethical duties. The participant may be surprised or hurt to hear about how the therapist experienced her, as the material may have been interpreted in a more digested way in the therapy room, or the dynamics may be emphasised in a different way in the writing up in order to make the theoretical point clearer (Gabbard, 2000). The impact on the patient of reading the work was held in mind and all papers were written as sensitively as possible. The patient who was discussed in most detail and from whom informed consent was sought was presented from the point of view of the researcher's countertransference and reverie. She may thus not even be clear that the paper is about her should she ever read the paper, which should minimise any potential impact.

In all other cases, the treatment of the patients of the researcher included in the research had all been terminated at least six years previously. The HPCSA guidelines state "permission should be sought wherever possible". The words 'wherever possible' should not be seen as a loophole, but should only be relied

upon when there is no way to contact the patient or where contacting the patient may result in more harm than simply protecting their identity and confidentiality. With consultation with an experienced clinical supervisor, the researcher decided that contacting these patients suddenly and unexpectedly would be harmful to them. In these cases, all identifying details were changed by means of 'thick disguise' in order to maintain the highest degree of confidentiality, and only brief moments of the therapy (i.e. vignettes) which did not include information that revealed the patient's identity were made use of. When thick disguise was used, the researcher took care not to change any identifying detail that would be material to the case, in order to ensure that the integrity of the data was not compromised (Gabbard, 2000).

The material from patients who received therapy from other clinicians was treated in a similar manner: they were all patients who had terminated treatment a long time previously, their identities were not revealed to the researcher, and their details were changed appropriately so that they could not be identified. It is, in fact, likely that they would not even be able to identify themselves as they would not look for themselves in a patient described by the researcher. These processes are is in keeping with the ethical requirements of the University of the Witwatersrand, the HPCSA and the American Psychological Association, participants' written permission will be stored in a safe place together with case records. Where such permission was requested it was ensured that the patient was receiving some form of therapy at the time so that if any difficulties arose from the request they would have immediate access to help. The patient's emotional safety and the protection of the therapy are of the utmost importance. All use of case material also complied with the Professional Code of Ethics of the Professional Board for Psychology of the Health Professions Council of South Africa (HPCSA, 2008b) as well as with the ethics code of the South African Psychoanalytic Confederation (Silove, Schön, Berg, Green, & Levy, 2011).

This research was consequently conducted within the guidelines of the Human Research Ethics Committee (HREC – non-medical) of the University of the Witwatersrand and was granted ethical clearance by the HREC. The clearance certificate is attached as Appendix II.

CHAPTER 4: THE QUESTION OF PSYCHOSOMA

INTRODUCTION

This chapter, and the three which follow, are structured in two parts: in the short, preliminary section the reader is provided with a background against which the stand-alone manuscript that constitutes the remainder of the chapter can be read. In order to locate the paper in the broader thesis, the reader will also be informed about which of the research questions the paper intends to address.

The manuscript that constitutes the remainder of this chapter was submitted to the accredited Journal *"Psycho-Analytic Psychotherapy in South Africa"*, a bi-annual publication (http://ppsajournal.co.za/). It was accepted for publication in 2010 (Gubb, 2010). The paper is re-printed here with the journal's permission. The paper is also presented in its published format in the bound second volume of this thesis.

The paper is entitled "A Sense of Bodily Symptoms" and introduces and illustrates one of the overarching themes of the thesis, namely that conflicts in the mind can manifest as symptoms in the body even though they have no medical or biological origin. Following the rationale and aims of this research which were outlined in Chapter One, the history and development of the role played by physical symptoms in psychoanalysis warrants both investigation and documenting. A logical place to start that endeavour would be to track how the understanding of physical symptoms with a mental origin has developed and changed, and what sorts of classifications these symptoms are now divided into. The paper contrasts the origins and genesis of two different types of psychosomatic symptoms (i.e. conversion and somatisation), and illustrates the similarities and differences in the pathologies by making use of three case vignettes. It also engages with another of the major themes of the thesis, being the meaning behind the form of a physical symptom. Finally, the paper also suggests that different types of somatic symptoms may reveal different levels of mentalization that have been achieved by the patient. In doing so it prepares for the idea that what the practice of psychoanalysis as a curative method includes, is the interpretation of repressed unconscious material, and asks how

the therapeutic task might differ depending on the type of physical symptom involved.

This paper was intended to answer the first three of the identified research questions namely:

- What are the different ways in which psychoanalytic theory has understood the patient's symptomatic body?
- Which psychological anxieties and conflicts can be seen to underpin the main theories of the symptomatic body of the patient in psychoanalysis?
- How are failures of mentalization conceptually linked to physical symptoms in psychoanalysis?

PAPER 1: THE SENSE OF BODILY SYMPTOMS[2]

ABSTRACT

This paper explores the psychology of physical symptoms; how they present in the psychotherapy room and their underlying dynamics. From the beginning of psychoanalysis there has been an interest in those physical symptoms that do not seem to have a biological origin and, in particular, those physical illnesses that appear to be related to the patient's psychopathology. In order to explore such symptoms and illnesses further, this paper reviews the concepts of conversion and somatisation. The two concepts are compared and contrasted with specific attention paid to their genesis, to the meaning in the particular form that the symptoms take and to the therapeutic task associated with treating patients who present with these two types of pathology. Illustrative case material is introduced and the paper concludes that the distinction between the two pathologies can be understood in terms of relative mentalizing capacity. This understanding, it is argued, is clinically useful as it helps the therapist to make sense of the presenting problem as well as any shifts and changes occurring in the presentation of the physical symptoms during the course of therapy.

INTRODUCTION

Psychoanalysis is often described as having its origins in Freud's encounters with hysteria. This early association between hysteria and psychoanalytic thought and practice means that conversion symptoms underlie psychoanalytic interest in the symptomatic body and what it can tell the therapist about psychic life. In fact, Freud's development of the discipline of psychoanalysis began by exploring bodily symptoms for which no organic cause could be found (Breuer & Freud, 1893).

The object of enquiry in this paper is the symptomatic body and the focus includes all bodily symptoms that are associated with mental functioning. Historically in psychoanalytic theory, symptoms of these kinds have fallen into two broad categories: conversion and somatisation. However, there has been a lack of precision around the use and meaning of these concepts, and the terms 'conversion' and 'somatisation' are on occasion used interchangeably, sometimes to refer to partially differentiated phenomena and, at other times, used to describe significantly different forms of pathology (Avila, 2007; Taylor, 2003).

This paper will begin by tracing the development of the theory concerning, and the lack of precision around the theorisation and use of, the two concepts in the

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psychoanalytic literature. A particular focus will be on the meaning or personal psychic significance of the form that the symptoms take at the point of interface between the psyche and the soma. The paper will address the implicit and explicit similarities and differences of the two forms of bodily symptoms in order to make suggestions about implications for clinical practice. Particular attention will be paid to the cause of such symptoms, how severe or intractable the psychopathology is, and what the implications are for analytic treatment.

Further to this, the paper will suggest that the patient's attainment of differing levels of what is now called mentalization impacts on the forms of symptomatology and explains the differences between these forms. Recognising that there are distinctions is clinically useful in that the presentation and the underlying dynamics of a symptom may change during the course of therapy and thus the therapeutic task and interaction with the patient need to be adapted accordingly.

Clinical material will be used to illustrate how these two pathologies might present in the therapy room, and to support the claim that by understanding the level of mentalization at work in the symptom, the therapist is better able to respond therapeutically to the shifts and vicissitudes of bodily symptoms and their meanings.

FREUDIAN BEGINNINGS: THE QUESTION OF CONVERSION

In his work *Studies on Hysteria*, published with Breuer (1893) and in later works such as *Types of Onset of Neurosis* (1912d) and *The Sense of Symptoms* (1917a), Freud explored the mechanisms underlying the pathology in patients who presented with physical illnesses that did not seem to have an identifiable biological cause.

Freud suggested that although these patients were presenting with an illness in the body, they were in fact experiencing intrapsychic conflicts, or in other words, an illness in the mind (Breuer & Freud, 1893). A cornerstone of Freud's early conceptualisation of conversion is the idea that a patient presenting with a particular range of symptoms did so as the result of the experience of a psychic trauma which threatened their sense of self (rather than their body) in substantial ways. Such events were experienced as traumatic because they involved some form of humiliation, shame or moral conflict. This conflict was initially managed by the patient by means of a process of 'active forgetting', or repression, where the

thoughts and anxieties related to the conflict were expelled from the mind at the behest of the superego.

In accordance with what became a fundamental feature of psychoanalytic psychopathology, Freud came to view the physical symptom that resulted from the psychic trauma as a substitute or indirect way of expressing and satisfying some of the libidinal and vengeful wishes associated with the traumatic experience (Freud, 1917a). On this basis, the conversions closely associated with hysteria came to be seen as representations of psychic pain and conflict in bodily terms.

Freud's early work on conversion was based on three important tenets. The first of these related to the fact that the form the trauma took stood in a particular relation to the form of the symptom. The second was that the development of symptoms represented a way in which traumatic events could be both simultaneously forgotten and remembered because the origins of symptoms are disguised (Freud, 1917a). Finally, and because of their capacity to function in disguised forms, conversions were understood by Freud to satisfy two conflicting wishes simultaneously. It is this function of conversion symptoms (as is true of other symptoms) that led to them being described as compromise formations. While the second and third tenets of classical Freudian theory on conversions came to be characteristic of psychoanalytic psychopathology more broadly, it is the first point that is of particular interest to the field of psychosomatics.

It is the nature of the relationship between the psychical form of the trauma and the physical form that the symptom takes that distinguishes Freud's explanation and understanding of a conversion from later commentaries. Freud and Breuer reveal in *Studies in Hysteria* (1893) the extent to which conversion requires individually specific interpretation precisely because the form of the physical symptom cannot be explained in medical (i.e. physiological or anatomical) terms. Rather, the form of the symptom must be understood via a process of retrieval of the patient's particular repressed memories of the traumatic events.

Thus, throughout Freud's writing, his work maintains a strong sense of the fundamental premise that symptoms have meaning. This emphasis on the meaning of psychic symptoms is especially vivid in the case of conversion, where the body is often mapped in the mode of language according to its external or functional form. In conversions, the connection between the body and the traumatic experience is always a close and symbolic one. Anna O's phobia is a *hydro*phobia because *water* is linked to the traumatic experience of seeing her nurse allow her

dog to drink from her glass (Freud, 1893b). Elisabeth von R experienced severe pains in her legs for which no organic cause could be determined. Through her psychoanalytic treatment she associated these to the place she had rested her father's leg while redoing his bandages when he was very ill. She came to see that the pains had started after she had left her father's bedside to go on a date and her father had taken a turn for the worse in her absence. The guilt she felt over that made her determined not to leave his bedside again and the pains facilitated her remaining at home. The pains were also revealed to have other layers of meaning, such as her fear that she would never find a partner and would always 'stand alone', and further guilt at having taken a walk with her brother-in-law to whom she was very attracted (Freud, 1893a). In these cases the symptom was a re-enactment of the original trauma and treatment emphasis was placed on interpreting how the symptom related to the patient's personal experience.

In the case of hysterical conversion, then, the work is to interpret the patient's symptoms in order to reveal the repressed traumatic memory that is manifested in disguised form by the symptom. The aim of the intervention is to return the memory to the ego and thereby to lift the repression. This is done by following and creating the links that are revealed during the patient's free associations. Bringing the meaning of the symptom to consciousness in this way lifts the repression and allows the patient to remember the traumatic memory. This allows patients to choose new ways of behaving as they are no longer compelled to keep responding in the same unconscious manner. The conversion symptom disappears after the repressed memory is retrieved and discussed in therapy (Freud, 1905), and this is significantly different to what is seen in the treatment of physical illnesses. Stated differently, the aim of the 'talking cure' is to reunite the affect and the idea of the trauma and to interpret that which already has meaning and which the body of the converter has already 'spoken' about (Taylor, 2003).

The following case synopsis of a patient, who I will refer to as Ms A, demonstrates the particular and specific nature of the form that a conversion might take, and also illustrates the therapeutic task when treating a symptom of conversion.

Ms A was an orthodox woman who had divorced her husband due to his continuous infidelity. She had needed to start working full time following her divorce in order to take care of her four children. Ms A developed a symptom of profuse foot sweating. This caused her great distress and embarrassment. She took all kinds of powders and sprays with her to work for fear that her feet might smell and

that others would notice. She also frequently washed her feet in the basins at work. She wore open-toed, often inappropriate sandals to work even when it was cold, in the hope that this would minimise the sweating. In therapy, I asked her about the way in which the symptom manifested, including the times and places that it seemed worse. In thinking about the symptom in this way, she realised that the sweating of her feet started at two o'clock every afternoon. She associated this to the time her children finished school and began to walk home. She eventually understood her symptom result from her hatred towards her ex-husband, whose behaviour had caused her to get divorced (which was against her religion) and forced her to start working. Holding down a job meant she was no longer able to fetch her children from school and walk them home. Her symptom represented her desire to 'walk out' of work and walk with her children. Furthermore, although she knew that she could not leave work, her getting up to wash and powder her feet allowed her to leave her desk. Her symptom provided her with a vehicle through which she would act out her wish to leave her work and be with her children as they walked home. The symptom also served to placate her superego, which left her feeling like she was a bad and absent mother, as it gave her a way to 'leave' her work with the constant trips to the bathroom, and yet still fulfil the financial obligations she now had, by not going home. When the idiosyncratic meaning of the form of the symptom was analysed and understood by the patient, the symptom quickly resolved, as would be predicted by a Freudian formulation.

The therapy with Ms A was successful in a relatively short period. I would argue that this can be attributed to the clearly symbolic form of her symptom. In terms of Ms A, this suggests an already well-established capacity to symbolise and mentalize. I am going to develop the idea that such a capacity is central to the dynamics underlying the development of a conversion. As a result of an interpretation strongly driven by the patient, it became apparent that the symptom was related to the many symbolic associations to walking: her husband *walking* out on her, her desire to *walk* out of her job, and her wish to walk with her children in their walk home from school. There is an implicit question in this: Why did Ms A develop the symptom in the first place when her previous level of functioning, her capacity for mentalization and her ability to read bodily symptoms in psychological terms suggest more resilience? I would postulate that the context of Ms A's divorce and its negative impact on her religious standing and financial situation, together with the resulting threat to her self representation overwhelmed her ego resources.

This led to a regression to conversion symptoms and an earlier developmental organisation.

This case provides evidence that it is still useful to employ Freudian ideas of the mechanisms involved in conversions, namely that there is symbolic meaning in the form that the symptoms takes, that repression plays a role and that there is value in interpreting the symptom's form and the conflict it hides. Implicit in all of this is that a conversion reveals the patient's ability to symbolize and to produce a symbolic re-enactment of the trauma. By following the links and association made by Ms A, the symbolism behind her symptom was revealed, the associated emotions expressed and the symptom resolved.

CONVERSION AFTER FREUD

Freud's examples of conversion suggest he understood that conversion symptoms occurred mainly in bodily sites innervated by the voluntary motor nervous system (Freud, 1905). Authors such as Rangell (1959) and Engel (1968), who reinterpreted the notion of conversion, broadened this definition when they proposed that parts of the body innervated by the autonomic nervous system (i.e. the visceral organs) and a number of conditions not previously considered in the concept of conversion, should also be included in the category. Engel (1968) stated that organs involved in a conversion are unconsciously targeted on the basis of the potential for these organs to link with mental representation through innervation, perception and fantasy. Thus, any bodily experience perceived by an individual leaves behind memory traces which have the potential of becoming associated with other types of mental content and thereafter being used in a psychopathological way. He therefore proposed that perceptions of bodily processes which are not under voluntary control can also come to represent repressed wishes.

Implicit in the Freudian view is the idea that a conversion is a regression from a previously achieved Oedipal level of development (Aisenstein & Smadja, 2010). This assumption results from linking the idea that the superego is an integral part of the conversion mechanism, with an understanding of the superego as heir to the successful resolution of the Oedipus complex. Engel (1968) challenged this Freudian view by stating that conversion mechanisms can occur at pre-genital levels.

Sperling (1973) theorised that the ego and superego structure of a patient with a conversion hysteria will not allow forbidden aggressive and sexual impulses to be gratified in reality, so when the repression of these impulses is about to fail, the impulses and actions are acted out physically as conversion symptoms. In his view, patients who develop conversion symptoms are defending against Oedipal level fantasies and wishes by regressing to a pre-genital level. Fox (1959) suggested that the process is used most especially in times of regression when other defences are ineffective.

Work on the subject of conversion after Freud foregrounded questions such as the depth of pathology that conversion represents and the sexual developmental level associated with it. Freud neither raised nor addressed such issues. Commentators on the topic of conversion also seemed to focus less on the symbolic and sexual aspects of the symptoms than Freud did except when trying to differentiate which mechanisms underlie which types of bodily symptoms (Taylor, 2003). Writers who followed Freud in this area of psychopathology, whether they were contesting or supporting Freud's ideas, were all paving the way for contemporary questions concerning the distinction or overlap between conversion and somatisation.

THE QUESTION OF SOMATISATION

The term 'somatisation' is attributed to Steckel who coined it in the early 1920s and defined it as 'the conversion of emotional states into physical symptoms' (Kellner, 1990, p. 150). In terms of this early definition, the concept was initially equivalent to Freud and Breuer's concept of 'conversion'. Steckel eventually departed from Freud's position, arguing that all neuroses, including what Freud had called 'actual neuroses' were caused by psychological conflict. Steckel also understood psychological conflict to be the underlying cause of somatic complaints which Freud had thought purely somatic or organic (Taylor, 2003).

Much of the understanding of the divisions between conversion and somatisation turn on the early debates around the mechanisms underlying what Freud called the 'actual neuroses'. By 'actual neuroses' Freud was referring to the intense physical symptoms such as paralysing attacks of anxiety (which he called 'anxiety equivalents') that accompany or mask fear. He proposed that these are as a result of physical sensations which cannot access the mind. This explanation stands in contrast to that offered in relation to the development of conversion symptoms, in which psychic stimulation occurring as a result of internal conflict is repressed and

after being ejected from the mind is expressed as an organic symptom (Freud, 1894a).

In his paper *Types of Onset of Neuroses* (1912d) Freud explained that the actual neuroses are not caused by an original trauma, nor do they have a particular symbolic meaning (as in conversions) in terms of the form that they take. Freud argued that the actual neuroses were brought about as a reaction to real, everyday tension and, in particular, to the frustration of libidinal satisfactions. Since the symptoms of the actual neuroses were principally somatic and without symbolic meaning, interpretations made about their form were unnecessary and unhelpful (Freud, 1912d). For Freud, the actual neuroses were part of the ordinary unpleasant experience of being human, as opposed to the pathological misery of hysteria and obsessions, and would resolve when the libido was satisfied. They were therefore outside the scope of what could be treated by psychoanalysis. It can thus be concluded that, according to the Freudian model, a person suffering from an actual neurosis is showing 'less' psychopathology than someone in the grips of a neurosis proper.

Authors such as MacAlpine (1952) and Taylor (2003) theorised that somatisation is a variant of the actual neuroses, and understood the anxiety symptoms to be caused by rudimentary or partly expressed emotions. This could be understood as being one of the forerunners to the theories of mentalization which are discussed in more detail below. As with Freud, they did not see these symptoms as being symbolic or having meaning. They put forward the idea that neuroses are not the only objects available to psychoanalytic investigation, and in their extended understanding, they included actual neuroses as well as other illnesses previously considered purely organic. In contemporary terms, they see the treatment of these symptoms as developing the patient's ability to mentalize and to make sense of the bodily sensations they experience. These experiences can then be contained by other people and eventually by language, which will ultimately allow the patient to develop a capacity to tolerate bodily unpleasantness.

Since Freud saw the 'actual' neuroses and other somatic illnesses as having purely organic origins – related to libidinal frustration rather than psychological trauma – he believed these to fall outside the realm of psychoanalysis and consequently did not work specifically in the area of somatisation. Instead this endeavour fell to other authors, including Pierre Janet.

Janet worked extensively to understand the genesis of somatic symptoms. He proposed a model of hereditary mental weakness in those who presented with such symptoms and suggested that if an individual experiences sufficiently intense trauma, the binding of the internal psychic elements that constitute the personality becomes weakened regardless of the trauma's meaning. The fragments of a traumatised psyche can then cause somatic symptoms. One of the implications of Janet's understanding is that in the psychogenesis of physical symptoms, thought, and more generally the mind itself, is bypassed in the initiation of somatic symptoms and consequently there is no sense, symbolism or meaning in the form that the symptom takes (Gottlieb, 2003). This means that the symptoms are not intelligible, lacking reason or meaning. Consequently, interpreting their form during therapy would serve no purpose.

This idea of the sidestepping of the mind is developed in the work of many psychosomatic theorists since Janet, including Marty and de M'Urzan (Gottlieb, 2003). Pre-genital conversion theorists such as Steckel and Groddeck did read primary symbolic meanings in the symptoms of many somatic diseases (including ulcerative colitis and bronchial asthma); however, Reiser and Weiner have argued that bodily events in autonomically innervated organs and tissues can become *secondarily* linked with fantasies and affects. This suggests that the symbolisation frequently uncovered in therapy may have played no role in initiating the disorder in the first place (Taylor, 2003).

McDougall proposed a combination of the views of both the French Janetian school advocating 'mind-free' theories, and the Freudian view which stressed the meaning of the symptoms (Gottlieb, 2003). Her view in the 1970s was that psychosomatic symptoms were a result of troubled early backgrounds, which resulted in difficult emotions not entering the mind but rather being expressed by the body in the form of symptoms of physical illness which appear to have no psychological meaning. In this thinking (which was in line with the views of Janet) she proposed that psychosomatic patients were unable to process their experiences mentally or put their feelings into words. This is usually demonstrated by their alexithymia and 'operational thinking' – a term coined by the French psychosomaticians to describe patients' inability to recognise or express affective states, and to indicate a lack of vitality and delibidinised ways of relating. Implicit is the idea that feelings are absent and are thus not represented in the individual's language (Avila, 2007; McDougall, 1974).

However, by the late 1980s, McDougall (1989) no longer felt that this explanation was adequate as she saw many patients with serious psychosomatic illnesses who were able to express their feelings and/or did not demonstrate the operational thinking described by the French psychosomatic school. She concluded that an 'archaic' form of symbolic mental activity occurs in some of these patients, but that it is different to that seen in hysterical conversions. The symbolism seen in psychosomatic patients is not verbal, but is processed by the mind to give it some intelligibility before its outcome is revealed in the body. Although the illnesses may appear to have no apparent symbolic significance, they are nonetheless linked with the patient's psychic structure, life circumstances and history. It is concluded therefore that there is some psychological link to the form that the symptoms take. The symptom does have some intelligibility and relates to a developmental arrest. Analysing the form of the symptom of a somatic illness, however, does not represent a productive therapeutic intervention and will not reveal hidden clues to the patient's psychological conflicts. McDougall's thesis lends itself to an explanation that is concerned with different levels of development and different points of fixation in individual patients. When somatisation arises as a result of developmental deficits it appears to be reflected in points of fixation. By contrast, conversion reflects a regression from a previously achieved developmental milestone.

Whatever the position taken regarding the intelligibility, mental status and symbolic meaning of somatic symptoms, the current thinking does not give importance to the form that the symptom takes in somatisation, and contemporary authors have moved away from the idea that there is a specific retrievable meaning in the symptom's form. The genesis of somatic symptoms is also not linked to particular causal trauma as is the case with conversion symptoms. It is likely that this is because the origin of somatic symptoms is now understood to be a sustained, continuous set of experiences that result in arrested emotional development (Fonagy, et al., 2004; Mitrani, 1993).

The case of Ms B will be used to demonstrate some of the points made above. Two of McDougall's ideas will be illustrated: firstly, that there does appear to be some form of psychological significance to the form that some somatic symptoms take and, secondly, that interpretation is unhelpful in treating the symptoms because the level of mentalization in patients who present with somatisation is not sufficiently developed.

Ms B presented for therapy with severe anxiety and career and relationship difficulties. She had experienced a serious vaginal infection for many years and had consulted many doctors about it. Several doctors had suspected various STDs while others diagnosed Candida. Ms B suffered great discomfort and the infection had a profoundly negative effect on her sexual life with her husband. While that sometimes distressed her, it also appeared to have had some secondary gain in that the symptoms appeared after her husband had cheated on her. Her discomfort having sex, and the consequent reduction in its frequency, may have been a way to unconsciously punish him for his betrayal. She had also been sexually abused by a teacher as a child, and I suspected that the infection held some meaning associated to that event. Her doctors had prescribed everything from antibiotics to a diet change, but very little seemed to make a difference. It was eventually recommended that she go into psychotherapy.

Ms B's therapy ended prematurely after she took a job in another city, and although her anxiety was considerably reduced and she was seriously considering leaving her husband, there was very little change in the status of the infection. Any attempts in therapy to understand or interpret the meaning of Ms B's symptom – such as suggesting that it was a way to punish her husband or a reflection of her rejection of her sexuality following the sexual abuse – were met with blankness. She was not able to free associate or make links about her illness and merely suggesting that the symptom may have meaning led to expressions of frustration on Ms B's part. She would respond to such suggestions with long details of the research she had done on her physical illness and would regale me with medical facts. If she felt unwell in any way, even if it was as a result of anxiety before an event such as a work presentation, she would go to the doctor and insist on having blood tests or other medical investigations. She would become very defensive of her symptoms and tell me about the results of these tests, as though my suggestion that there was any psychological meaning behind the symptom had somehow minimised the symptom's genuineness. Her reluctance to consider that there may be another way of understanding her symptoms appeared to be an *inability* to think symbolically rather than an *unwillingness* to do so.

It seemed that at some points her range of symptoms would bypass her mind and she struggled to think about or conceptualise them in a symbolic way. I would contend that Ms B demonstrated some 'operational thinking', although the form of her symptom suggested that there was an archaic symbolism in its development.

What does seem to be at the heart of the development of bodily symptoms in all the theories reviewed is the collapse of higher-order psychological systems. From a Freudian perspective, a well-functioning mind can bind, organise and structure inputs from the body, the mind and the external world, and can allow an individual to operate according to secondary processing principles, while a failure of these processes can result in symptoms ruled by primary processing. Janet (in Gottlieb, 2003) explains the collapse of higher order functioning in the following terms: a mind in which the fragments of the personality are no longer cohered or intact will produce hysterical and somatic symptoms. In both of these explanations, it is an intact mind which can mentalize that serves as a protection against developing these types of symptoms.

MENTALIZATION AND PSYCHOSOMATIC ILLNESS

Allen, Fonagy and Bateman (2008) define mentalization as 'imaginatively perceiving and interpreting behaviour of oneself and others as conjoined with intentional mental states, shorthand for which is holding mind in mind' (p. 348). Fonagy (1991) articulates the idea that in order for an individual to be able to achieve control over intense affects, the individual needs to be able to represent the idea of an affect. Fonagy includes in his definition of mentalization the ability to understand the mental state of oneself and others. He sees mentalization as a form of imaginative mental activity which allows one to perceive and interpret human behaviour, including one's own (Fonagy, et al., 2004).

Freud saw thought as existing between the instinctual demands of the body and the actions taken to satisfy those demands. Freud emphasised the importance of bindung, or linking, in secondary process thinking, which creates associations between internal states (which Freud conceived of in energetic terms) and gives them meaning. This is opposed to primary process thinking which is by definition physical, immediate and without psychic meaning (Freud, 1915c).

Using Freud's topographical model of the mind, Luquet (in Bouchard & Lecours, 2004) described a model of four different layers and forms of thought. The most primitive of these is the 'U Level', which consists of unmentalized sensory experiences for which no mental representations are available. The next layer is the Primary Mental Representation Level where the first psychic processes occur. The third layer is the System Preconscious which is made up of two types of thought: a) metaprimary thought and b) metaconscious and intuitive thought. In this third layer thought starts to take on a symbolic and more organised form. The

material in this level is not yet verbal but is used to form judgements, choices, decisions and ideas. The final level is the Conscious Level which is achieved when language is acquired. The Conscious Level inhibits the previous levels but does keep them potentially active.

These layers of thought are useful in the conceptualization of the differences between conversation and somatisation and will be discussed in the following section.

Continuing in this tradition, authors such as Lecours and Bourchard (1997) define mentalization as the ability ‘to elaborate the thoughts of our desires’ (p. 879) and integrate Freud's concepts of ‘binding’ and ‘psychical working out’ into their theory of the process of mentalization.

While the Freudian school focuses on the binding of the instinctual drives, the second explanation of mentalization focuses on intersubjective and developmental aspects, emphasising the mother’s role in helping the infant develop the ability to tolerate affect. Bouchard and Lecours (2008) discuss Fonagy’s proposal of an interpersonal interpretive function (IIF) which is involved in processing new experiences. Its development is driven by the shared affective experiences of early attachment and precedes cognition. During these attachment experiences the infant internalizes the caregiver’s empathic expressions and in this way develops a secondary representation of his own emotional state. Infants who are neglected and traumatised will later present with problems of interpretive mentalizing, self-regulating and attentional mechanisms (i.e. the IIF) (Bouchard & Lecours, 2008).

Theories of mentalization are helpful in understanding the underlying mechanisms of psychosomatic symptoms as well as the differences between conversion and somatisation. It was in fact as a result of work with somatising patients that the first account of mentalization was developed by Marty, who observed that these patients showed a marked lack of psychic representations and psychic processing, which he came to conceive of as mentalization (Marty, 1968). Marty and de M’Urzan then went on to describe the operational thinking devoid of fantasy life seen in psychosomatic patients, which erodes the patient’s relationship with their object (Marty & De M'Urzan, 1963).

It would thus appear that in poorly mentalized structures one observes meaningless discharge in action or via the somatic field, rather than in thought. It

would seem then that somatic symptoms have their origin in the ‘U layer’ of thought described by Luquet (Bouchard & Lecours, 2004).

Contemporary writings about the genesis of somatisations suggest that these are due to problems that occur in very early development when the mind is just forming. During normal development, the infant learns to integrate sensory, visceral and motoric excitations with images and words into his or her emotional schemas. A very important factor in this process is the parents’ ability to attune to and regulate the child’s emotional states in order to help the child transform emotional arousal into something that can be thought about, named and communicated (Fonagy, et al., 2004; Taylor, Bagby, & Parker, 1997).

Mitrani (1995) uses the term ‘unmentalized experience’ to denote internal or external elemental sense data which have not been transformed and integrated into symbols or mental representations, or into signal affects such as anxiety. She argues that experiences which are unmentalized are experienced as concrete objects in the mind, or as bodily states such as somatic symptoms or actions. These can neither be thought about nor stored as memories, and thus cannot be repressed. Mitrani equates this idea with Freud's notion of the ‘anxiety equivalent’.

If the parents’ containing and reflective functions are not adequate, or if the child experiences trauma during childhood, the resulting attachment difficulties may lead to problems in affect development or to regression. Such environmental failure may result in the emotions being only weakly connected with images and words and being experienced mainly as somatic sensations (Krystal, 1997). Individuals with developmental histories of this kind may later present with alexithymia, somatisation or other medical and psychiatric disorders associated with dysregulation of affect (Fonagy, et al., 2004; Taylor, et al., 1997). LeDoux (1996) found that emotional learning can be mediated by neural pathways that bypass the neocortex, concluding that emotional responses can occur without the higher order processes of thinking and reasoning. This means that an individual's mind does not need to register, understand, elaborate, or evaluate the symbolic meaning of a traumatic stimulus and can instead bring forth ‘direct’ responses from the body. This again links to the ‘U level’ of thought (Bouchard & Lecours, 2004) where the empty and severely restricted psychic world results in somatisations and reenactments with no sense or meaning.

In a conversion, the superego does not allow any thought of the patient’s desire, and this is the very reason for the development of the symptom. Using the more

contemporary language of mentalization, this can be understood as follows: since the desire cannot be reflected upon (i.e. mentalized) it cannot be expressed consciously and thoughtfully. It therefore remains unconscious and is communicated in the form of a symptom. It would thus seem that conversion symptoms demonstrate a problem in the preconscious layer of thought, or at Luquet's metaprimary or metaconscious and intuitive layers of thought (Bouchard & Lecours, 2004). Since symbolism and verbal thinking have obviously already been achieved, the symptom must reveal regression to a preconscious level of thought. The superego judges the thought as unacceptable, again suggesting that it has reached metaconscious thought. The implication for somatisation, therefore, is that since the fixations occur at an earlier developmental level and at a lower level of mentalization, somatisations are a more 'severe' form of psychopathology. As such, they are more difficult to treat and can be considered more intractable than hysterical conversions which present, by contrast, in individuals with higher degrees of mentalization. It is the ability to symbolize that is absent or compromised in somatising patients (Aisenstein & Smadja, 2010).

Since the psychic difficulties involved in somatisation appear to be around symbolisation, linking and mentalization, I would argue that the therapeutic task with somatising patients is to help them develop this capacity with the view to aiding them to put their thoughts and feelings into words so that they are not compelled to show them in their bodies (Taylor, 2003).

THE PSYCHE AND THE SOMA: THERAPEUTIC IMPLICATIONS

As is true with most aspects of human functioning, what is seen in therapy rarely fits neatly into the discrete categories of theory. It is the task of the therapist to carefully attend to how the patient presents in the room, to try to understand the underlying dynamics of what the patient is presenting with and to define the therapeutic task based on that understanding.

It is clear from the arguments presented above that it is almost impossible to draw an absolute line between somatisation and conversion. It appears that the ideas of 'conversion' and 'somatisation' do indeed describe different processes, but that these processes are related. Ron (1994) puts conversion and somatisation on a continuum and suggests that they share some underlying mechanisms in that unexpressed psychic elements are kept out of consciousness and manifest instead as bodily symptoms. Ron's view is an extension of what Rangell (1959) suggested several decades earlier when he concluded that, given that there are many

different forms of bodily symptoms, an individual case may frequently be over-determined and hierarchically layered with dynamic mechanisms stemming from multiple points of fixation and regression.

It is my hypothesis that, during the process of psychotherapy, the form that a bodily symptom takes may develop and change along the continuum of bodily symptoms. As the patient develops the ability to symbolise and make links (i.e. to mentalize), the structure and the form of the symptom may move from a more intractable, less symbolic somatic symptom to one which holds unique, symbolic meaning for the patient. Similarly, if the patient enters a more regressed state or if their ability to mentalize becomes compromised for any reason, any bodily symptoms presented may take on a less symbolic, more primitive form.

To illustrate these ideas, I will discuss the case of Ms C who presented for treatment with debilitating Irritable Bowel Syndrome:

Ms C experienced severe anxiety when facing new situations as her concern about whether she would have ready access to a toilet was overwhelming. Initially she conceived of the illness as purely biological, treating it with medication and a change of diet. She sought therapy because of the anxiety her physical symptoms caused her, not because she thought that there was a psychological dimension to the symptoms. She linked the development of the symptom to a case of gastroenteritis she had suffered some months earlier. The gastroenteritis appeared to provide the opportunistic route the symptom took. Over the course of therapy, Ms C began to associate the IBS with particular events which she found to be stressful, particularly those events that evoked negative feelings such as anger. She was initially unable to express these feelings, which were interpreted in therapy as needing instead to be evacuated through the diarrhoea and flatulence. There were some occasions when she met her father in work situations, and she reported that her symptoms would flare up at such times. She was eventually able to stay at a higher level of mentalization, to ‘think about what the thing in my body means rather than panicking and running to find a toilet’.

Ms C also associated bouts of her illness with interactions with her boyfriend’s mother, who ‘made her sick’. She came to understand that the symptom was also a reflection of her feelings for her mother-in-law and that it provided her with an excuse to absent herself from family situations without appearing rude or rejecting. Her anger towards her mother-in-law appeared to be linked to the older woman's envy of Ms C’s youthfulness and attractiveness. This was interpreted when Ms C

reported that she had been accused by her mother-in-law of 'flirting' with her husband (i.e. Ms C's father-in-law). There were other instances where Ms C engaged in passive aggressive behaviour, particularly at work. When it was interpreted that she dealt with anger and aggression in indirect ways (e.g. avoiding situations through illness, disguising hurt and angry feelings with a sort of syrupy sweetness), she could start to see that her symptoms had meaning and played a role in her life. Ms C began dealing with the situations more directly and her symptoms abated.

In order to explain the changes in this patient's presentation and how she came to understand and conceptualise her symptoms differently, we need to understand the underlying mechanisms involved in the different forms of pathology she manifests. When Ms C first entered therapy she was not able to think symbolically about the symptom or make psychological links. During this initial phase of therapy, the form that the symptom took had little significance for her. Hence the initial therapeutic task was managing anxiety. As the therapy progressed and the patient became more able to symbolise, create links and hold ideas in her mind, she was able to conceive of the symptom differently. During this phase she was able to work with the form that the symptom took and to understand that her somatic symptoms may have psychological meaning. By thinking about these symbols and meanings she also began to exercise more control over the symptom because she was able to anticipate and deal with trigger situations. Ms C reached a point of being able to think about and manage her symptom and in one session said: 'When I start feeling my tummy is upset and worrying about needing the loo, I try and think what I might be worried about, or angry about, and deal with it at that level rather than get myself into a whole state about where the nearest toilet is'. This demonstrates how she eventually came to see that her symptoms had meaning.

From an object relations perspective, Ms C's case could be understood in the following way: she is aware of feeling anxiety and it seems that her boyfriend's mother and her father elicit this response in her. Perhaps her relationship with her mother-in-law, and the accompanying anxiety, is a transference repetition of her primary object relationship with her own mother. Her internal mental representations of her father are also re-evoked when she meets him in work situations. Anxiety is the only conscious manifestation of her aggressive feelings, which are otherwise expressed in bodily symptoms, as she has not developed an ability to mentalize these affects – or this ability has become compromised – and

her aggressive feelings are embodied in primitive affective memory structures. The triggers of the new job and an often difficult relationship, coupled with these primitive affective memory structures infused with hostile primary object relations, led to the somatised aggressive affects. The containment provided by the secure base of therapy, together with accurate mirroring of affects by the therapist (Fonagy et al., 2004), helped her to develop a capacity to mentalize these. Ms C was then able to mentalize her symptoms. She ended therapy when her financial circumstances changed, but said that her therapeutic journey had been very important because through it she had 'developed a mind'.

The case of Ms C serves to illustrate how strengthening the patient's ego during the therapeutic process allows for the shoring up of a capacity to symbolise and mentalize. Over time, the symptom becomes more accessible to the ego. Initially the symptoms appeared to have an anal character in that they served the purpose of expelling unwanted thoughts and feelings, i.e. aggression. As the treatment progressed and the patient became more able to mentalize and thus make more meaning of her symptoms, the symptoms appeared to take on a more Oedipal form, used now as communications to both her boyfriend and his mother. She used the physical symptoms as an excuse when she did not want to have sex (even at times when she was not feeling unwell) and when she did not want to spend time with her mother-in-law.

Returning to the case of Ms B, the argument could be made that her husband's infidelity was experienced by her as a trauma. This trauma and the feelings of neglect and humiliation associated with it seem to have reawakened similar affects related to her early primary object relations. Her mother had fallen pregnant again very shortly after her birth and Ms B had experienced the birth of her sister as a rejection. She subsequently developed a very competitive relationship with 'the other woman' who her sister came to represent. The abuse by the teacher was also a profound trauma, but the memory of it is fragmented and cannot be thought about and verbalized. It is bound up in primitive affective memory structures filled with anger, disgust and shame, which reveal themselves in a bodily way.

Perhaps if Ms B had stayed in the therapy she might slowly have developed a more robust psychic structure which would have improved her ability to mentalize and make links. This might have manifested as an improvement in her symptom. The symbolism of the symptom might also have become more apparent and accessible, and therefore available for more classically Freudian work. It is my

hypothesis that, just as in the case of Ms C, the developmental stage at which the fixation presented might too have shifted.

An understanding of how important mentalization is to the therapeutic process in general is suggested by Mitrani (1995), who argued that psychoanalysis traditionally aimed at seeking out internal psychological conflicts and understanding how these affect the patients' daily lives. However, ideas concerning the role of unmentalized experiences and mentalization itself have changed the analytic task to one in which the analyst helps the patient to shift bodily sensations or body memories out of the body and into the mind. This moves them out of the sphere of action into that of logical, verbal expression, where they are then available for investigation. According to this understanding, the aim of therapy is to create a psychic structure and develop a mind ego in place of the original body ego proposed by Freud (1923a).

During treatment, the unthought, unmentalized parts of the patient's mind arrive first in the therapist who is able to keep them in mind, endure them, think about them and then give them meaning before eventually being able to drip feed them to the patient (Mitrani, 1995). In my own experience this has usually occurred in a countertransference experience which very often takes a physical form, such as a vague feeling of nausea in some sessions with Ms B, or a rush of anxiety that occurred frequently when Ms C pressed the buzzer. The initial focus of adult psychoanalytic treatment is therefore the development of mentalization. This brings with it the ability to define and regulate the self and the self-with-other, as well as the capacity for reflective functioning. In order to promote the development of mentalization, the therapist is required to fulfil the function that the patient's parents were unable to. She must 'lend her mind' to the patient (Grebow, 2008).

Allen, Fonagy and Bateman (2008) advocate that, when working with patients who have difficulties in mentalization, the therapist must use a reasonably structured and supportive approach, focusing mainly on the present. They suggest that engaging in therapy is in itself an act of mentalization as both the therapist and patient are engaging in a process where they are working in an attachment dyad in which their mental states are the object of their joint attention. When therapists interpret the transference, they are presenting the patient with a different perspective of their subjective experience.

DISCUSSION AND CONCLUSION

This paper has reviewed some of the similarities and differences that exist between the understandings of the concepts of 'conversion' and 'somatisation' as they have been defined since their original coinage by Freud. Much of the literature, supported by my own work in this area, concludes that the two concepts, though distinct, can be understood to operate on a continuum of bodily meaning.

From the arguments and distinctions discussed in the paper, it is apparent that somatisation can be considered to be a result of fixations which have occurred at an earlier and more primitive level of development and mentalization and for this reason the symptoms may be more intractable and harder to treat. Somatic patients are very commonly described as being alexithymic which points to difficulties with symbolising and other verbal processes. By contrast, the very nature of a particular conversion symptom is often built around a symbolic turn of phrase and therefore, by definition, the patient has the language and symbolic skills required to have initialised the conversion, even though this process is not conscious.

The distinction between somatisation and conversion symptoms is important for treatment as it defines the therapeutic task. If the patient is concrete, 'operational' and alexithymic, it is better that the treatment occurs face to face and focuses on the here-and-now and on creating the links between what is happening in the patient's body and what is happening in their mind (Aisenstein & Smadja, 2010; Lombardi, 2008). If the patient has a more developed ability to mentalize and symbolise, and can better 'play with words', the interpretation of any associations to the presenting symptoms may be useful and may bring about shifts in the patient's understanding and in his or her illness (Freud, 1893b).

It is, however, important to remember that symptoms are frequently layered, and it is sometimes hard to tease out conversion dynamics from those of somatisation. It is not possible to know the underlying dynamics simply by noting the symptom; a deeper understanding of the structure of the patient's mind is required. The manner in which a patient engages with an interpretation will often reveal the level of mentalization present. Fonagy et al. (2004) and Allen et al. (2008) have discussed how the capacity for mentalization can break down in the face of trauma. When treating a patient who is showing bodily symptoms, the therapist should look for evidence in other situations in which the patient can (or could previously) mentalize and should try to determine whether there is a link between the breakdown of

mentalization and the traumatic situation. In this way they will be able to assess whether they are dealing with a regression or a developmental fixation. This will inform the clinical process.

Following the understanding that the therapeutic process can result in structural changes in the mind, this paper proposes that similar shifts in the mechanisms underlying a particular bodily symptom may also occur over the course of therapy. Such shifts may take the form of the patient's presentation moving from a less mentalized, less symbolic manifestation to a more symbolic and meaningful symptom presentation. This will demand of the therapist a more interpretive role as the patient's ability to engage with, conceptualise and understand their symptom matures. It is, however, important to bear in mind that the shift can also happen in the opposite direction. Under circumstances of trauma, regression or breakdown, the therapeutic task again becomes one of forging links and promoting the ability to mentalize.

Theories of conversion and somatisation suggest that it might be possible to relate the two forms of pathology on a sexual developmental axis. While a detailed discussion of this is outside the scope of this paper, it is interesting to note how the symptoms of Ms B and Ms C were quite concretely representative of the genital and anal stages respectively. The symptom of Ms A was not linked to the early psychosexual stages of development, suggesting that it is linked to difficulties that occurred later and after a higher level of mentalization had been achieved. Somatisation symptoms are more likely to occur at a pre-Oedipal level, while conversion symptoms imply by their symbolic nature that they are Oedipal or post-Oedipal. The symbolism and mentalization capacity seen in patients who present with conversion symptoms suggests that they are regressing when they become ill. This regression may result in them developing either conversion symptoms or somatisations, depending on how far the patients regress. Individuals who have developed fixations at early, primitive developmental levels are likely to develop bodily symptoms in the form of somatisations, as they have not yet achieved the capacity to symbolise, a requirement for conversion symptoms. Some of the early developmental level fixations may be resolved through the process of therapy and the structure of the pathology may take on different forms at higher developmental levels.

CHAPTER 5: PSYCHOSOMATIC ILLNESS

INTRODUCTION

The paper in this chapter is the second of the two papers which comprise the first half of the thesis and which focus on the symptomatic body of the patient. It is entitled "Psychosomatics Today: A Review of Contemporary Theory and Practice" and was published in the accredited international journal "*The Psychoanalytic Review"* in its 100th anniversary edition in March 2013 (Gubb, 2013a). When this paper was accepted for publication, the editor invited commentaries from two authors with an interest in the area and these two commentaries were included in the edition of the journal in which the paper was featured. Relevant points from these commentaries are included and discussed in the discussion chapter at the end of the thesis. The paper is reprinted here with the journal's permission. Please see the second volume of the thesis for a copy of the paper in its published format.

The paper takes the form of a theoretical review of recent literature on the topic of psychosomatic illness and builds on the foundation of the paper in the previous chapter. Having differentiated between two ways in which illnesses of the mental may manifest in bodily terms (i.e. conversion and psychosomatic illness) in the first published paper, this paper now explores the idea of psychosomatic illness in greater depth.

The paper begins with an introductory section which establishes the two contemporary schools of psychosoma theory which are then discussed in detail. The first of these theoretical approaches is the well-defined French school of psychosomatics, and the second is one which the paper identifies and argues for: the Attachment Approach. The paper explores in detail how each of these approaches understands the concept of mentalization and how this in turn informs the theorisation of the mechanisms involved in psychosomatic illness and consequently its treatment and the clinical implications resulting from these differing theoretical approaches.

This paper develops a number of the themes which were introduced in the first paper. The first of these is the question of whether the very form that the physical symptom takes has a meaning related to its origin and genesis or any underlying intrapsychic difficulties that the patient might have. The second of the overall

thesis themes discussed further in the second paper is the concept of mentalization, specifically different definitions of the concept are compared, and mentalization's underpinning of the link between psychic pain and physical symptoms is highlighted. The third theme that is developed in this paper is the idea that the talking cure facilitates acts of mentalization which then allows the symptom to move into the realm of the mental.

The paper broadly addresses similar research questions as the first paper. It differs from the first paper in so far as it also addressed a fourth research question, namely:

- What implications do the different understandings of the process of somatisation have for treatment of psychosomatic illnesses?

What the first two papers have in common is an understanding of the significance of mentalization in psychopathology. This issue will be taken up again in the Discussion chapter which will unite and differentiate the concepts presented in these two papers and will then explore the implications for clinical practice. The first half of the thesis as a whole, therefore, is a clinical contribution to the understanding of the role of the patient's body in psychopathology and how this is related to mentalization.

PAPER 2: PSYCHOSOMATICS TODAY[3]: A REVIEW OF CONTEMPORARY THEORY AND PRACTICE[4,5]

ABSTRACT

In the past few years there has been a dramatic increase in the number of psychoanalytic publications on the topic of psychosomatic illness, including edited collections and special editions of psychoanalytic journals. This paper is a critical conceptual review of the topic of psychosomatic illness using the material contained in a number of these recent publications as a basis, but also drawing on other works by the key authors of the publications discussed herein. This paper proposes that currently there appear to be two schools of thought around the origin, development, and treatment of psychosomatic symptoms. The first of these is the well-established "Paris School of Psychosomatics." The second approach does not formally exist, but is referred to in this paper as the "Attachment approach" since there are a number of authors who theorize about the treatment of psychosomatic symptoms in a similar and important way. The paper will compare and contrast the two approaches with respect to their underlying theories, treatment approaches, and conceptualization of the mind–body problem, with particular attention paid to how this is related to mentalization. The understanding of how problems in mentalization may be linked to psychosomatic illness can be conceptualized as the "speechless mind" from the perspective of the Paris School and as the "speaking body" by the Attachment approach. The paper concludes by engaging with these two conceptualizations and suggests that in order for an individual to achieve both psychological and physical health, the work of sensation must be located primarily in the logic and function of the body, while the work of making sense of these sensations and interpreting them must be located in the mind.

During the past few decades, psychoanalysis has not paid much attention to psychosomatics, and the field appeared to be losing relevance. There has, however, been an explosion of interest in this field in recent years. In the past three years alone, there have been special editions dedicated to the topic in the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* in 2008, and in *Psychoanalytic Inquiry* in 2010, an edited collection titled Psychosomatics Today: A Psychoanalytic Perspective (edited by Marilia Aisenstein and Elsa

[3] The main title of this paper is a reference to the collection titled *Psychosomatics Today* edited by Marilia Aisenstein and Elsa Rappoport de Aisemberg. This paper explores exactly the issues raised by the edited collection as well as other recently published works on the topic of psychosomatic illness.

[4] Copyright for this manuscript resides with the publisher: The Psychoanalytic Review. Citation: Gubb, K. (2013). "Psychosomatics today" : A review of contemporary theory and practice. *Psychoanalytic Review, 100*(1), 103-142.

[5] The paper is reprinted here exactly as it was published. As it was published in an American journal the spelling is US spelling which is different to the UK spelling used in the rest of the thesis.

Rappoport de Aisemberg) in 2010, as well as three papers published in the education section of the February 2011 edition of the *International Journal of Psychoanalysis*. This paper aims to explore the interesting phenomenon of this renewed and growing fascination with the field.

The paper engages with this recently published material and attempts to examine and analyze some of the key points and theoretical implications of the work presented in these special editions and the edited collection, supplemented by other works or references by key authors of the publications. This paper is based on the literature in the publications listed in the preceding paragraph, but is not limited to that literature.

I propose that there are two clusters of theoretical thrust contained in the literature. The first of these is a major school of thought that arose in France during the 1950s. This school is based on Freudian drive theory and has special interest in concepts such as alexithymia and operational thinking (Taylor, 2010). These theorists -including Aisenstein, Smadja, and Green - identify themselves as belonging to "The Paris School of Psychosomatics" and have the most coherent and well-developed psychoanalytic theorization of the topic of psychosomatic illness today; they are also the only school to stake a claim on the area of psychosomatics in particular. Some recent work, such as that being done in South America, consciously aligns itself with the Paris School (Fischbein, 2011). Much of the literature reviewed that discusses the theory and approach of this Paris School is taken from the edited collection *Psychosomatics Today*, but there are papers in both of the special editions whose authors explicitly identify themselves as belonging to the Paris School.

The second school of thought is an emerging, new approach in the psychoanalytic treatment of psychosomatic illnesses. While the theorists describing and making use of this new approach (including authors such as Griffies, Sloate, Kohutis, and Katz) do not identify themselves as belonging to a particular approach or express affiliations to each other, this paper attempts to demonstrate that members of this group are working with similar conceptual underpinnings distinct from those of the Paris School. This cluster of theorists focuses particularly on attachment theory and mentalization as described by attachment theorists such as Fonagy, Allen, Bateman, and Target, and their work will be referred to as the "Attachment approach" in this paper. Most of the writings from these authors were included in the special editions of *Psychoanalytic Inquiry* in 2010 and the *Journal of the*

American Academy of Psychoanalysis and Dynamic Psychiatry in 2008. A number of these authors had papers in both of these editions.

A condensed critical review based on a close conceptual reading of the material contained in these publications is presented next. It outlines the principles that underpin the diagnosis and treatment of psychosomatic symptoms of both the Paris School and the Attachment approach, as they are described in current literature, and then compares and contrasts them. In doing so, the paper will highlight the differences and similarities in the understandings of the two schools around a number of themes including the diagnosis, formulation, and treatment of patients who present for psychoanalytic treatment of psychosomatic illnesses. The paper ends with a critical discussion focusing on the clinical implications of the two approaches when working with the psychosomatic patient, based on the understanding that how a psychotherapist practices will be directly related to how he or she conceives of the cause of the pathology being treated, and by implication what is involved in its cure.

As the clinical implications of the differences and similarities of the two approaches are explored, the mind–body question is reexamined. That discussion is guided by questions concerned with how each approach conceptualizes the relationship between the mind and the body, and how this relationship is closely tied to the development of mentalization. I propose that from the Paris School's perspective, problems in mentalization which are linked to the development of psychosomatic illnesses can be understood as being related to the patient presenting with a "speechless mind": one that cannot do the work that a mind should because it has not developed sufficiently. From the perspective of the Attachment approach, problems in mentalization linked to psychosomatic illness may be thought of as the patient having a "speaking body," where the body attempts to do the work that should be located in the mind.

THE HISTORY OF THE DEVELOPMENT OF PSYCHOSOMATIC THOUGHT

A very brief history is presented here in order to highlight the origins of particular theories and propositions that are specifically discussed in the paper. For a more detailed history, readers are referred to papers such as those by Bronstein (2011) or Aisemberg (2010).

Freud did not write much about what is now considered psychosomatic illness; however, many of the debates that exist currently around the understanding of

such physical symptoms find their origins in Freud's early work, in which he differentiated between the bodily symptoms of psychoneurosis and those he called "actual neuroses." By "actual neuroses," Freud was referring to intense physical experiences, such as such as overwhelming anxiety that may accompany or mask fear. He understood these experiences to be a consequence of physical sensations that have not been able to gain access to the mind and contrasted them to the physical symptoms of hysterical conversions, in which psychic stimulation resulting from internal conflict is repressed and, after being thus kept out of the mind, is instead expressed in a physical way (Freud, 1894a).

It was his view that the actual neuroses are not caused by an original trauma, nor do they have a particular symbolic meaning in the form that they take (as in conversions), but that they were instead reactions to real, everyday tensions, particularly to libidinal frustration (Freud, 1912d). Thus for Freud, the actual neuroses are beyond what could be treated successfully by psychoanalysis, since making interpretations about their form or attempting to find a meaning behind them would not lead to a fruitful outcome (Gubb, 2010).

The whole debate about which physical symptoms can be treated using psychoanalysis seems to result from Freud drawing this distinction between the classic psychoneuroses (where the symptoms are symbolic and result from internal conflict, often based on early trauma, sometimes of a sexual kind, and where patients cannot take satisfactions available to them) and actual neuroses (often related to frustration, which is the result of sexual satisfaction not being available in the real world, where the nervous system is bombarded with reality). The distinction between the physical symptoms of the psychoneuroses and those of the actual neuroses turns quite strongly on the concept of hysteria, as it is here that the differences are most vividly expressed. In the hysterical conversion symptoms of the psychoneuroses, the relation between body and mind is entirely symbolic, unlike how the mind–body relationship manifests in actual neuroses or in organic illnesses (in which Freud [1912] saw no evidence of the mind).

Following Freud, the growth and expansion of the concepts of psychoneuroses, actual neuroses, and organic illnesses, and arguments for and against how are they distinguished, permeates the history of the development of psychoanalytically informed thought on psychosomatic illness.

Building on the Freudian foundations, the development of psychosomatics as a speciality began in earnest with the work of psychoanalysts such as Sándor

Ferenczi, Felix Deutsch, Georg Groddeck, and Flanders Dunbar. In a 1926 paper titled “Organ Neuroses and Their Treatment,” Ferenczi expanded on Freud’s actual neuroses and proposed the idea of “organ neuroses” as being “real” disturbances in the normal functioning bodily organs, and in this way attempted to distinguish organ neurosis from hysteria (although he acknowledged that the distinction was not always that clear-cut). Ferenczi’s account of organ neurosis proposed the notion of “organ eroticism,” in which, as well as being involved in maintaining life, organs are able to produce pleasurable sensations. His hypothesis was that if an organ were manifesting with an organ neurosis, it was evidence of a build-up of that organ’s erotic function (Bronstein, 2011; Ferenczi, 1955), which was similar to Freud’s idea that in actual neuroses satisfaction cannot be achieved.

Ferenczi’s ideas of organ neuroses were expanded by Felix Deutsch, who worked particularly on the concept of organ specificity. It was his proposal that early developmental occurrences might affect specific organs, and that the interaction of an intrapsychic conflict and a specific organ created a “psychosomatic unit” which was activated every time the individual experienced that conflict again (Bronstein, 2011; Deutsch, 1939). Authors such as Deutsch and Groddeck (1977) understood somatic illnesses to have symbolic meanings in line with Freud’s hysterical conversions. Thus, they saw illnesses as expressing unconscious fantasies and conflicts and believed that where these were interpreted successfully, just as with conversion symptoms, the patient would be restored to health (Taylor, 2010).

Flanders Dunbar emphasized the complexity of the combination of factors that are involved in a psychosomatic response, but did link certain personality profiles to particular illnesses. Her other major contribution to the field was the methodology of investigation that she established (Aisenstein & Smadja, 2010; Bronstein, 2011). Dunbar’s understanding of physical symptoms (just as those of Deutsch and Groddeck) then fell closer to the Freudian understanding of psychoneuroses than that of the actual neuroses.

Psychosomatics as it is understood today was, however, first studied systematically by Franz Alexander, who was a student and collaborator of Ferenczi, and who founded the Chicago School of Psychosomatic Medicine. Alexander attempted to relate specific somatic syndromes to specific psychological conflicts (Aisenstein, 2008), and based his work on two theoretical principles. The first of these expanded the idea of organ neurosis, and stated that overwhelming emotions that are psychically repressed are carried along the autonomic nerve

pathways to the organs. The functioning of these organs is altered after receiving these messages, and this effect is seen in the form of functional disorders. The second principle Alexander made use of was the theory of specificity; he proposed that specific emotions and personality types corresponded to specific physical dysfunctions (Aisenstein & Smadja, 2010; Smadja, 2010). He saw symptoms as symbolic expressions of unconscious psychic conflicts and explored how the individual's "choice of illness" related to particular types of conflict (Alexander, 1934). Alexander's work presented somewhat of a conceptual challenge in that he located these illnesses somewhere between hysterias, actual neuroses, and organic illnesses.

Contrary to Groddeck (1977) and Deutsch (1939), Alexander and his followers understood somatic illnesses to be asymbolic (as Freud understood the actual neuroses to be). In this understanding, illnesses are not a result of unconscious conflicts, but are rather a product of complex interactions between an individual's constitution and the physiological consequences of unrelieved emotional arousal (Taylor, 2010). Alexander suggested that in fact every physical illness was psychosomatic as it necessarily involved both physical and psychological factors. Thus, even though he had a dualistic view of the mind–body relationship, he still emphasized the very close connection between heightened emotions and the effect they have on the body (Alexander, 1950). He listed seven illnesses which he saw as "classic" psychosomatic illnesses. These were bronchial asthma, essential hypertension, peptic duodenal ulcer, regional enteritis, ulcerative colitis, Graves' disease, and rheumatoid arthritis (Bronstein, 2011; Smadja, 2010). Alexander's work thus seemed to be the beginning of a body of thought that rereads what would otherwise be regarded as purely organic illnesses as psychosomatic illnesses, and the upshot of this is that illnesses that traditionally would have fallen into the category of organic illness were reframed as being available to treatment by psychoanalysis. Thus in psychoanalytic work, some illnesses began to occupy a broad category that came to gain a coherence of validity in itself, and which rethought the extent to which a psychic dimension informed illnesses that were previously conceived as of organic.

These early ideas in the field of psychosomatics prompted much research, but were often met with the criticism that many personality types and intrapsychic conflicts are seen in individuals who do not present with a given illness as predicted by theories of Dunbar and Alexander. This critique is still relevant for even the most recent psychosomatic theoretical paradigms.

Alexander's work eventually felt out of favor in the United States, but it was especially well received in France, particularly his works *Fundamentals of Psychoanalysis and Psychosomatic Medicine*, and laid the foundations for the later work of the *psychosomaticiens* (Aisenstein & Smadja, 2010; Taylor, 2008b). It was however, criticized by the French thinkers for the dualism between the mind and the body that it proposed (Smadja, 2010).

THE PARIS SCHOOL OF PSYCHOSOMATICS

In an attempt to capture what is central to the treatment of psychosomatic illness as understood by the Paris School, it is important to discuss, first, the overall theoretical approach and its Freudian underpinnings; second, to link this to the Paris School's understanding of the mind–body conundrum; and, third, to explore how the theorists of the Paris School translate their theoretical understandings into clinical practice.

THEORETICAL UNDERPINNINGS

The Paris School of Psychosomatics has a long and well-established history. Calling themselves "psychosomaticiens," theorists writing in this tradition are affiliated to medical treatment centers such as oncology clinics, and also have day clinics that have been set up specifically to treat patients with what the Paris School classify as psychosomatic illnesses (Aisenstein & Smadja, 2010). It is interesting to note that some of the illnesses treated by the Paris School include those not typically considered to be psychosomatic, such as cancer. This is largely due to the fact that the Paris School rejects any dualism between the psyche and the soma and instead understands that these two entities are in a continuous interaction (Oliner, 2010). Therefore, they do not engage with concepts such as the difference between illnesses of the body and illness of the mind, an important tenet of their approach.

The roots of the school are acknowledged to be found in Freudian economic principles and concepts such as representation and transference, and the material I reviewed for this paper often quoted Freud (1915a): "If we apply ourselves to considering mental life from a biological point of view, the 'instinct' appears to us as a concept on the frontier between the mental and the somatic, as the psychical representation of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body" (pp. 121-122). In her paper "The Mysterious Leap of the Somatic into the Psyche," which was published in the edited collection

Psychosomatics Today (which she also co-edited), Aisenstein (2010) interprets this quotation as meaning that there is a demand from the body for the psyche to do a significant amount of work, but that this work cannot be done while the demand is in its crude and unrefined state, so the demand must first be interpreted by the psyche before it is able to respond. Crucially, she argues that if the body receives no response from the psyche, the body will increase its demands in both force and quantity. Such an increase in energy within the mind–body unit leads to tension that ideally needs to be discharged in a positive way in order to restore calm and homeostasis. This discharge of libido is experienced as pleasurable.

Aisenstein, who has written extensively on the subject of psychosomatic illness from the perspective of the Paris School, has three papers in the material listed at the beginning of this paper, and many others published in previous years. She describes how the drive signifies this constant, internal excitation psychically. The aim of instinctual impulses is to achieve discharge, and to this end, the drive directs the individual to seek out an external object that will allow the release of the tension. The drive and the object thus become indivisible (Aisenstein, 2010; Sechaud, 2010). While Freud wrote about the constancy of the drive thrust and how this is linked to the demands of creating psychic representations, the Paris School extends these concepts by exploring what happens when there is a discontinuity in the drive thrust (Aisenstein, 2010) or, in other words, when the discharge of libido depletes the ego.

Oliner (2010), who is the only author writing in the special edition of *Psychoanalytic Inquiry* from the Paris School's perspective, focuses specifically on the discharge of libido, and proposes that the inability to stem the outflow of libido results in the individual risking being gripped by the death instinct. She further suggests that this economically based preservation of libido is not inherent, but requires that the individual has reached the psychic organization level of "desomatization," which is the state where the individual moves from an undifferentiated stage to one that is more organized and in which somatic components achieve psychic representation. The attainment of such a developmental organization allows for the preservation of libido and the chance that emotional rather than somatic responses can be expressed because an organization of this kind is capable of containing the outflow of libidinal energy. If this level of organization has not been achieved, distress leads to fatigue, lethargy, or somatic illness. In fact, Marty hypothesized that it is this libidinal collapse that stops patients who stay sick from attempting to get better (Oliner, 2010).

In his writings about the discharge of bodily excitation as described earlier, Freud (1895) had understood that psychoneurotic functioning develops from memory traces resulting from satisfying engagements with the primary objects. He described how during such experiences of pleasure, endosomatic excitation resulting from internal and external perceptions of the relationship with the object is transformed into the drive and then again into psychic representation, and serves a structuring function. Aisemberg (2010) summarizes this idea by stating that this form of psychic functioning is the arena of Eros, which is a drive that organizes and objectivizes.

In contrast, beyond neurotic functioning there may be some somatic excitation that has failed to be transformed into drive, and which thus has no psychic inscription yet, and that shortcircuits to the soma. This is termed “non-neurotic” functioning by the Paris School’s theorists, who see it as being derived from the sensorial traces left by the experience of displeasure or pain that has not been transformed into drive and therefore remains unbound and on the border of the psyche and the soma. It is important to note that in the material I reviewed, the term “non-neurotic” was used as though it were common and understood, and appears to be referring to psychic functioning that is on the more psychotic or borderline end of the spectrum. Kriesler (cited in Fischbein, 2011, p. 92) describes non-neurotic subjects as acting rather than thinking, and as having no real mental life. They cannot manage internal objects, and are thus empty and without imagination. This functioning is summarized by Aisemberg (2007, 2010) as being in the arena of Thanatos, which is a drive that disorganizes and disobjectivizes.

Aisemberg (2010), who co-edited the edited collection with Aisenstein, explains that such non-neurotic functioning can coexist with psychoneurotic functioning. Somatosis is one manifestation of this non-neurotic psychic functioning, and is understood as an expression of the genuine unconscious, as opposed to the repressed unconscious of psychoneurotic functioning. Somatosis occurs at the point where possibly traumatic sensorial traces that are as yet untransformed, and that cannot be converted into drive, are short-circuited into the soma. These sense traces are preverbal, archaic experiences and will never become verbal. A trauma or significant loss in adult life may set this somatizing process into motion (Aisemberg, 2007).

Thus, according to the Paris School, the process of somatization may occur in one of two ways. The first of these routes to somatization is through regression, and the

somatization that occurs through regression usually leads to bouts of somatic illnesses that are not life-threatening and from which the patient can recover, such as asthma or colitis. This somatizing process typically arises in individuals whose psychic functioning is on the neurotic–normal spectrum, and occurs when there is an irregularity in mental functioning after an experience that overloads work of ego-binding, such as a trauma. The patient then regresses, with a resulting libidinal overcathexis of bodily functioning that leads to a physical system either over- or underfunctioning. The regression to this state brings temporary relief to the overloaded psyche, and the patient may be able to recover to his or her usual psychic efficiency as the situation resolves, or through therapy (Aisenstein, 2008; Smadja, 2010, 2011).

The second somatizing process Aisenstein (2008) and Smadja (2010, 2011) describe occurs when the drives become unbound, and the resulting illnesses are usually progressive and serious (such as autoimmune diseases or cancer), and may even lead to death. This unbinding of drives is usually seen in patients who are non-neurotic or in patients who have suffered a psychic trauma so severe that it has reopened early, deep narcissistic wounds.

What the theory of the Paris School suggests, then, is that it is the level of mentalization which the individual has achieved that determines which somatizing process occurs as well as the final outcome of the symptom. This will be discussed further in the following section.

The conclusion drawn by the *psychosomaticiens* following the theory outlined in this section is that there is no meaning in the form that the physical symptom takes; hence, they are more interested in the type of psychological functioning that the patient presents with (Oliner, 2010; Sechaud, 2010). Meaning is seen as important, but is understood to be a retrospective construction resulting from the work done in therapy. This reconstruction and meaning making becomes imperative in the patient's recovery and allows the patient to reintegrate somatic experience by making links and working through the conflicts (Aisenstein, 2008). In his paper titled "Thoughts on the Paris School of Psychosomatics," which was included in the edited collection, Green (2010) summarizes the view of the Paris School by saying that there is no meaning or significance in the form of the physical symptoms, but there is meaning and significance in the fact that the individual produced symptoms that are physical.

What this approach suggests, therefore, is that unlike in the classic formulations of psychosoma that can be seen to have originated in Freud's (1893b) "The Psychotherapy of Hysteria from Studies on Hysteria," the whole issue of the meaning of the form that the physical symptom takes is of much less interest to the clinician than the underlying psychic structure that resulted in the patient developing a symptom in the first place (Gubb, 2010).

The Parisian Perspective on Mentalization and the Mind–Body Conundrum: The "Speechless Mind"

In both the approaches to the treatment of psychosomatic illness under discussion, "mentalization" is the process that is identified as fundamental to understanding, avoiding, and treating psychosomatic symptoms. It is not surprising therefore that what links the Paris School and the Attachment approach is a concern for mentalization, but it is important to understand that the term is used differently by the two approaches.

The term "mentalization" was coined by Pierre Marty (1968), one of the founders of the Paris School, based on his work with somatizing patients. He observed that these patients showed a lack of psychic representations and psychic processing, as though their minds were empty. He built his theory of mentalization on the foundation of Freud's view that thought exists between the instinctual demands of the body and the actions that are taken to satisfy those demands. Freud underlined the importance of *bindung*, or linking, which occurs in secondary-process thinking, and which creates associations between internal states (which were understood in energetic terms) and gives them meaning. He differentiates this from primary-process thinking which is physical, immediate, and without psychic meaning (Freud, 1915c).

Following these Freudian origins, Marty (1968) understood mentalization as the mind's ability to do the work of interpreting and responding to the body's demands: Experiences of pleasure will allow mentalization to develop and to respond to the drives and cohere the parts of the mind, while an excess of excitation, and the resulting displeasure, causes the individual to have difficulties in the development of mentalizing abilities. Consequently, patients who somatize present with restricted mental functioning. Marty and de M'Urzan (1963) described this "operational thinking" as being devoid of fantasy life and as eroding the patient's relationships with his or her objects. They suggest that, rather than thinking,

individuals with poorly mentalized structures instead discharge excessive psychic excitation in action or via the somatic field in ways that have no symbolic meaning.

Aisenstein (2008) applies the preceding theory of mentalization to clinical practice. She believes that it is important to understand the level of the patient's ability to mentalize in order to work with him or her. Aisenstein explains that since the work of binding of representations takes place in the preconscious system, assessing the quality of the mentalization of a patient requires that one work at the level of the preconscious. She supports Marty's idea that mentalization can be assessed on three axes—depth, fluidity, and lasting quality—but suggests the addition of another axis: whether the activity of representation is dominated by the pleasure–displeasure principle or by automatic repetition.

The Paris School's theorists identify problems with mentalization by the way that psychosomatic patients present in the therapy room, and they have identified a number of ways of engaging that reveal the difficulties somatizing patients have in being able to mentalize. These include "operational thinking," "essential depression," and "alexithymia."

Operational or mechanical thinking is factual and makes no use of metaphor, and it is not tied to fantasy or symbolization. During analytic work, patients with this kind of mental functioning have real difficulties in associating to material and present with a narrative that appears to be dead and mechanical, and that is profoundly without affect. Functioning in this manner, with its associated reduction in the capacity to integrate traumatic events, puts the patient at high risk of becoming disorganized somatically (Aisenstein, 2008, 2010). These patients lack the ability to do the psychic work of elaborating, or working through, as the connections among the parts of their psychic apparatus and between their psychic apparatus and their body are non-existent; thus, they are not able to mentalize (Sechaud, 2010).

Essential depression is characterized by a lack of desire (rather than sadness or pain) and little or no emotional life, resulting from a libidinal loss. Patients with this form of depression describe just feeling empty (Aisenstein, 2006; Marty, 1968). Aisenstein (2008) views it as the negative of the trace of the self-destructive movement of the unbinding of the drives. Essential depression often develops following trauma, when the disorganization immobilizes and erases all mental expression (Smadja, 2010).

Alexithymic patients also have difficulties in mentalizing, specifically with putting their feelings (both positive and negative) into words. They cannot distinguish one affect from another, and have compromised nonverbal emotional expression. They often experience interpersonal difficulties, since they find it a struggle to understand the behavior of others. Their lack of emotional expression makes it difficult for them to elicit empathic emotions from others (Krystal, 1997; McDougall, 1986).

Read together, the Paris School of Psychosomatics' theoretical understandings of the cause and genesis of psychosomatic symptoms, the relationship of these symptoms to difficulties in mentalization, and the consequent manifestation of the symptoms of operational thinking, essential depression, and alexithymia allow one to conceive of somatizing patients as having a "speechless mind." The Paris School's reliance on Freudian economic principles repeats the notion that psychosomatosis is related to unbound affect. In this view, people who somatize are still operating on the side of the pleasure principle in the pleasure–unpleasure series. The development of the ability to mentalize may be likened to the early acquisition of the ego and the early instincts, as formulated by Freud. Once this development takes place, the mind can become one that has the ability to perform such symbolic tasks as speaking, thinking, and remembering, and is thus able to express itself without needing to rely on the body to do so in its stead. If this task is not completed, the mind cannot speak, as it has not fully developed its capacity to think and make physical experiences mental. Such a mind is all affect that is not modulated or controlled. This mind cannot express itself as a mind because it is all body.

In the literature I reviewed, it becomes apparent that the members of the Paris School are arguing that almost all illnesses that are not caused by a specific pathogen can be treated, and in some sense helped, by a specific form of psychotherapeutic intervention. This is precisely because of their conceptualization of how the body functions and what the mind–body relationship should be in illness or in health. The relationship between the physical and the mental is such that if a patient has an illness of the physical, it is likely to be closely linked to the level of mentalization the patient has achieved. In other words, from an economic point of view, what happens to the drive plays a part in the way in which physical illnesses function, and, therefore, incapacity in the primary relationship between the body and mind (understood here as being expressed by the level of mentalization achieved) exacerbates, and may possibly even cause, illnesses.

The *psychosomaticiens* thus present a theory of mentalization that suggests that there are possible relative components of the psyche and the soma in any psychosomatic illness which are dependent on levels of mentalization achieved by the particular patient. It then follows that there is an implicit understanding of the type of treatment required and how effective it may be. There is, however, an important question that is not identified and addressed in the literature, and that is the question of how the Paris School delineates which illnesses are purely psychological, which are psychosomatic, and which (if any) are purely physical.

Psychoanalytic Treatment of Psychosomatic Patients within the Paris School

It is interesting that the *psychosomaticiens* are very integrated with the medical treatment of physically ill patients and that the biological and psychological treatments occur hand-in-hand in Paris (Aisenstein & Smadja, 2010). Many patients are therefore referred to these clinicians after they have received a diagnosis of a medical illness, but they may also seek analysis due to psychological difficulties such as anxiety or depression which they do not directly associate with physical illness. It is worthy of note that many of the patients who have had psychoanalytic treatment "prescribed" following a somatic illness, and who have no interest in anything psychological, still manage to remain in treatment for many years. Aisenstein (2010) proposes that this is due to what she calls a "transference compulsion," which exists in everyone. In somatizing patients, however, this transference compulsion is less developed and integrated than in classical transferences, but does still meet the drive's need that representation is transferred from the physical to the mental. This may explain why these patients become attached to therapy and to the therapist.

When a somatising patient is first seen by a clinician from the Paris School, whether the patient was referred by a medical doctor or approached the clinician directly, he or she will be assessed in an attempt to uncover whether a regression or a complete unbinding of the drives is at play, as this School believes that it will be one of these factors which is causing the difficulties. This assessment will determine how the patient's pathology is formulated and what form the therapy will take (i.e., a classical analysis or a face-to-face therapy) (Aisenstein & Smadja, 2010).

Patients who are assessed to be neurotic and somatizing due to regression are likely to be offered a classical analysis, while those patients described as non-

neurotic and presenting with an unbinding of drives are more likely to be offered face-to-face treatment (Smadja, 2011). Whichever of these is chosen, the aim of the therapy remains the same: trying to awaken in the patient an interest in his or her own survival (Oliner, 2010) which he or she may have lost, or never had. This is achieved (as in all psychoanalyses) by the fostering of a transferential relationship. The transference is an expression of the unconscious, and is also the only tool that the analyst has to access these parts of the psychic apparatus. The aim therefore is to facilitate the development of a transference and to encourage the patient to make use of the fundamental rule in order to allow the unconscious derivatives to be revealed to the therapist. Memories can then be constructed from the repetitions that play out between patient and analyst in the transference, and in the countertransference, since these transferential manifestations are the symbolic equivalents of unconscious wishes. Aisenstein (2010) describes how in a transference there are many levels of transformation at work. There is the transformation from the somatic into the psychic, which is then in turn transformed into language, and then there is the transformation of the impulse from one object onto another. This final transformation is what ultimately makes it possible for regression in the therapy to occur.[6]

While working with patients who are experiencing an unbinding of the drives, the therapist will not be confronted with the typical defences of neurotic patients, such as resistances or compromise-formations, since these somatizing patients often present as though they are experiencing no internal conflict at all. Many times the only affect appearing out of the unconscious that the patient presents with is anxiety, which is used by these patients to avoid any libidinal impulses or activity. The therapeutic aim is to make use of the transferential–countertransferential relationship to give this anxiety back its meaning and eventually restore it to the status of being a real affect (Aisenstein, 2010). In order to achieve this, the unconscious derivatives need to be accessed and new material needs to be constructed on the primitive traces causing the anxiety. This is done through building a positive therapeutic relationship where the primitive experiences of pain and nonpleasure are replaced by experiences of pleasure. This occurs as a result of a holding, nonjudgmental and validating relationship that starts to structure the patient's mind and organize the repressed unconscious material (Aisemberg,

[6] It appears that Aisenstein (2010) is broadening the concept of "transference" to denote a drive to transformation as well as rudimentary relating that occurs in the early stages of treatment with a somatising patient, in relation to the more traditional sense, where a patient reenacts a past relationship in a current one. As she writes in French and her work is translated, there may be the possibility that there are slips in the usage of the concepts of "transference" and "transformation."

2010). The repetitive and consistent nature of the therapy and the transference allows the patient to give meaning to the sensorial traces, thus transforming them into representations (Aisemberg, 2007).

THE ATTACHMENT APPROACH

Before introducing what I am calling the "Attachment approach" to the treatment of psychosomatic illness, it is important to first introduce the notion of attachment and its theoretical foundations. What is distinctive about the Attachment approach is the way in which the conceptualization of attachment to mentalization unfolds, as well as how it is related to the mind–body question in terms of the way in which somatizing patients present in therapy, why and how they manifest physical symptoms, and the treatment of these symptoms.

The approach I am attempting to characterize here is rooted in classic developmental attachment theory originating with theorists like Bowlby and more recently expanded on by authors such as Fonagy, Allen, Bateman, and Target. Attachment theory started with the work of Bowlby (1969), who saw the aim of attachment as providing the infant with closeness to the caregiver in order for the child to feel secure. Advances in attachment theory began to focus more on the internal workings of the mind and moved away from Bowlby's theory that the individual's mind reflected the external world directly. Mary Main's (1991) contributions, specifically, understood the internal workings of the mind in a more complex way than Bowlby's did, but still described the mind in terms of cognitive structures and did not give much consideration to the role played by affect.

The application of psychoanalytic thought has brought a richness to attachment theory; in particular, mentalization is a very useful theoretical device with which to integrate attachment and psychoanalytic thinking (Jurist, 2005). The foundations of the notion of what is now understood as mentalization were seen in Bowlby's work, but were added to significantly by Main in her work on "metacognitive monitoring," which she defined as the individual's capacity to reflect on and think about his or her own thought processes (Main, 1991; Seligman, 2007). She understood that the quality of an adult individual's attachment symbols will determine the level at which that individual will be to think about his or her own thinking and, consequently, to represent complex emotions and memories accurately (Main, 1995; Slade, 1999). Fonagy (Fonagy & Target, 2007) later linked these early ideas to classical psychoanalytic concepts such as Freud's (1915c) linking (*Bindung*), Klein's (1975) depressive position, and Bion's (1962) alpha function.

THEORETICAL UNDERPINNINGS

The Attachment approach as it is described here does not formally exist, yet on reviewing recently published material, a large number of the writers (particularly those featured in the special editions of the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* [2008], and in *Psychoanalytic Inquiry* [2010]) seemed to conceive of and treat psychosomatic illnesses in a similar way. The Attachment approach's theory, as it is explained here, relies mainly on the work published in the two special editions cited. Some authors, such as Kohutis and Sloate, published work in both special editions, and their work is referred to extensively here. This work as it relates to psychosomatic illness may be seen as an extension and elaboration of some of the concepts used by the Paris School, and often provides evidence for some of the Paris School's concepts, as a result of scientific observations of mothers and infants.

These attachment theorists do not have a robust and explicit theory about the origins of psychosomatic illness, but they do write about and discuss many of the same illnesses as the Paris psychosomaticiens (particularly gastrointestinal difficulties). Attachment theory is a view based on a theory of normal development and focuses on how early attachment experiences influence the infant's attainment of an individuated body. This is a crucial early step in psychological development, as the emergence of the mind occurs out of the individual's sense of a coherent body and consequent sense of self (Fonagy, et al., 2004). This consideration of the infant's relationship to its body, in particular, seems to suggest that the Attachment approach contains theoretical ingredients that might credibly link it to the understanding of psychosomatic illness.

Attachment theorists state that during uncompromised development, the infant integrates sensory, visceral, and motoric excitations with images and words, and in this way expands existing emotional schemas. A fundamental aspect of this learning is dependent on the parents' ability to mirror and regulate the infant's emotional states, and in this way help the infant to convert emotional arousal into psychic elements that can then be thought about, named, and communicated (Fonagy, et al., 2004; Taylor, et al., 1997). The early mother–infant symbiotic attachment regulates the way the brain matures after birth, and also influences the basic neurobiological stress and affect-regulation systems. Early attachments have a profound impact on the child's physical health, regulation of affect, body ego development, and object relations, and also aid in the development of symbolic structures. When the attachment relationship is successful and the child

experiences pleasure, it will begin to develop an awareness of its physical self as a cohered unit (Maunder & Hunter, 2008; Sloate, 2010). The capacity to mentalize body and affect requires this type of secure attachment (Griffies, 2010).

Those attachment theory writings that do exist concerning the origins of somatizations in particular suggest that these are due to difficulties experienced by the child very early in life, which occur as the child's mind is forming (Taylor, 2008a). The authors from the Attachment approach (including Sloate, Griffies, Katz, and Taylor, all of whom are published in the two special editions) expand the general understanding of attachment and relate it to psychosomatic illness. It is their view that when attachment difficulties occur and the mother is unable to regulate and organize the child's experiences, the infant may not develop a capacity to modulate its own arousal and other affective states (Maunder & Hunter, 2008). Psychosomatic patients often describe their mothers as being either overpossessive and overwhelming or unattuned to the needs of their child. Authors such as Griffies (2010) and Sloate (2010) formulate such cases by understanding that this kind of mother may have engaged with her child's body as though it was her own narcissistic possession. In order to function, the individual may develop a split in his or her ego that will create a picture of pseudo-normal functioning. This is seen in many psychosomatic patients who can achieve great success in isolated areas of their lives. However, in creating this split, their unresolved conflicts and unprocessed affects, particularly those regarding separation and individuation, remain avoided, denied, unintegrated, and never symbolized (Sloate, 2010).

Griffies (2010) hypothesizes that some of the pain-processing dysfunctions seen in somatizing patients may stem partly from such problems in attachments. It is therefore possible that the irregularities observed in neuroimages of the basal ganglia of patients with chronic pain may be a sign of abnormalities in the neural circuits developed in early attachment. He illustrates these points in a paper published in the special edition of Psychoanalytic Inquiry by describing a case of a patient who suffered from fibromyalgia. The patient remembered his mother's care for him being mechanical and not in line with his needs. Since preverbal development, his attention had been exquisitely attuned to the sensations stemming from the fusion with his mother's body, which made it difficult for him to perceive and make sense of his own bodily sensations. This was revealed and interpreted in the transference by means of his intense sensitivity to any bodily movement made by his analyst. This patient's deficient capacity to mentalize

appeared to be a result of his poor separation from his mother and the resulting insecure attachment (Griffies, 2010).

Importantly, this focus by the Attachment approach on the process of separation and individuation differentiates them from the Paris School, for whom this is not of interest. Many of the cases published by these authors in the two special editions discuss the difficulties that the patients had in separating from their mothers. Many of them described the experience of having "one body for two" (Katz, 2010; Sloate, 2010; Taylor, 2008a). In the case of a somatizing patient described by Sloate (2008), this played out in the transference when the patient described feeling like there was only one body for herself and her therapist. For this particular patient, her lack of separation and individuation, as well as the parental prohibitions she had internalized against knowing herself, had made it impossible for her to grow up and develop past magical thinking to a more advanced level of mentalization.

The conclusion that can be drawn from a review of this collection of material written specifically about psychosomatic illness, as well as about attachment theory more generally, is that the separation–individuation phase will need to be worked through again in therapy in order to allow the patient to begin to view his or her body as his or her own and in that way to start to pay attention to the feelings within it.

While the Attachment approach authors are in agreement on the points described thus far, they appear to be divided on the question of whether or not a somatic symptom has symbolic meaning. Some of the writers in working in this approach state that somatization lacks symbolic meaning, and instead, in a way similar to the Paris School, understand it to be the result of compromised development (Beutel, Michal, & Subic-Wrana, 2008). However, while many of the cases described by these authors did not engage with the questions of the symptom's symbolism explicitly, the cases were formulated in a matter that implied an understanding that the physical form that the symptom took was relevant, important and necessarily symbolic[7] (Griffies, 2010; Kohutis, 2010; Sloate, 2010).

[7] In this sense, a symptom is understood as being meaningful and symbolic in the same sense as hysterical symptoms. In such cases the form that the symptom takes is in some way related to the underlying psychological conflicts experienced by the patient.

The Attachment Perspective on Mentalization and the Mind–Body Conundrum: The "Speaking Body"

As stated earlier, "mentalization" is for both approaches a concept that is vital to understanding the psychogenesis of psychosomatic illness. It is a term which is used widely in the literature of psychosomatics, as well as in current psychoanalytic literature more generally. Although the term was coined by the Paris School, there are some nuanced and some more significant differences in the way that it is used by the Attachment approach.

The term "mentalization" is used generally by attachment theorists such as Allen, Fonagy, and Bateman (2008) to mean "imaginatively perceiving and interpreting behaviour of oneself and others as conjoined with intentional mental states, the shorthand for which is holding mind in mind" (p. 348). Fonagy (1991) explains that for an individual to be able to achieve control over intense affects, he or she needs to be able to represent the idea of what an affect is. The attachment theorists see mentalization as a form of imaginative mental activity that allows a person to perceive and interpret one's own and others' behavior (Fonagy, et al., 2004).

While the Paris School focuses on the binding of the instinctual drives and how unpleasure handicaps the development of the psychic structure and thus mentalization, the attachment account of mentalization focuses on intersubjective and developmental aspects, with particular emphasis placed on the mother's role in helping the infant develop the ability to endure and make sense of affects. During normal attachment experiences the infant internalizes the caregiver's empathic expressions and thus develops a secondary representation of his or her own emotional state. Infants who are neglected and traumatized may later reveal problems in mentalization and self-regulation (Bouchard & Lecours, 2008). If the infant experiences either inadequate parental containing and reflective functions or trauma during childhood, he or she may experience emotions that are only weakly connected with images and words and that are subsequently experienced as mainly somatic sensations (Krystal, 1997). He or she may later present with somatization, alexithymia, or other medical and psychiatric disorders associated with dysregulation of affect (Fonagy, et al., 2004; Taylor, et al., 1997). In summary then, there is not a significant difference in the understanding of what mentalization is between the Paris School and the Attachment approach; rather, the difference lies in the understanding of the factors involved in the development of the ability to mentalize. The Paris School emphasized the impact of innate drives and their

frustration or satisfaction, while the Attachment approach focuses on the type and quality of early interactional experiences.

The use of the concept of mentalization in general attachment theory has been expanded by the theorists of the Attachment approach to apply to the understanding and treatment of psychosomatosis. For example, Katz (2010), who writes about psychosomatic illness in the special edition of *Psychoanalytic Inquiry*, uses the term “mentalization” to describe the reflective function that allows an individual to be aware of his or her emotions and thoughts. He explains the role of mentalization in preventing somatization by highlighting that the ability to mentalize is a significant developmental accomplishment which depends on the child being cared for well enough to assist the child in making meaning of his or her experiences and thus not to somatize. When an individual has not achieved a robust capacity to mentalize, the result may be deficient self- and object-representations and consequently a reduced capacity to hold overwhelming experiences within the mind. The individual then either needs to find someone else to contain the experience—distancing himself or herself from the intense emotion by acting out physically or projecting it into someone or something else—or to thrust it into the body in the form of illness or pain. So in summary, from the Attachment approach’s perspective, mentalizing is the intrapsychic capacity that contains and transforms bodily experiences. When it is deficient or unavailable, one needs to make use of other techniques of handling emotions. One such method is somatization, where unbearable and chaotic feelings are forced from the experiencing mind, leaving behind them physical residues of affect that continue to work on the body.

The question that is raised by this understanding of mentalization is how a patient with this form of psychic structure will present in therapy. Just as the Paris School links essential depression, operational thinking, and alexithymia to poor mentalization and the psychosomatic processes, the Attachment approach links concrete thinking to psychosomatosis.

People who are “concrete” tend to describe events rather than reflecting on them, and only attribute meaning to objects that can be perceived through touch or sight. They also experience emotions as events that happen to them, rather than as their own distinct responses to experiences. This way of being may not simply be a defense, but often suggests that the individual is unable to think abstractly, to symbolize, to reflect on himself or herself, or to tolerate uncertainty. It is well

accepted in the literature reviewed here that somatizing patients typically think very concretely (Kohutis, 2008, 2010; Taylor, 2008a; Tylim, 2010).

Kohutis (2010), for example, describes a case of a patient with irritable bowel syndrome in the Psychoanalytic Inquiry special edition. This patient knew the names of negative affects intellectually, but could not associate them with the way he experienced himself. During the therapy he was eventually able to integrate his feelings into his self-experience and could then talk about them freely rather than having to act them out in criticisms, control, and diarrhea as he had done previously.

In an earlier work published in the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* special edition, Kohutis (2008) relates the concepts of concrete thinking to alexithymia when she asks whether her patient who engaged in a very concrete manner and who presented with gastrointestinal and gynaecological problems was alexithymic. She argues that alexithymic patients have difficulties with identifying and describing their feelings and also have a limited fantasy and dream life. They tend to view the world literally and make little use of symbolic thinking. Unlike most alexithymic patients, Kohutis's patient was a prolific dreamer. Kohutis makes sense of this apparent contradiction by referring to Krystal (1997), who points out that alexithymic patients might be able to dream, but they will not be able to associate to their dreams, just as Kohutis's (2008) patient was not able to do so. Kohutis then seems to be creating a parallel between the understanding of operational thinking and of alexithymia and the understanding of concrete thinking.

Taken together, the Attachment approach's conception of the relationship among concrete thinking, mentalization, attachment theory, and psychosomatic illness is conceived of in Kohutis's paper as the "speaking body." Attachment theory emphasizes how emotions and experiences are initially physical, and it is a developmental task to learn how to read, interpret, and make sense of these physical stimuli. When problems occur in this process, and the mind does not learn to think, symbolize, and communicate, the body does so instead.

What is revealed after reviewing the work in the collection *Psychosomatics Today* is that the Attachment approach theorists appear to engage with illnesses implicitly described as psychosomatic using the same theory of mentalization that they have applied to a number of other illnesses traditionally seen as being psychological. This approach would thus define an illness as being psychosomatic if it is in any

way related to unexpressed, inaccessible or disavowed emotions. The Attachment theorists therefore do not have a theory of psychosoma in particular, but view all suffering that can be treated by way of a talking cure in the classic psychoanalytic tradition as being related to early development.

Psychoanalytic Treatment of Psychosomatic Patients Based on the Attachment Approach

While the Paris School has clear ideas on how different types of psychic functioning may result in the patient presenting with different types of illnesses, theorists from the emerging Attachment paradigm do not take a clear stand on which psychosomatic mechanisms are associated with which illnesses. The Attachment approach does not propose different underlying mechanisms (e.g., unbinding or regression) in different physical illnesses and therefore treats all psychosomatic illnesses in the same manner. However, the cases described in the collection of Attachment literature reviewed include many of the same illnesses that the Paris School engages with, such as cancer, chronic pain syndromes, irritable bowel syndrome, and colonitis.

Unlike the patients of the Paris School therapists, the patients described by the Attachment theorists were not “prescribed” psychotherapy by medical doctors, and all sought psychotherapy of their own volition. What is more, the majority of these patients did not seek therapy in order to treat their physical illness, but instead began therapy in order to better manage the psychological difficulties they experienced in coping with their physical illness, or for other unrelated psychological difficulties (Griffies, 2010). Like patients described by the therapists from the Paris School, many of these patients denied any connection between their emotional life and their physical malady (Sloate, 2010).

In treating patients with psychosomatic disorders, the Attachment literature reviewed describes the aim of the treatment to be for the therapist to help to maintain the patient’s self- and object representations within his or her reach so that the patient can slowly develop a capacity for independent mentalization. In other words, the therapeutic task is to assist the patient in creating a psychological space in which he or she becomes aware of, and curious about, his or her mind and body and the relationship between them, so that the patient can begin to hold on to his or her own experiences and to reflect on them, instead of simply ejecting them into the body (Katz, 2010). Until the patient has developed such a mentalizing mind, interpretation (which is by definition metaphorical and symbolic) is not

beneficial (Griffies, 2010), so the therapy begins by helping the patient recognize and then verbalize his or her physical and psychic experiences.

This was illustrated in many of the cases discussed in the two special editions, where the authors described that as the patient's reflective capacity developed, somatization was no longer the patient's sole mode of expression. Patients began to realize the importance of putting physical experiences into words, and to see how foreign they had previously found that form of expression. When they previously could not find words, they had made use of their soma (Ginieri-Coccossis & Vaslamatzis, 2008; Kohutis, 2010). As mentalization is fortified, the capacity for cognitive-emotional differentiation is enhanced, which allows patients to consciously process memories and affects that were previously repressed and dissociated. As these are worked through psychologically, they will no longer need to be played out in physical terms (Beutel, et al., 2008). The symbolism in the form that the physical symptoms takes gives clues to the underlying difficulties; when the symbolism is accessed and decoded, the patient and therapist can make sense of the symptoms. Thus, the patient can slowly be helped toward more effective or functional mentalization, bringing the conflicts and difficulties into the realm of the mind and of thought, and ultimately of language and speech.

As is true in psychoanalysis generally, as therapy progresses, conflicts will begin to be acted out in the transference. The analytic frame, and the associated holding and containing functions, together with the new object relationship that develops help the patient to understand his or her destructive enactments on the body, and allow the patient to develop new patterns of behaviour without fear of retaliation, overstimulation, or boundary breaches— in other words, to separate and individuate safely (Sloate, 2008; Taylor, 2008b). The patient will then develop through the psychosexual stages toward health. In other words, the initial treatment phase with these patients aims to help them develop enough of a mind so that they then will be able to enter treatment proper—where the approach that is used is not specific to the form of illness that the patient presents with.

Clinical Implications of Different Theoretical Understandings of Psychosomatosis

Given the Paris School's understanding of the different possible mechanisms at work behind any illness that they perceive to be psychosomatic, it follows that they would believe that psychoanalytic treatment would be of use. Since the patient's psyche is seen as playing a part in the origin of the illness (the "speechless mind"),

treatment is aimed at that very problem. The Paris School does not make claims about being able to cure any illness, but does assert that psychoanalytic intervention may halt the spread and development of an illness.

Following this understanding that psychosomatic illnesses result from compromised levels of mental functioning, it is important for the analyst to adjust and temper any interpretations made so that they will fit with the patient's level and type of psychic functioning. At all times the therapist should bear in mind the economic cost of the illness to the patient and the stage of progression it is in. Smadja (2011) refers to Marty when describing this vigilance and adaptation of the therapist, and characterizes the process that unfolds as moving "from the maternal function to psychoanalysis" (p. 229).

While the Attachment approach offers an explanation of the development of psychosomatic illness, it does not seem to suggest that this understanding requires an adjustment in technique in order to treat these patients. The focus would instead be on building links between somatic sensations and their meaning, or, in other words, allowing the "speaking body" to hand back communication to the mind. There is no requirement to change the format of the therapy, only the timing and format of the interpretations.

The Paris School describes how demanding it often is to be attuned to psychosomatic patients in the way required because of the difficulties in making therapeutic contact with alexithymic and operational patients, who function in a rationalizing rather than reflective way. Bronstein (2011) calls the initial relationship between the therapist and such patients a "relation blanche" and describes it as having no real emotional involvement. It is imperative therefore that the focus is always on keeping the psychotherapeutic relationship alive or giving it life, as it is this which reorganizes the patient's psyche. The therapist must defend against feeling bored and uninterested in treating these disconnected and unresponsive patients. Authors such as Smadja (2011) suggest making use of psychodrama and playful interpretation in order to achieve a flowing and alive conversation while still maintaining the analytic stance.

It is not only *during* treatment that caution is required; it is also imperative that the therapist is cautious at the termination of treatment. Although a patient may appear to have stabilized both psychologically and physically, a break or end in the treatment could result in the regeneration of a progressive illness with serious consequences (Smadja, 2011). Fischbein (2011) describes a sign of such a

deterioration, which may occur at any point in a treatment, as an absence of dreams in the patient's narrative or the appearance of repetitive, operational, or "raw" dreams. These are indicative of the impact of a new trauma on the patient's psyche and should serve as a warning to the therapist.

This link between dreaming and psychosomatosis is also of great interest in the Attachment approach, whose theorists write prolifically about the relationship between dreaming and somatization. It is generally accepted as true that due to the concrete, asymbolic functioning that psychosomatic patients present with, there will be fewer dreams presented in therapy (Griffies, 2010). It is interesting, however, that this was not true in many of the case histories presented (Griffies, 2010; Kohutis, 2008).

The fact that many of the somatizing patients discussed by the Attachment approach did report dreams that were used in their treatment suggests the conclusion that symbolic and nonsymbolic mental functioning may occur alongside each other, depending on the patient and his or her circumstances. It might also suggest that fixations may occur at a number of different levels during the development of the ability to mentalize and, depending on this fixation point, the individual may dream more or less frequently. The dream content may be restricted or unlimited, and the patient may or may not be able to reflect on the dream and associate to its content.

Griffies (2010), for example, discusses a somatizing patient who was able to symbolize enough to produce a dream, but was not able to self-reflect (or mentalize) about the dream's meaning. Similarly, Kohutis (2008) presented a patient who dreamed frequently about houses. These dreams played a significant role in the treatment, although they had very limited content. In this treatment the dreams never developed into anything like a classical analytic dialogue, since the process that took place was the patient recounting her dreams and the analyst reflecting on them. The dreams did, however, provide a common language and space for the patient and analyst to work in. Nevertheless, it is important to note that while these examples are rich and add to the understanding of the individual cases, they do not appear to be particular to psychosomatosis, since any concrete patient may present with such dreams, but may not necessarily somatize. The link between certain types of dreams, concrete thinking, and psychosomatic illness is not yet well developed enough in the literature to be of any diagnostic significance.

Interestingly by contrast, none of the Paris cases in the material reviewed included any dream material. While there was no explicit commentary about the interactions of dreams and somatization, the lack of comment implies that it may not be an area of specific interest or focus. Secondary references comment that alexithymic patients do not typically report many dreams, and this implies that there is a known link between psychosomatosis and diminished dream activity (Krystal, 1997). Dreaming is a good prognostic sign in a therapy, as it demonstrates that a level of symbolization and creativity does exist in the patient's psyche. When the patient begins to produce dreams, it may suggest that his or her ability to mentalize is occurring at higher and more complex levels.

Fischbein (2011) writes from the Paris perspective, but his view reflects that of both approaches when he emphasizes that mental organization and its work provide protection for the patient from psychosomatosis. It follows, therefore, that the more plentiful and varied the products of psychological work are, the less chance there is of somatization in particular. The contrary is also true, and when the psyche is disorganized or impoverished, there is more chance that the patient will begin to somatize when better defenses fail.

DISCUSSION

The complexity that arises when trying to compare these bodies of theorists is that one group has an explicit and elaborated theory of psychosoma in particular, while the other does not. The Paris School has a theory that includes an understanding of the drives and how these are involved in mentalization. This approach does not have an explicit distinction between illnesses they would describe as psychosomatic and other physical illnesses, and this question is not addressed. So while the theory appears to apply to psychosoma in particular, the question is never raised theoretically about whether there are any other forms of illness (i.e., purely physical suffering, or purely mental suffering). Since the theory includes the idea that there are different levels of mentalization that can be achieved, and thus different degrees of somatizing, it is implicit, however, that there could be illnesses which are purely physical. The Paris School theorists do not explicitly say why some illnesses, such as rheumatic fever, are not treated psychoanalytically while some illnesses, such as cancer, are.

The Attachment approach does not have a theory of psychosoma in particular. In the interest of treating patients with illnesses assumed to have a psychosomatic dimension, this approach makes use of the general attachment theory of

mentalization and relates all forms of both bodily and psychic health to failed attachment. This school approaches all suffering that can be treated by way of a talking cure as being related to early development in the classic psychoanalytic tradition.

The consequence of these difficulties is that the literature, then, has all of the richness and many of the problematic aspects associated with a theory that does not delimit its object of intervention. While both schools have identifiable theoretical underpinnings, neither of the approaches specifies the particular domain of their intervention, and they do not answer the question of what distinguishes psychosomatic illness from other sorts of illnesses.

The apparent unconcern around this lack of clarity may stem from the observation that in psychoanalysis, as well as other areas of research and therapy, there is an increasing drive for less duality in the understanding of the relationship between the body and the mind. This is particularly true in the field of psychosomatics, although, as we have seen, different paradigms understand the mind–body relationship in different ways.

Having reviewed the literature on psychosomatic illness contained in recent publications, and having considered the two broad approaches contained in that literature, a number of similarities and differences have emerged in the understanding of the mechanisms at play as well as the diagnosis and treatment of psychosomatic illness based in the mind–body relationship.

As has already been noted, although the topic being discussed is physical illness, there is little in the material reviewed that comments directly on the types of physical symptoms that are targeted specifically by psychoanalytic therapy. The Paris School does classify groups of illnesses by their underlying psychosomatic origins, as well as making some comments on the different ways these categories of illnesses are treated. The Attachment approach does not, however, engage with the idea directly, but all the cases reviewed included the same kinds of illnesses as those discussed in the literature aligned with the Paris School. The physical illnesses targeted by psychoanalysis are illnesses where the body's functioning becomes unregulated and an organ or a system over- or underfunctions. They are thus illnesses where it is the "self" that is causing the illness (rather than an external pathogen), and where the body appears to attack itself, such as in autoimmune diseases or cancer. This implies that illnesses that are caused by

infections or bacteria are understood as having different causes, and thus receive no attention in this literature.

One of the biggest differences between the two approaches discussed is their understanding of the mechanisms involved in the origin and genesis of psychosomatic illness, which is related to their divergent theories about both infant development and what is understood to be at the origin of psychic life. The Paris School stresses the importance of the drive and sees the roots of psychosomatic illness as being in excessive physical sensations and the consequent need to reduce this unpleasant stimulation. The mind cannot make sense of such experiences and is unable to transfer them into entities that can be thought about—this is described here as the "speechless mind." By implication, the Paris School focuses more on individual constitutions than on early object relations. The Attachment theorists come out of an object relations tradition and give an alternative explanation for the genesis of psychosomatic symptoms. In this conceptualization, something goes wrong in the object relations when the mother cannot regulate the child's affects; the child thus does not develop the necessary level of mentalization to reflect on experiences, and instead expresses them in his or her body—by way of the "speaking body." As a result of their object relations roots and focus on the interpersonal, the Attachment theorists consider difficulties that occur during the separation–individuation phase to be important in the development of psychosomatic symptoms. When the child has an experience that there is only one body between himself or herself and Mother, the child may have difficulties identifying and making sense of his or her own bodily experiences. This is not a focus of the Paris School. Both theories, however, consider psychosomatic symptoms to be a result of psychic deficits rather than of the intrapsychic conflicts that result in neurotic symptoms (Bronstein, 2011).

Another important difference between the approaches is their understanding of the meaning of the form that the physical symptom takes. The debate that started between early theorists such as Deutsch and Alexander continues today. Theorists of the Paris School see no meaning in the form of the symptom (Oliner, 2010; Sechaud, 2010). There is some debate about this among the Attachment theorists, but the thrust is toward meaning. In the cases discussed in the literature reviewed, it appears that the meaning that the symptom holds has to do with the manner in which the object is taken in, and whether there was an identification with some sort of physical aspect of a primary object. An example of this was Tylim's (2010) case in the special edition of Psychoanalytic Inquiry, in which the patient's diarrhea was

linked to his identification with his mother, whom his father had described as being dirty. This case therefore demonstrates the patient's difficulties in mentalization, as the idea seemed to have been taken in as a form of a very concrete "symbolic equation" (Segal, 1957) rather than being thought about symbolically.

As described earlier, there are some major and some subtle differences in the way that the two approaches understand mentalization. The Paris School understands mentalization in terms of economic theory and intrapsychic mechanisms, and maintains that pleasurable experiences foster psychic cohesion and the ability to mentalize, while displeasure disrupts psychic cohesion, thereby handicapping the development of mentalization. The Attachment theorists understand the development of mentalization in interpersonal, object relation terms, asserting that caregivers help children to regulate their affects and that this is what allows the child to develop the ability to mentalize. Negative or traumatic experiences in childhood interrupt the development of mentalization. An interesting overlap is that Marty's (1968) formulation of the ability to mentalize included the power to associate as well as permanence and stability of internal objects, and in this way is very similar to what Bowlby described as the psychological faculties of the securely attached child (Fonagy, 1999).

An area where the two approaches do appear to agree is the view that the task of the therapist might change through the process of therapy. The Attachment approach proposes that there is an initial stage in the treatment that fosters the development of mentalization; once this is achieved, the patient is able to enter analysis proper. This concept seems to relate to the Paris School's idea that some patients might do better by starting with face-to-face therapy and then eventually moving onto the couch.

Having discussed the similarities and differences between the schools, it is important to note that *within* each of the schools there are also some areas of difference or contradiction. An example in the Paris School is Aisenstein (2006), who sees psychosomatic illness as an extension of Freud's "actual neurosis," while Smadja (2011) states that psychosomatic illness falls into what Freud called "illnesses of the body." It may be this very sort of contradiction that leads to the complications in the Paris School described earlier, wherein there is confusion about exactly which illnesses are included as "psychosomatic" and which are not. An example of internal difference in the Attachment paradigm is that a small number of these theorists question whether there is any symbolic meaning in the

form that the physical symptom takes (Beutel, et al., 2008), whereas the majority of the Attachment theorists take the stance that the symptom's form is meaningful. This paper has attempted to give a coherent account of each school, but there are some inconsistencies in the positions held within each school.

The differences in the two approaches to psychoanalytic treatment interventions appear to be subtle, and possibly no more dissimilar than what one would see on different continents anyway. While the theoretical underpinnings of the origins of psychosomatosis are substantially different, there are certainly some areas of similarity. This may mean that it is not beholden upon any analyst to locate himself or herself in any particular school or paradigm in order to successfully treat a somatizing patient. It seems that the clinician's understanding of the origin of the symptom only affects the treatment approach regarding questions such as whether the treatment should take place face-to-face or on the couch. However, following those initial decisions, the aim of the treatment in both the approaches, despite the significant and interesting differences between the two paradigms, is to help the patient become interested in the contents of his or her own mind, the sensations of his or her own body, and the relationship between the body and the mind, as well as to explore the transference relationship that develops between analyst and patient. The two approaches are therefore not mutually exclusive. In the literature reviewed, therapists from each of the treatment approaches described positive changes in their patients' health—both psychological and physical—and thus understood the treatment to have been successful.

CONCLUSION

It is my opinion that the most important aspect that the two approaches have in common is that the intervention on the bodily symptoms is made via speech. This implies that there is an understanding that bodily suffering is intimately connected to psychic suffering and that both of these can be treated by means of the mind via language. The very basis of the "talking cure" is that words can interact with feelings and in this way create both psychic and physical change (Bucci, 2010)—that the therapist can make contact with both the conceptual "speechless mind" or the "speaking body" and cultivate the development of mentalization, so that the patient can move away from either of these problematic positions to one which better promotes both physical and mental health.

Both the speaking body and the speechless mind are concerned with forms of illness that can be described as psychosomatic, and both arise from some form of

disturbance or inadequacy in what belongs in the mind and what belongs in the body due to problems in mentalization. It is mentalization that underpins the form that the relationship between body and mind takes.

Both schools argue for a conceptual unity of body and mind as a goal or requirement, and see body and mind as being intimately connected and yet necessarily functionally separate since early development: They must work in tandem, but they must work differently. The mind must be able to take account of the body's affects and appropriately allocate meaning to them, rather than letting the body itself do the meaning making. In other words, the work of sensation (both pleasure and unpleasure) must be located primarily in the logic and function of the body, while the work of making sense of these sensations and interpreting them must be located in the mind. Psychic health is dependent upon this ability to spontaneously achieve the capacity to distinguish between pain and meaning.

As the very term "psychosoma" suggests, the ways in which the body and the mind are related in someone presenting with a psychosomatic illness involve a transfer of the functions and locations of the relationship between the mind and the body. In psychosomatic illness the forms of the connection between the mind and body are in some way deformed, and functional elements of that ongoing complex connection have somehow not been established as functionally distinctive, either developmentally or in some return to a bodily focus due to a trauma. The Attachment approach conceives of this in terms of the body behaving as if it was a mind; in the case of the Paris School, the mind is behaving as though it were purely body. However, both schools suggest that the aim of therapy is for bodies and minds to express themselves in conjunction, but in the right registers, in the right locations, and with the right emphases. This will allow the patient to "speak" his or her mind, and not his or her body.

CHAPTER 6: THE ANALYST'S PHYSICAL RESPONSE TO THE PATIENT

INTRODUCTION

The paper in this chapter is entitled "Craving Interpretation: A Case of Somatic Countertransference" and is the first of the two papers which make up the second half of the thesis which focuses on the body of the therapist. The paper has been provisionally accepted for publication by the accredited journal "*The British Journal of Psychotherapy"* in August 2013 pending some minor changes which are currently being processed[8].

The first half of the thesis is a theoretical understanding of how psychic symptoms can manifest in the body. The second part has more of a clinical orientation and focuses on the body of the analyst rather than the body of the patient. It is not saying that the analyst's body is necessarily symptomatic, but is suggesting there are concepts from that original literature that are useful in understanding how the analyst's body can present in a therapy, and how it might become a therapeutic object.

The paper has a clinical emphasis and advances some of the ideas presented in the first two papers. This third paper mirrors the work done in the first two papers by suggesting that the same mechanisms are at work when the analyst experiences bodily 'symptoms' as when the patient somatises (as described in the first two papers). The paper proposes that what the therapist has learnt thus far about the nature of somatisation, then needs to be applied by themselves to themselves. The paper gives a clinical example of how this may done, and suggests that the therapist's reverie does the interpretive work about the therapist's own 'somatisation' that the therapist's free floating attention and interpretation would do for the patient.

One of the most important of ideas in the paper is an extension of the common understanding that it is the therapist's role to foster mentalization in the patient, and in fact that the therapist may even need to mentalize on behalf of the patient on the

[8] This paper was published during the time that the thesis was being examined. Copyright for this manuscript resides with the publisher: British Journal of Psychotherapy. Citation: Gubb, K. (2014). Craving interpretation: A case of somatic countertransference. *British Journal of Psychotherapy, 30*(1), 51–67.

assumption that there are times when material that is unavailable to the patient's mind is being revealed physically in the patient's pathology. The task of therapy could therefore be conceived of as the therapist promoting the development of the patient's ability to mentalize by means of their own mentalization. The second set of two papers expands on this notion by suggesting that it is as important for the therapist to apply the process of mentalization to their own bodies and to carefully attend to what doing so may reveal about what has, until that point, not been available to the therapist.

The paper is therefore advocating that if focus is given to the therapeutic dyad which the contemporary writings on countertransference recommends it should, it then becomes necessary to theorise the clinical practice to include thoughts on how the therapist should read and engage with her own "failures" of mentalization that emerge at the level of the body and engage in a process which gives meaning to these physical experiences and moves them to the realm of the mental. The argument is therefore being made that the therapist needs to take the impact of the patient on her own body seriously, and to interpret this in the context of the dyadic relationship

The clinical development which thinks of the notion of countertransference in a wider sense than what was originally presented by Freud, together with the more contemporary move in the countertransference literature which brings the other half of the therapeutic dyad – the therapist – into greater focus than might previously have been the case, facilitates this opening up of the idea of the therapist's own body emerging in the room, and enables the therapist to think about the moments in the therapy where they may not have been able to (immediately) mentalize. It is these historical and theoretical moves which open the door to the second half of the study.

The paper makes the specific points that Ogden's understanding of reverie makes it possible for the analyst to engage in reverie specifically relating to any somatic experiences that might occur during a particular treatment. It will therefore suggest that while reverie is broadly a part of the literature on technique, it is also an instrument of mentalization.

The research questions which are directly addressed by this paper are:

- What information about the therapeutic dynamics are revealed by the therapist's physical response to the patient, and how can this be used in the treatment?
- What might the patient's references to the therapist's body reveal about the therapeutic dyad, and how can this information be used therapeutically?
- What are the potential benefits of paying particular attention to the embodiedness of both members of the therapeutic pair?

PAPER 3: CRAVING INTERPRETATION: A CASE OF SOMATIC COUNTERTRANSFERENCE

ABSTRACT

Contemporary psychoanalysis views the countertransference as equally important to the therapeutic endeavour as its counterpart, the transference. This paper focuses on a particular kind of countertransference phenomena: those which are bodily in form and perceivable to the patient. It begins with a brief rehearsal of some of the fundamental psychoanalytic principles related to bodily symptoms, and then reviews the developments and changes that have occurred in the understanding of the concept of countertransference. The focus then shifts to theoretical developments around somatic countertransference in particular, and the division seen in the literature between authors who locate the source of the phenomenon of somatic countertransference in the patient's unconscious, and those who locate it in the therapist's personality or psychic history. The paper will argue that while attempting to characterise somatic countertransferences into a generalizable set of personality types of either the patient or therapist may provide a general understanding of the phenomenon, exploring the uniqueness and specificity of the therapeutic dyad will reveal important information about the dynamics at work in the therapy. The paper uses a clinical example to illustrate the specificity of the form that a somatic countertransference takes in a particular therapy. It then proposes that in order to make sense of the rich information that this unique response provides, the therapist must mentalize and make meaning of her particular somatic experience by way of a therapeutic analysis of reverie. The paper concludes with several comments on issues to consider when working with perceivable somatic countertransferences in particular.

INTRODUCTION

This paper is located within the context of attempting to 'mind' what the analyst's body can bring to a therapeutic process. The paper focuses on moments in the therapy when the analyst's body enters the room in ways that cannot be controlled by the analyst and on how engaging with these moments may lead to therapeutic gains. The paper concentrates specifically on those countertransferential bodily phenomena which are perceivable by the patient.

In contemporary psychoanalysis, countertransference is seen as being equally fundamental to the analytic endeavour as its complementary process, the transference (Carlson, 2009). However, somatic countertransferences receive less attention than more common, 'mental' forms of countertransference such as the analyst's thoughts and fantasies. It is likely that this is because countertransferential manifestations in the form of thoughts or fantasies are in the same register (i.e. language) as that in which therapy takes place.

Understanding somatic countertransferences can result in useful therapeutic gains, but these phenomena can often be difficult to deal with and complex to understand. The mere fact that these are bodily reactions may make them less controllable, less easy to disguise and less easy to interpret than other forms of countertransference. When these reactions are perceived by the patient they may become even more alarming to the therapist as they reveal material about the therapist before the therapist has a chance to interpret and understand it herself.

Considered widely and generally, "psychosomatic" events in the analyst are commonly seen as pathological and problematic failures of mentalization. This pejorative view is unhelpful and does not encourage these experiences to be considered and understood. The paper attempts to challenge that view and instead argues for the clinical usefulness of paying attention to bodily countertransference reactions, particularly those perceivable to the patient, in order to reveal the psychodynamics at work in the particular dyad. The paper begins by briefly framing the theoretical context in which it is positioned, and then makes use of a case example in order to illustrate the points being made.

THEORETICAL CONTEXT

In order to place this paper in a theoretical context, it is important to briefly review two areas of psychoanalytic literature. The first of these is the psychopathology behind psychosomatic responses, and the second is the literature regarding somatic countertransferences.

PSYCHOSOMATIC RESPONSES

The earliest understandings of symptom formation and the interpretation of those symptoms was generated by Freud's work on Hysteria. This work understood that mental conflict could be expressed in bodily terms (Breuer & Freud, 1893; Freud, 1912d). Hysterical symptoms were treated in the mode of language using interpretations which were intended to lift the repression of the traumatic memories which lay behind the symptoms, and to transform these, and their related wishes, from physical symptoms into psychological objects. The aim of this treatment was for the analyst to aid the patient to develop insight into the symptom and into the unconscious meaning behind its form (Freud, 1905).

I am suggesting that when the countertransference is somatic, similar processes may be at work and that therapists then needs to 'mind' their own body by uncovering and interpreting the meaning behind their own physical response. In

other words, there should be a diagnostic, interpretive dimension to the psychoanalytic practice of making use of somatic countertransferences in the therapy room.

SOMATIC COUNTERTRANSFERENCE

While there is a substantial body of literature on countertransference generally, there is less written about somatic countertransference in particular. The area of countertransference is theoretically complex and its development is tracked and commented on by authors including Gabbard (1995, 2001), Richards (1989), Smith (2000) and Zachrisson (2009). The concept has undergone two fundamental shifts since it was first introduced by Freud (1910b) where it was understood as the analyst's transference to the patient's transference and viewed as a difficulty which analysts should do their best to overcome. Following the work of Winnicott (1958), Little (1951), Racker (1957, 1968) and particularly Heimann's (1950) paper "On Counter Transference", the concept of countertransference has now come to include all the feelings and reactions that the analyst experiences while in relation to a patient (Jacobs, 1999; Lazar Smith, 1990; Young, 1995). This wider view of the concept further suggests that all countertransference reactions can be used in order to gain a deeper understanding of the patient, and sees countertransference as the analyst's reaction to the patient's unconscious dynamics and how these manifest in the therapy, rather than being merely a reflection of the analyst's own internal, unconscious material (Epstein & Feiner, 1979; Zachrisson, 2009). Most importantly, this widely accepted, broader understanding no longer sees countertransference as problematic and something to be avoided, but rather as a helpful tool to be added to the therapist's repertoire (Epstein & Feiner, 1979; Zachrisson, 2009).

The second important shift is as a result of the more contemporary view of countertransference which does not look for the origin of a countertransference in either the therapist or the patient alone, but instead understands that it is the unique material that develops in that particular therapeutic dyad which results in the specific countertransference manifestation. Gabbard (1995, 2001) describes this understanding of countertransference as the patient drawing the therapist into playing a role that reflects the patient's internal world, but that the specific dimensions of that role are coloured by the therapist's own life history.

Despite the various definitions and understandings of countertransference, one point which is not disputed is that it is essential that the analyst detect and name

the countertransference (even if only to herself) in order for the clinical endeavour to progress effectively (Schwaber, 1992). Any concern about somatic countertransference in particular is rooted in the general moves in the acceptance of countertransference generally as these moves have allowed for an interest in the analyst's responses to the patient as well as the development of tools to make sense of these responses.

Much of the theoretical writing that does exist on somatic countertransference seems to be divided into two categories: the first category is concerned with the kind of patients who are likely to elicit somatic countertransferences, while the second explores the kinds of traits, defences and personal histories that might make it more likely for an analyst to experience somatic countertransferences.

Authors who locate the source of a somatic countertransference in the patient include McLaughlin and Samuels, who focussed their writings on the types of patients who are likely to produce somatic countertransferences. McLaughlin (1975) identified two types of patients. The first type is patients who use defences that control and dull anyone they deal with, while the second type includes borderline and psychotic patients.

Following McLaughlin's work, Samuels (1985) conducted empirical research on somatic countertransference. His results also situated the source of the countertransference in the patient. Samuels's research noted that patients who presented with instinctual problems, such as difficulties regarding sex, aggression or eating, were more likely to evoke a physical countertransferential response (Samuels, 1985).

Focussing particularly on countertransference feelings of hunger, Greene (2001) suggests that hunger in the therapist generally represents deprivation that the patient is beginning to explore, and that the deprivation is resonating with a deprived place in the therapist. Greene's work is starting to suggest the idea that for a somatic countertransference to develop, it is a combination of the patient's pathology and the therapist's psyche that play a role.

In contrast, Jacobs (1973) and Stone (2006) focussed their attention on researching what it is about a therapist that makes it more likely that he or she would experience countertransferences somatically. Jacobs proposed three circumstances which might result in the countertransference taking a physical form: firstly, when the patient's material revives similar past physical experiences in the

therapist; secondly, if a therapist is consistently faced with material that relates to highly conflictual bodily experiences; and thirdly, the quality of the bodily experiences in the analyst's own childhood (Jacobs, 1973). What Jacobs highlights is the important role that the therapist's own history plays in the formation of somatic countertransferences.

The more recent work of Stone (2006) mapped the Myers-Briggs Type Indicator personality characteristics of analysts who are likely to experience bodily countertransferences and saw a high incidence of the introvert-intuitive construct in these analysts. He concluded that when the therapist resonates with the patient on the physical level, thoughts and feelings remain unknown to the conscious mind (Stone, 2006).

What the groupings of literature discussed here (i.e. locating the source of the somatic countertransference in either the patient or the therapist), have in common is that they seem to aim at a developing a general theoretical understanding of somatic countertransference. I am suggesting that to take these general concepts further it is useful to adopt a clinical approach which looks at the personal and unique dynamics of each therapeutic dyad specifically.

It is widely accepted that countertransference reactions should be worked with by the analyst, and the process for doing so would obviously be similar for all forms of countertransference, although somatic responses may require more work as they manifest in the somatic domain and need to be processed and mentalized by the analyst in order for them to enter the domain of language and thought. While the importance of interpreting countertransference reactions, whether they be somatic or otherwise, is clear and well-established, countertransference reactions which the patient notices bring a further dimension to the process, which is worth exploring.

Following the changes in the perception of the usefulness of countertransference, it became necessary to develop tools and theories so that therapeutic use could be made of countertransference reactions. A foundation for this endeavour was laid by Freud in "The Interpretation of Dreams" (1900a, 1900b) in which he explicated the process in which the analyst analyses and interprets his own internal world by means of the process of free association which was developed in order to overcome the patient's resistance and to allow the analyst access to unconscious parts of the patient's psyche (Bollas, 2002). Freud suggested that analysts are required to submit to a similar free associative process as a counterpoint to the demand placed on the patient (Freud, 1912c). In order for analysts to do this,

Freud described the way in which the analyst should attend to the patient's material and which has become another fundamental tenet of psychoanalysis: free-floating attention (Lothane, 2006; Miller & Aisenstein, 2004; Parsons, 2006).

Lothane (2006) extends Freud's original concept of free-floating attention when he suggests that the analyst should not only hear what the patient says, but that he should also notice any thoughts, images, fantasies, emotions, and memories which the patient's words evoke. Making use of such a process combines the analyst's internal world with that of the patient which allows the analyst to understand the manifest content of the patient's material as well as the underlying, unconscious content. This analytic stance relates to concepts described by other writers such as Bion's (1962) 'reverie', Ogden's (2004b) 'dreaming' and Fonagy's (1994) 'reflectiveness' (Israelstam, 2011).

Ogden (1997a, 1997b, 2004a) has extended Bion's (1962) term "reverie" in his discussions of therapeutic technique regarding how to make use of countertransference responses. He sees reveries not as the product of the psyche-soma of the analyst alone, but as resulting from the combined unconscious of patient and analyst. It is his view that through the use of reverie, the analyst transforms the unprocessed material which the patient has projected into her mind, into thought (Brown, 2009). What is particularly useful about Ogden's work in this paper is his specific inclusion of the analyst's somatic responses in his descriptions of working to understand countertransferences.

A Clinical Example

In order to demonstrate the complexities involved in uncovering the meaning behind a physical response to a particular patient, I will discuss a case in which the usefulness of interpreting and understanding the form that the physical countertransference takes was clear. The patient in question (whom I will call Ann) presented herself as a kind and sensitive person who always put others first. She was softly spoken, friendly and obliging. Her anorexia was entrenched, and she would severely restrict her eating, but would also taunt herself by exposing herself to food that she would not allow herself to eat, like standing in a bakery and smelling meat pies cooking. She would feel great triumph when she was able to walk out of the store and deny herself what she was craving.

Ann would always arrive for her sessions a few minutes early, and would frequently comment on whether I called her from the waiting room on time (which she

measured by the second hand reaching the '12' on the clock in the waiting room), or if I was a few moments early or late. While she presented this in her 'sweet' way by saying that I was "spot on so much of the time", she was a little triumphant if I called her into the session a moment early or late.

During many sessions with Ann, I would experience sudden and severe hunger. My stomach would rumble loudly, to the point that the patient would notice and pull a disapproving face as if to express her disgust at my apparent desire to eat. What was particularly noteworthy was that on these occasions I would crave a very specific type of pizza with a number of meat toppings, and I sometimes had a visual hallucination[9] of the pizza floating between us just out of my reach. This type of pizza was not something that I would ordinarily eat, and significantly, the patient had stopped eating meat a number of years before in order to restrict her calorific intake.

I became aware of the depth of the transference-countertransference dynamics and how I enacted them, when I invited a friend, with whom I have a competitive relationship, to join me for a pizza. She said that she was expecting my call as I called every Monday to suggest that we go for a pizza. Mondays were the days on which Ann was the last patient of the day.

Of particular importance here were the frequency and intensity of the stomach rumbling (known as borborygmi) and the accompanying severe hunger and visual hallucination of the pizza. I did not have any of these 'symptoms' with any of my other patients, even those that I saw at a similar time of day or who also restricted their food intake.

INTERPRETING THE SOMATIC COUNTERTRANSFERENCE

My stomach rumbled frequently in the sessions with Ann, and she always pulled a disgusted face in response, and would sometimes comment on the sound. She would (unconvincingly) attempt to apologise for making me work late and for keeping me from the food that I "obviously" desired. Interpretations were met with a shrug and smile, but I was left with the strong sense that her comments and gestures indirectly meant "you poor mortal having these base, physical needs". This seemed to be a part of her transference which was superficially so sweet, polite and self-deprecating, but which certainly seemed to have a sting in the tail.

[9] I use the term 'hallucination' rather that 'visual image' in order to evoke the idea of an hallucinatory gratification and to highlight the sensory quality of the experience.

It was after I had called my friend and invited her for pizza yet again, and she had commented that I did that regularly on a Monday night, that I developed further awareness of the dynamics at work. After eating the entire pizza, the craving was satisfied, but I felt over full, guilty and disgusted with myself and I was aware of the very clear thought that 'Ann would never have eaten that'. Reflecting further allowed me to be become more aware of the idea of "Ann vs me". I had had the physical response, the craving and hallucination of the pizza, however, the hallucination was not satisfactory and therefore needed to be enacted, and so I had allowed myself to satisfy the wish, but all of that had occurred against the backdrop of how that was in contrast to the way in which Ann would engage with the world. This experience echoed Renik's (1993) idea that the analyst often develops an awareness of their countertransference only after an enactment, and Deveraux's emphasis on the importance or deciphering and working through the enactment (2006).

In the following sessions, when this somatic response occurred, my reverie included all the different factors which were at work in this transference-countertransference dynamic. These included the time at which the response occurred (it was always on a Monday, the day when Ann was my last appointment of the day); the food that I was craving (a high calorie, high fat meal which I did not usually eat); the friend whom I had called (someone with whom I have a competitive relationship, and it seemed that I had unconsciously tried to mitigate my failure by making my friend complicit in it, in order to defend myself from feeling defeated by my patient and envious of her iron will) and the thought which had occurred to me that Ann would never have eaten the pizza.

After reflecting on these elements, and following my reverie, what emerged was the competition that Ann was setting up between herself and me. I know myself to be compelled to do 'difficult' things and to enjoy the success achieved in completing difficult tasks, but what was being activated in this transference-countertransference experience was a feeling that the patient triumphed over me because she was able to resist the temptation and do the 'difficult' thing of not eating. She was able to walk away from the meat pies, but I had eaten the meaty pizza. I felt that I was not as 'strong' as she was and knew that the patient would certainly not have 'given in' or 'caved' as I had done since she would simply never eat a pizza, much less a meaty one. Recognising Ann's competitiveness and seeing how it was disavowed, but present in a disguised form, in her sweet but patronising manner I could then see how her minding of my body in the form of her

comments about the borborygmi (as well as her comments about session start times) had lured the competitiveness in me. It was her reaction to that which was perceivable in me which became a crucial trigger to my understanding of the therapy dynamics.

I became aware, however, of a paradox in the win-lose competition with Ann. My enactment which took the form of calling my friend and eating the pizza meant that I had 'lost' the competition of control over bodily urges, but in eating, I also allowed myself to be healthy and not trapped in the anorexic web that Ann found herself in. While I initially felt shamed and defeated, it was through the creative act (Rosenberg, 2006) of understanding the countertransference and putting it into words (if only to myself) that my interpretive capacity was re-established and my therapeutic role retrieved. Holding the physical response in mind, noting the moments in which it appeared and trying to link it to specific material that the patient brought facilitated the mentalization of my physical experience. The consequently improved understanding of the patient's unacknowledged competitiveness sharpened my focus on this issue. Listening for such material it was then possible for us to start talking about the competitiveness in her relationships which allowed her access to a part of herself that she had, until that point, not allowed herself to acknowledge. As Ann became more consciously aware of her competitive nature, she began to engage differently with those in her world. At that point my countertransference no longer took a somatic form.

On reflection, it was clear that there had been a two stage process involved in the interpretation of my somatic countertransference. Ann's comments on my stomach sounds and my experience of the accompanying craving, drew my attention, firstly, to the form of my response and thus to the ideas of eating, the desire for food, and most importantly control over that desire. Importantly, however, my reverie made it clear that the physical response was occurring in relation to her. Enacting those cravings allowed me to then mentalize the deeper, more unconscious dynamic of competition between us.

DISCUSSION

I will reflect on this case material by discussing three issues. The first is a rehearsal of the existing literature specifically the literature concerned with the origin of the somatic countertransference and that on borborygmi in particular. The second point to be discussed is the use of reverie in the interpretation of somatic countertransference. The final area of focus is the specific concerns brought to the

therapy when the therapist's somatic countertransference is perceivable by the patient.

In order to make sense of the transference-countertransference dynamics at work in the case of Ann, it was necessary to establish why this response was occurring with this particular patient at this particular point in the therapy. The patient, Ann, did have some borderline defences which were identified by McLaughlin (1975) as being involved in the development of somatic countertransferences. She was also eating disordered which Samuels (1985) recognised as a potential factor in the development of a somatic countertransference. These points were helpful in developing some thoughts around what it was about Ann that was triggering this response in me. It was important to note, however, that I treat a number of eating disordered patients with borderline defences, and while it is well known that countertransferences with patients with that combination of pathologies are often very intense (Russell & Marsden, 1998), the physical response in question occurred with only this patient. It followed that attention should also be given to what it might have been about me that might have been activated by the patient, as Stone (2006) and Jacobs (1973) suggested. It was clear that I did contribute something general to the relationship with my patient (i.e. my competitiveness), but although that is a stable part of me, competitiveness was a part of this therapy and does not occur with all my patients. It is then clear that while there were aspects of both the patient's pathology and the therapist's personality which had played a role in the developing of the somatic response to the patient, it was the interaction of all the relevant elements of the therapeutic dyad which were required for the somatic countertransference to be produced in the form in which it manifested.

Da Silva (1990) and King (2011) have written about the physical response of borborygmi specifically. This literature establishes the idea of gastro-intestinal movements as having a strongly metaphoric dimension and thus the authors suggest that they hold a psychic meaning, and consequently link body and mind. Instantiated in the case of Ann, it was clear that this particular understanding of gastro-intestinal responses allowed me to enter the site at which her pathology (anorexia) played itself out, but that this was merely the arena in which our competition occurred. With Ann, the form of the somatic countertransference was a clue to the final understanding, but was only the vehicle with which to reach that understanding.

Da Silva (1990) makes the point that when borborygmi occur in the analyst, it is a signal that the patient's conflict has resonated at a point of sensitivity within the analyst. Since my sensitivity is not related to food, it meant that the physical response was pointing to something else. This highlights the complexity of the relationship between the generalised understanding of the form of somatic countertransference and how the body of the analyst can become treated as an object of transference activity in unique ways in each individual therapeutic relationship.

In this case, my borborygmi was accompanied by a severe hunger as well as the visual hallucination of the object that my hunger craved. The image of the pizza that appeared to hang between Ann and myself emphasised the physicality of the countertransference: it was not a vague wish for some sort of food, but instead I had visually and specifically conjured up the precise object which I desired in a very physical way. There are of course limits to the form of satisfaction that fantasy can provide which is why hallucinatory satisfaction is partial, and my hunger persisted. Only my enactment of actually ordering and eating the pizza satisfied the craving.

In order to explore the meaning of my countertransference and the manner in which it manifested, Ogden's writings on reverie were very useful in developing an understanding of what was at work in this case. Four points arose from Ogden's extensive writings on the subject of the analytic use of reverie that were especially useful. The first of these points is that working with, and interpreting, reverie transforms unconscious, intersubjective experiences into verbal metaphors which are then accessible to the analyst. From a position of free-floating attention and reverie in the treatment with Ann, it became possible to track the associations and follow the links in order to move them from the physical response of stomach rumbling into a more mentalized space where it became possible to begin to reflect on what was being played out on the level of hunger and the control of physical desires.

The second point made by Ogden (Ogden, 1996a, 1996b, 1997a) which was helpful here is that the content of a reverie needs to be interpreted and understood rather than simply shared concretely with the patient, because doing so will lead to superficial interpretations in which manifest content may be mistaken for latent content. This point was particularly helpful in the described case as it ensured that the understanding of the dynamics at work moved from the first level which

focussed on food and eating, to a second deeper, more unconscious level which revealed the dynamics of competition.

Ogden's (1997a) third important point is that the responses which make up the reverie of the analyst are not just simply the analyst's own unresolved conflicts, current distresses, physical state or personality. Every situation experienced by an analyst is framed differently in the face of each patient and thus becomes a different "analytic object" in each therapy. As described in the case with Ann, it was her comments and the manner in which they were delivered which brought the dynamics between her and me to life. Reflecting on the way in which Ann presented and engaged in therapy – superficially very sweetly, but always a little critical and patronising – allowed for an understanding to develop about what role that played in my countertransferential response to her. Thus Ann's way of engaging with her therapist brought out something in her therapist which revealed something about Ann.

The final of Ogden's (1994a, 2004a, 2004b) points made use of in understanding this case was his idea that it is not helpful to discuss the highly personal emotional experience that is reverie with the analysand directly. It should first be made sense of in terms of the patient's material and the analytic relationship. In the case of Ann it would not have been helpful to simply reveal the craving, hallucination and enactment to Ann. It was far more important that the work of understanding how all the elements fitted together and what they revealed needed to be done first, and then for that digested understanding to be used effectively in the therapy room.

The contribution that I am attempting to make here is the idea that the analytic use of reverie is a process which facilitates mentalization in the analyst. Ogden's suggestion that the contents of the therapist's mind are as important as the responses in their bodies (Ogden, 1997a) in the process of reflecting on and making use of reverie, is particularly helpful in this regard. Clearly, unmentalized material is often present in a treatment, and when a patient is not able to express their internal conflicts in words, their preverbal transference may instead be manifested in the analyst's countertransference (Jacobs, 2001; Richards, 1989). The point at which the 'unmental' become sufficiently accessible to the conscious mind is the moment it becomes possible to use that material in the talking cure. The first signs of this process in this case were the rumblings in my stomach. Reverie was then useful to render coherent the thoughts, physical sensations and

the wandering of my mind, thus giving the bodily and the mental due and equal attention which eventually allowed for significant therapeutic gains to be made.

Despite the volume of literature that discusses countertransference generally, there is relatively little written on the technique of exactly how interpret and work with it. The work of Ogden is very significant in that regard for this paper as his examples do not only explicate the process of using reverie (see for example Ogden, 1994a), but the notion of reverie and the affective overtones as used by Ogden seem to have a particular applicability to somatic countertransferences precisely because they allowed me make associations to responses that were not as yet in the medium of words (Ogden, 1994a, 1997a). This paper is arguing that drawing attention to the physical aspects of reverie allows the analyst to reflect on, and in that way mentalize, their somatic responses eventually enabling them to interpret their somatic countertransference.

An important issue raised by the case of Ann is the complexity brought to the therapy room when the therapist's somatic countertransference response to the patient is perceivable by the patient. Somatic countertransferences in general are often more difficult to make sense of than those which occur in other domains because they need to be translated from the language of the body to the language of the mind. An extra layer of difficulty is added to managing somatic countertransferences when the somatic responses are perceivable to the patient, whether it be visually (e.g. tears or blushing) or audibly as in the case of borborygmi. The fact that the patient becomes aware of these physical responses in the therapist may have unanticipated consequences.

I am in agreement with Ogden's (1994b) view that not every thought or feeling that an analyst has when with a patient is countertransference. There are times when a therapist may respond somatically to a patient, and where it is immediately clear to the therapist what the somatic response means. For example, a therapist may get tears in their eyes when they are told a sad story that reminds them of similar pain or loss in their own life. While these responses are of course important, they often occur at the level of the ego and are likely to be manifestations of sympathy or identification. They do not therefore require sustained interpretive activity on the part of the therapist. When responses such as these occur, the therapist may be required to acknowledge their response, and it is clearly always important to pay attention to and interpret the patient's reaction to the analyst's physical responses. For example, a patient may feel comforted and validated by their therapist's tears,

or may become irritated or angry if they feel that it is now their responsibility to comfort the therapist. This material then becomes grist for the therapeutic mill. In this type of physical response it is the content of the material that moves the analyst to 'ordinary' affects like sympathy or identification, where, even if the intensity is determined by the therapist's history, the extent to which this is a countertransferential response might be questioned and debated in the sense that it does not have a disguised, unconscious component. It is also likely that the same event being narrated by *any other patient* in conjunction with the analyst's history would have produced the same effect.

The distinction being made here is one that is based on the therapist's own intuition: while some somatic responses might need to be talked about with the patient, others immediately call for interpretation before they can be used therapeutically because their meaning is still unconscious and therefore not immediately available to the analyst. Everything that the analyst experiences in relation to the patient in the therapy room is relevant and potentially useful, but there is a fundamental distinction between that which only requires further reflection from that which requires interpretation.

What is of interest in this paper is the type of strong somatic countertransference reaction whose meaning is not immediately clear to the therapist and which is perceivable to the patient. The presence of these physical manifestations in their undeniable bodiliness is not easily disguised from the patient by the therapist and are therefore more uncontrollable in their visibility or audibility than other forms of countertransference (such as affect or fantasy). They therefore bring something into the therapeutic space of the dyad which may need to be explored before the therapist develops an understanding of what the response might mean and in what way it might a reflection of therapeutic dynamics.

In these instances the therapist's response immediately becomes a shared 'analytic object' (Ogden, 1997a). By contrast, countertransference reactions which occur in the domain of thought or fantasy can be kept from the patient and remain in the therapist's reverie until they have been unpacked and understood and the therapist can then make use of the information they reveal in the therapeutic process. In the case of Ann, it was the particular way in which she perceived and commented on my borborygmi which highlighted and brought the transference-countertransference dynamics to the fore, and made it a part of the dyad even before its meaning had been fully interpreted. In the long run, the information it

provided was crucial for the progression of the treatment and provided access to the highly beneficial material, but did require an active process of interpretation by the therapist first.

CONCLUSION

This paper contributes to how it is possible to think about and make use of somatic countertransferences. Since these responses occur in the physical domain, they require an additional layer of interpretation to other forms of countertransference. The form that the countertransference takes provides hints and clues to what the dynamics at work are, but it is important that the therapist understand these thoroughly and in the context of the particular dyad, since interpreting them simply at the general level may lead to simplistic understandings of their meaning. While it can be argued that some of this understanding would obviously apply to countertransference generally, somatic countertransferences need particular attention and focus, and once this has occurred and the underlying unconscious material has been understood the wider implications for the therapy will be exposed.

'Minding' the body of the analyst in this way may reveal important aspects of the dynamics at work in a particular therapy. However, there are particular issues that arise in the relationship when the therapist does not have the choice whether or not to disclose their understanding of, or reaction to, those dynamics. This 'decision' may be even more apparent if the psychotherapy takes place in the chair rather than on the couch. The use of the couch in psychoanalysis was designed to control the frame and the setting and to allow unconscious material to be revealed by the patient with as little influence from the analyst as possible. Sitting across from the therapist, and looking directly at them results in the therapist being much less of a 'tabula rasa'. Face-to-face psychotherapy puts the therapist's body in a much more central role even before it may gain attention by the therapist's crying, grumbling or blushing. An unexpected consequence of psychotherapy taking place on this face-to-face manner is that somatic countertransferences may be more visible to the patient. The therapist should be vigilant for such events so that if they bring new material to light when the patient notices the physical response (as it did in the case of Ann) that this can be worked with and made use of. When the as yet unprocessed material of the therapist is brought into the room, it is incumbent on the therapist to make use of all the tools available (particularly that of reverie) in order to reveal the meaning of such a response as deeply and thoroughly as

possible to themselves first, and then to apply that understanding to that particular therapy's dynamics. These situations may add pressure on the therapist to maintain their analytic stance and not engage in an enactment, but even if slips in these areas do occur, thoughtful and careful analytic work can reveal those underlying dynamics which crave interpretation.

CHAPTER 7: THE TWO BODIES IN THE ROOM

INTRODUCTION

The paper in this chapter is the second of the two papers which make up the second half of the thesis and which focus on the body of the therapist. The paper is entitled "Re-Embodying the Analyst" and was published in the accredited journal "*Psycho-Analytic Psychotherapy in South Africa"* in June 2013 (Gubb, 2013b) The paper was the recipient of the Mervyn Glasser award for the best postgraduate student submission of the year, and is reprinted here with the journal's permission. Please see the second volume of the thesis for a copy of the paper in its published format.

The nexus of the first three papers of this thesis is an increased understanding of the clinical dimension of work with physical symptoms which have a mental origin based a common psychoanalytic idea about the aetiology of psychosomatic symptoms and how these are related to levels and kinds of mentalization achieved by the individual.

The third paper "Craving Interpretation: A Case of Somatic Countertransference" focuses specifically on somatic countertransferences which are perceivable by the patient and which consequently cause the body of the analyst to become an object of the patient's interest or inquiry. If the analyst's body is perceivable to the patient through the countertransference, it is likely that it is also a site of transference relations. The argument made by this, the fourth paper, is that the therapist must think about their own body not only as an object of their own free floating attention and reverie, but also as a potential object of meaning making and transferential sense-making in the eyes of the patient.

The interest and theorisation around countertransference in the broadest sense is very well established, and what is important here is how the advancement of the phenomenon has evolved psychoanalytic practice. It has drawn increasing modulation and development to the role of the analyst and led to more of an understanding about the analyst's role (despite the different understandings of what the role might / should be).

However, while the practice turn, the countertransference literature and the analytic practice coming out of a more intersubjective tradition together combine to suggest

a focus on the individuated person of the analyst, that literature does not draw much attention to the analyst as *embodiment*, but rather focuses on the psychological individuating (i.e., the clinical and psychological rendering) of the figure of the analyst. The analyst therefore gets a more personal density, but the embodied presence of the analyst in the room doesn't receive the appropriate amount of attention. This thesis argues that there needs to be an investigation of the role and implication for practice of the analyst as embodied.

This 'gap' paves the way for this fourth paper which looks at the analyst's physical body as an object of the patient's attention and in this way fits the "Minding the Body" theme. The focus of the fourth paper is how the analyst's physical body provokes transference, and there are two practical or clinical contributions made by the paper. The first of these is related to how to treat the patient's relation to the therapist's body under a number of specific conditions (such as the therapist's pregnancy or illness). The second is a discussion of the implications of the surfacing of the analyst's body by the patient on the question of technique or practice.

This paper addresses the same research questions as the previous paper.

PAPER 4: RE-EMBODYING THE ANALYST[10]

ABSTRACT

This paper focuses on comments made by patients about the body of the analyst in therapeutic exchanges. The paper begins by exploring the nature of the asymmetry between analyst and patient and its theoretical foundations in psychoanalysis. The question is then posed as to whether considering some of the specific features of the form and timing of the references to the analyst's body in light of this asymmetry may help therapists understand the dynamics of particular therapeutic dyads. Making use of the existing literature and clinical material to support the argument, the paper suggests that using the nature of the therapeutic frame as a preliminary aid to interpretation may cast light on the extent to which references to the analyst's body can be understood as resistances to the defining features of the therapeutic frame, and in so doing illuminate aspects of the transference-countertransference dynamics.

INTRODUCTION

For a long time, due to the belief that a 'non-tendentious' psychoanalytic technique (Freud, 1923b, p. 252) fulfils scientific principles, any examination of the analyst's influence acting upon the patient was neglected (Thoma, 2009). As intersubjective models develop and expand psychoanalytic theory, and there is more focus on the dyad in the room, the therapist is compelled to become more aware of her[11] own body and the important information which the patient's interaction with it can provide (Cornell, 2009). While this shift in paradigm has raised awareness of the fact that there are two bodies in the therapy room, there is still relatively little written about the impact of the analyst's physical body and appearance on the patient and the therapeutic process. This relative neglect is not surprising given the understandable focus on speech and thought in 'talking cures', as well as a general social emphasis away from the physical body in professional arenas where engagement is usually intellectual and little personal information is shared by the professional.

While such an asymmetry is common in professional relationships, what is of interest in this paper is the particular one-sidedness of the psychoanalytic exchange in which the patient is regularly expected to reveal personal and intimate

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[11] The feminine is used in the paper, but is assumed to encompass both the masculine and the feminine.

material while the analyst[12] does not reciprocate in the exchange. References to the analyst's body by the patient during psychoanalytic psychotherapy occur within this broader context of asymmetry, and gain particular meaning because of this asymmetry which is designed as an integral part of the psychoanalytic frame.

Following a consideration of the asymmetry of the therapeutic setting, this paper provides an historical account of the place occupied by the therapist's body in the therapy room. It begins by reviewing how and why the therapeutic situation was designed to keep personal information about the analyst to a minimum and argues that this results in the analyst's body acquiring a particular significance. The paper briefly reviews the limited literature on the impact of profound physical changes in the analyst's physical body in psychoanalytic treatment, or differences in body size between the patient and the therapist.

The paper then explores how any particular patient might uniquely engage with their analyst's body during a therapy. Clinical material is presented in the form of three vignettes in which patients' thoughts about their therapist's body specifically emerge. These vignettes illustrate that patients' references to the analyst's body are an important and rich source of information about the transference and countertransference dynamics at work in a particular therapy.

The paper concludes with a discussion of some theoretical issues that arise out of the case material concerning the clinical usefulness of paying attention to the intersubjective nature of the therapeutic relationship, how this is reflected and represented in the way the particular patient engages with the analyst's body, and how the therapist may respond to the resulting complexities of interpretation.

THE ASYMMETRY OF THE PSYCHOANALYTIC THERAPEUTIC SETTING

The analytic situation, with its therapeutic frame, is an unusual setting in which a patient seeks help within a context that is significantly different from other forms of human interaction and caregiving. In this setting the patient is expected to reveal all manner of intimate and personal material while the analyst is expected to engage with neutrality and anonymity. In psychoanalytic literature the analytic concepts of 'neutrality' and 'anonymity' are varyingly understood and seen as either interchangeable or distinctive terms. Laplanche and Pontalis (2006), in their review of the development of the term 'neutrality', explain how the term was initially

[12] Many of the concepts used in this paper find their roots in classical psychoanalysis – not so much to the setting of the couch, but instead to the psychoanalytic approach to the frame, transference and interpretation. The argument presented in the paper has applicability to both psychoanalysis and to psychotherapy. For this reason, the terms 'analyst' and 'therapist' will both be employed in the paper.

used to describe the non-judgmental stance of the analyst in relation to the patient's material. The definition was later expanded to include the idea that the analyst should not make himself felt in his own 'psycho-social specificity' (p. 272). In his discussion of analytic anonymity, Aragno (2008) describes Freud's (1912c, p. 118) recommendation for analysts to be 'opaque' to their analysands, reflecting back only what is shown to them, and by implication not revealing anything about themselves. This asymmetry is fundamental to the practice of psychoanalysis as it emphasises the nature of the exchange and produces a form of interaction that is different to others. Importantly, it creates an arena in which to lure the unconscious of the patient. The classical approach to neutrality is thus the idea of the blank slate onto which the patient projects. Contemporary theorists have increasingly come to insist upon an acknowledgement of the person of the analyst in the room, and complex debates have consequently emerged regarding what happens to analytic neutrality if the analyst as a person is acknowledged (Burka, 1996; Renik, 2007). Despite these differing views, however, there is agreement that it is important for the focus to remain on the patient. What always remains is the asymmetry in the material that the analyst and patient reveal.

Many widely accepted elements of therapeutic practice emphasise impersonality in order to foreground that this relationship is not an exchange of confidences between analyst and patient. The room is set out in a way that is different to rooms of medical professionals, the analyst deliberately withholds personal information, and there is the 'oddness' of the transferential relationship (van Zyl, 2003). Into this peculiar context is brought the 'fundamental rule' whereby the patient is instructed to say whatever comes into her mind. Thus the analytic space, which is at once so private, is also a space in which nothing of the patient's is private at all and in which the analyst reveals nothing personal in response to the patient's revelation of very intimate material. Freud emphasised that the most difficult thing the patient is asked to do is to talk aloud about things that might feel too disagreeable or too indiscreet to express (Freud, 1917a). It is a safe assumption that some of the most difficult of these disagreeable thoughts and feelings to give voice to are those regarding the analyst themselves (Adler & Bachant, 1996), and yet that is what patients are required to disclose.

This asymmetry suspends many of the common ways in which human beings engage, and emphasises that psychoanalytic psychotherapy is a form of relating which is different to most others. This unusual way of relating is resisted by patients, manifesting in attempts to personalise the relationship and thereby

remove the difference or distance patients experience between themselves and their analyst. The analyst's body acquires a density and becomes a potential place for the patient to try to discover something personal about the analyst. It is accessible to the patient in a unique way in the therapeutic setting – it is in plain sight all the time in face-to-face treatment, and at the beginning and end of the session in psychoanalysis proper. The analyst's body is one signifying presence that will allow the patient to individuate the analyst. In fact, in the absence of other signifiers, the physical appearance of the analyst may become 'hyper-signified' by the patient. In this way the analyst's body becomes a privileged place from which the patient attempts to draw personal information – to 'read' the analyst's body – because most other forms of personal expression are prohibited.

The use of the couch in psychoanalysis further highlights the structured asymmetry of the psychoanalytic therapeutic setting. The reclined position of the patient in classical psychoanalytic treatments is a legacy of psychoanalysis's beginnings when hypnosis was still the method of treatment used, but the positioning of the patient on the couch with the analyst out of view was continued by Freud even after the psychoanalytic method replaced hypnosis. The reason Freud continued to use the couch was that he did not want his facial expressions to 'lead' his patients; instead he wanted to foster the development of the transference as much as possible (Adler & Bachant, 1996; Eissler, 1993; Lable et al., 2010; Seeley, 2005; Wolf, 1995). Freud believed that knowing too much about the analyst interfered with the patient's use of the analyst as a transference object and impeded the psychoanalytic process (Freud, 1913). When the analyst is not visible to the patient the development of the transference is believed to be encouraged: the inability to see the analyst's facial expressions, body movements and overall demeanour encourages the patient to explore unconscious constructions of the analyst rather than to focus on the external and visible aspects (Lable, et al., 2010).

This analytic seating arrangement privileges the auditory over the visual modality in psychoanalysis even more than is true in other forms of talk therapy (Seeley, 2005). However, even when psychoanalytic psychotherapy occurs face-to-face and the therapist is in the patient's line of sight, therapists still endeavour to keep as much as possible about their personal lives private and unknown to their patients. It is common for psychotherapists to try to avoid revealing anything significantly personal through their attire and to keep the clinical space, and their own appearance, free from individualising visual cues which may alert patients to some aspect of their personal lives (Seeley, 2005). Therapists can try to dress neutrally,

not have anything personal on display, and behave neutrally. It is not, however, possible to control and exclude the appearance and size of their physical bodies. The intimacy of the therapy situation is not only in the emotional, psychological and verbal domain, but also in the physical. Patient and therapist repeatedly sit together in a comparatively small space in a way in which their bodies echo each other (Burka, 1996).

The psychotherapeutic asymmetry is uncomfortable and unfamiliar to the patient and at key moments may produce vulnerability which the patient will try to reduce by 'equalising' the situation. I am arguing that because of the therapist's attempts to achieve relative impersonality, and the patient's desire to move to a more personal relationship, the patient may be extremely sensitive to the analyst's appearance, tone of voice, gestures, posture, moods and even their office in order to gain clues about the therapist's person. Simply because a patient is looking straight at the therapist's body, however, does not mean that they will perceive that body objectively, nor does it predict how the patient will use the therapist's body unconsciously (Burka, 1996). The patient builds up both conscious and unconscious images of the analyst that are comprised of subjective features as well as components of reality (Eissler, 1993). How the patient perceives any 'realities' about the analyst is important grist for the therapeutic mill, and the patient's reaction to these 'realities' must be analysed and interpreted in the psychoanalytic session. An analyst's actual appearance, manner, way of speaking and surroundings are all important and play a role in any therapy, but the exact effect that they have and the particular type of role that they play will be unique to each patient and may differ at different points in any given treatment (Eissler, 1993).

An unintended consequence of the desire not to reveal anything private, together with the analytic setting, is that the analyst may unwittingly become disembodied and depersonalised. As described above there is commonly a wish by the patient to resist what the framing of the therapeutic relationship does to relating, and commenting on the analyst's body may be a way to re-embody the analyst. This paper focuses particularly on physical characteristics of the analyst's body which are fairly stable and unchanging, and while the analyst's style of dress and office furnishings are important, they are not the object of investigation here. When fully understood, the form and timing of these references to the body may helpfully reveal transference dynamics.

THE ANALYST'S BODY IN THE PSYCHOANALYTIC LITERATURE

There is little focus on the role of the analyst's physical body in the psychoanalytic literature (Burka, 1996). Such literature tends to fall into two categories. The first concerns the theoretical implications related to particular forms of visible change in the analyst's body. Secondly, a theoretical basis for the clinical use of material about the analyst's body in psychotherapeutic practice is offered.

VISIBLE CHANGES TO THE ANALYST'S BODY

The majority of the literature regarding the role of the analyst's body discusses occasions when the analyst's private life enters the therapeutic space in a dramatic way consequent to profound changes to the analyst's body, such as when the analyst is pregnant or becomes significantly ill.

Most of the literature about the effects of an analyst's body changing during pregnancy focuses on how it affects, and often sharpens, the transference. Many writers suggest that the fact of the pregnancy may trigger deep infantile conflicts, sometimes earlier than might otherwise have occurred in a particular treatment (Eissler, 1993; Paniagua, 1998; Richman, 2006). For example, the pregnancy might highlight old sibling rivalry issues or remind the patient that the analyst has a private life which excludes the patient. These writings explain why an analyst becoming visibly pregnant may re-activate in patients the developmental stage during which they began to separate from their mothers and became aware of the painful reality of the father's relationship to the mother. When patients respond intensely to the analyst's pregnancy analysts may experience countertransference guilt, which might make them reluctant to address the Oedipal issues being raised (Linderholm, 2009). Balsam (2012) writes about the suspicion and anxiety that the plasticity of a changing woman's body might evoke. Whyte's (2004) review of the literature on analysts' pregnancies explores these themes, but also includes how patients of different gender or sexual orientation may respond differently to the pregnancy. Whyte therefore examines not a general response to the analyst's pregnancy but rather the importance of different responses from particular patients.

In contrast to the literature on the analyst's pregnancy, the majority of literature concerning changes to the analyst's body following illness focuses on the ethical considerations of self-disclosure, enactment, absence and whether the analyst can and should keep working while they are ill (Fajardo, 2001; Galatzer-Levy, 2004; Kahn, 2003; Robutti, 2010; Rosner, 1986; Silver, 2001; Torrigiani & Marzi, 2005). Plotkin (2000) includes some comment on how an analyst's absence due to illness

might impact an older patient who might experience fear of the same illness, or how a patient may experience anger about the analyst's absence. The analyst's body is of interest in this literature in terms of the general themes that may be evoked by illness rather than in terms of the potential meanings of individual and unique responses.

The published work about the pregnant or ill analyst thus focuses predominantly on a general range of possible meanings, but does not look specifically at how a particular patient might respond to the changes in the analyst's physical body. It therefore deals with the fact of the change rather than the question of how and why the patient might make reference to it in particular circumstances. It also demonstrates that in the circumstances of profound physical changes, such as pregnancy and illness, even the safety of the analytic frame is not able to maintain analysts' impersonality and limit patients' access to their bodies.

Clinical Use of Material about the Analyst's Body

Nearly a century ago Ferenczi (1928) addressed the question of the importance of the patient's observations about the analyst's appearance. He believed that such comments may reflect critical feelings about the analyst, and he highlighted the need for the analyst to pay attention to such comments and be sensitive to their possible meanings. More recently Blechner (2009) suggested that it is important for the analyst to notice comments on, and engagements with, the analyst's body by the patient and to make sense of these. His particular focus is on how these comments might signify the presence of an erotic transference and may take the form of flirting. He helpfully states that, as with any other transference, the analyst should accept the patient's feelings with curiosity and explore an erotic transference fully before it is interpreted. I would like to suggest that this approach is helpful when dealing with any comments about the analyst's body, whether they are reflective of an erotic transference or otherwise.

Ferenczi also commented on the importance of urging clients to express their observations about the analyst: 'Every patient without exception notices the smallest peculiarities in the analyst's behaviour, external appearance, or way of speaking, but without previous encouragement not one of them will tell him (sic) about them' (Ferenczi, 1928, p. 93). Tintner's (2007, 2009, 2010) experiences of losing weight led her to appreciate how this affected her patients and, following Ferenczi, how essential it is to ask for observations about one's body directly. She explains how patients might be hesitant to share their perceptions of the therapist

and adds that therapists may also be disinclined to elicit these. She stresses that the therapist may not even be aware that there is something to ask about: the patient's perceptions may emphasise issues that the therapist cannot bear to think about. She suggests that the patient's observations of the analyst's physical body may be used to access and express underlying unbearable feelings, and for these unbearable feelings to be known and talked about.

Tintner's suggestion that the therapist should directly ask patients for their observations is made in the context of a significant change in her physical appearance. The risk of her suggestion is that therapy becomes led by the therapist's agenda. If there are significant and obvious changes to the therapist's appearance that the patient fails to notice or comment on, it may be important to discuss this. There is an important difference, however, between noticing how comments (or the lack of comments) reflect dynamics and moving to unprovoked and unnecessary self-disclosure. Conversely, failing to engage with comments a patient does make may lead the patient to believe that the therapist is not able to hear the patient.

In one of her papers addressing how the therapist's physical size and weight impacts patients, Tintner (2009) refers to a publication by Margaret Little (1990), who discusses her experience with two different analysts. The first did not engage with Little's comments and observations about the analyst's declining health and Little (a medical doctor) was left feeling frustrated, silenced and very angry when the analyst suddenly died, proving her observations correct. The second analyst discussed Little's comments openly and even confirmed Little's observations about his health. Little describes how helpful this felt and how it removed her from the previous double-bind in which she was faced with two conflicting realities – on the one hand she was required to say whatever was on her mind, but on the other hand the lack of reply from the therapist left her feeling that the subject was off limits and that she was being rude by divulging her observations (Little, 1990). Little's work emphasises how important it is for the analyst to engage with the patient's comments about the analyst's body.

CLINICAL EXAMPLES

The first vignette I would like to present to illustrate my thinking comes from the treatment of a paranoid patient. This vignette demonstrates the usefulness of asking patients to reflect on their observations about their therapist's body. This young man had applied for a full-time position at an organisation, but had only

been offered a temporary placement as an intern with a view to his suitability for full-term employment being assessed. He had found this experience painful and humiliating and a real blow to his self-esteem, and he worried that others would see that he had not 'made the grade'. He began to have temper outbursts at home and his family encouraged him to enter therapy. Mr A, as I will call him, struggled to settle into treatment and asked many questions about 'this thing called therapy' and how it worked. During our third session he interrupted his own account of how things were going at work to ask me about my badly scarred hand. He told me that he found it distracting and demanded to know what had happened. I asked him about what he thought had happened to my hand and he replied that he was trying to work out whether my hand had been scarred by violence inflicted on me, or by me inflicting violence on another. I interpreted that he was not able to work out if I was safe or frightening, and whether I would help or harm him. The conversation moved to how this was true in all of his relationships and how for him the world is full of people and things that cannot be known or trusted. A few sessions later Mr A again turned the subject to the scar on my hand. He was angry that I would not tell him what had happened and was frustrated by what he experienced as my withholding of information. He said repeatedly that he couldn't understand why I 'wouldn't just tell him'.

Mr A's frustration at me not 'just telling him' what had happened surfaced his experience of the therapeutic asymmetry and of the frame as frustrating and persecutory. His frustration when I was not forthcoming with information was a clear resistance to the therapeutic frame, but also revealed something about the way he operated in his world. He struggled to work out where he stood with people and that made it hard for him to trust anyone. He was mistrustful of therapy from the outset (which was likely exacerbated by his family requesting that he go into therapy), and it was almost impossible for him to trust me until his questions were answered to his satisfaction. He was afraid that he had been sent to a persecutory therapist he could not trust, but then paradoxically found that he was dependent on that same therapist. This was very difficult for him to bear. His questions about my scarred hand and the fantasies he had about it seemed to represent an attempt to determine whether I was friend or foe, and reflected his internal dynamics and the paranoid way in which he experienced the world. The desire to know whether my hand had been damaged or had done the damaging represented the split in his mind in which he saw people as either victims (like himself at work) or as persecutors (like his bosses). More importantly, however, fixating on my scarred

hand was a way for Mr A to resist the dependence he had developed on me. If he could keep alive the idea that I was a dangerous, frustrating perpetrator, he could avoid his wish to know me more intimately and keep his view of the world alive.

In Mr A's search to find 'me' by searching for clues in my body, he was projecting a part of himself into my body. It became the task of the therapy for him to try to work out, with my help, what of that projection was of him, what was of me, and what was of him in me.

The second vignette illustrates how references to the therapist's body often occur in a throw-away manner 'at the door', and how these can make the therapist very uncomfortable. A colleague told me of a patient who returned to therapy after an absence of three years. As the patient (whom I will call Ms B) walked into her first session after the break she commented that the therapist must have been happy in the three intervening years as she had put on weight. The therapist felt unable to reply. This is an illustration of experiences which are not uncommon for therapists. Comments which occur at the start and end of sessions are often silencing.

Ms B made her throw-away comment as she entered the room. She may have felt small, anxious and vulnerable as she did so. It could be assumed that needing to return to therapy had put her in touch with the feeling of needing her therapist and made her feel she had failed in some way. She was possibly also attacking her therapist's happiness while demonstrating her own unhappiness by needing to return to therapy. Her comment could be read as evidence of defending against such feelings and resisting the asymmetry of the therapeutic relationship by attempting to re-embody, and in this case belittle, her therapist by calling her 'fat' which is generally an insult when said by one woman to another. In her comment, Ms B appeared to be projecting her vulnerable, 'unattractive' feelings into her therapist. This example foregrounds the particular vulnerability of the frame during moments of transition. More relevant to the current argument, however, was my colleague's reference to how she felt about the personal content, which opens the question of the countertransferential dimension of body comments.

The second of my own patients I would like to discuss, Mr C, demonstrates how comments about the therapist's body may occur at the close of a session. This was a difficult therapeutic relationship defined by a lack of emotional connection. The young man had enormous potential at work and had been given extraordinary opportunities, but was a procrastinator and was never able to achieve the success that his potential promised. It was only after a session in which I spoke to him in a

very direct way about how he was engaging in his world, and with me, that he was able to admit that he had no interest in those things that others wished for him. His resistance to the therapy process was also acknowledged. He seemed relieved to have been able to admit this, and relieved that I seemed to understand rather than judge his lack of ambition. When I opened the door at the end of the session, he noticed my scarred hand for the first time (having been in therapy with me for over a year). He seemed shocked to see the scar and wanted to know what had happened. He asked whether I had been hurt since our last session, which was clearly impossible. It seems in this case that I needed to really 'see' the patient and understand his resistance in order for him to be able to see me in my physicality.

Mr C seemed to only be able to notice my body at a point in the therapy when the transference had shifted and he felt that he could be more honest and real. It is significant that his comment came at the end of the session, perhaps when it could not draw too much of a response.

DISCUSSION

The past two decades have seen a marked shift in our conceptualisation of psychoanalysis from a one-person to a two-person process (Sapountzis, 2009). Intersubjective psychoanalysis now recognises that the analyst's physical appearance is an important contributor to the therapy process (Burka, 1996) and that careful attention should be paid to the patient's references to the therapist's physicality. It is important to note that references to the body do not all do the same work or have the same meaning in every therapeutic process.

The case of Mr A highlights the usefulness of asking for the patient's thoughts and fantasies about the therapist's body, and how this reveals information about the therapeutic dynamics and what the patient is projecting onto the analyst's body. Had I simply answered Mr A when he asked about the scar, and not encouraged him to share his thoughts, I would have missed his fantasies of me as a perpetrator of violence. His lack of information about me allowed for the production of his fantasies, and in that way lured his unconscious processes into the open.

The therapy with Mr A also demonstrates how, in the absence of other cues, the therapist's body becomes hyper-signified. Mr A openly struggled with our relationship and how it was defined by the frame, and he tried hard to know me personally, making particular use of my hand in his attempts. With reduced availability of other information, his attention on the little that he did know was intensified and my scarred hand became his focus. The concentration on my hand

was a way in which he could protest against the therapeutic setting which he found so frustrating. When he could not get the information that he desired from me verbally, he looked for other ways in which to do so and tried to read it off my body.

If the therapist does not allow the patient's thoughts and feelings about the therapist's body to be talked about, it is likely that the patient will assume the topic lies in a spectrum from rude or impertinent to forbidden, because of the social view that it is intrusive to talk about the person of others, particularly their bodies. When patients are asked directly about their feelings towards the therapist's body, they frequently deny noticing or feeling anything at all (Little, 1990). A therapist's reactions to this may include relief, surprise, confusion, amusement or scepticism. If she pursues the issue and encourages exploration, a myriad of fantasies often emerges (Lowell & Meader, 2005). Allowing Mr A to share his fantasies about my scarred hand gave me access to his split and paranoid world, and underscores the helpfulness of exploring the meaning behind such comments before interpreting them (Blechner, 2009).

If the analyst is supposed to be a 'neutral' receiver of a patient's projections and fantasies, talking about the analyst's body is an obvious way for the patient to try to get the therapist to break this neutral and impersonal way of engaging. The patient makes things personal in order to keep them less one-sidedly intimate. Mr A's demands for information are an example, an attempt to get me to share personal information so that the exchange could be more reciprocal and therefore more comfortable for him.

The manner in which Mr A and Mr C engaged with my hand is illustrative of Burka's (1996) idea of the therapist's body as analytic object. Burka (1996) makes use of Green's (1975) concept of the analytic object to understand the role of the therapist's body. In her description she combines Ogden's (1994a) concept of the analytic third with Green's notion of the analytic object and proposes that the analyst's body as an analytic object is co-created by the intersubjectivity of the analyst and patient. Such an object is neither strictly internal nor strictly external but exists in shared unconscious space between the patient and the therapist. Samuels (1989) raises a similar point: 'What I am trying to convey is that, in analysis, the analyst's body is not entirely his or her own and what it says to him or her is not a message for him or her alone' (p. 164). The physical body of the analyst is always present, but not always an analytic object. It only manifests as such when it becomes the carrier of meanings that had not existed prior to a

particular moment in a treatment. Its meaning and the dimensions it takes may change at different points in the treatment.

When the therapist's body does become a focus it develops into something that has a substantive impact on treatment outcome. Burka (1996) proposes that the body assumes the position of an analytic object under some conditions and not others. This may be out of the analyst's control, such as during the dramatic and unavoidable physical changes of illness or pregnancy. The analyst's body may also only emerge as an analytic object in response to certain intersubjective transference-countertransference dynamics. The analyst's body therefore only becomes an analytic object under certain conditions, but there are conditions under which the chances that it becomes an analytic object are higher than others.

My scarred hand became an analytic object for much of Mr A's therapy (especially in the early stages), but gained significance and became an analytic object for Mr C only after a particular therapeutic interchange allowed him to notice it. For Mr A, my hand represented information to which he was not privy, and which reinforced that he was not accepted and included as he wished to have been. This emphasised his split worldview. Mr C's observation of my hand signified a growing closeness and a more real and accurate appraisal of each other in the relationship. My scarred hand is one of my unusual and outstanding physical features and may thus opportunistically become an analytic object in therapies with my patients more than hands might do for other therapists. Other therapists will be embodied in different ways. Responses to my hand will not feature significantly in every treatment and requires that certain conditions (like those described with Mr A and Mr C) arise.

The case of Mr C illustrates a paradox provoked by the hypersignifying of the analyst's body. Due to the absence of other cues, the patient focuses more on the analyst's body than they might do in other circumstances. In some cases however, they may only be able to see the analyst's body accurately (i.e. notice what is really there) when they are able to experience the analyst as a separate and real person (and in turn, this might only happen when they experience being seen in that light). In other words, when there is nothing else to see, the patient sees the therapist's body, but they may resist seeing the body of the therapist in its uniqueness until there is a shift in the transference-countertransference dynamic which makes the resistance no longer necessary. Only when I was able to demonstrate being able to see Mr C psychically was he able to see me physically. This intersubjective

dynamic allowed for a therapeutic breakthrough. In this case, it was the avoidance of the physical rather than a focus on it which reflected the resistance to the therapeutic process. This case highlights the context and therapy specific nature of references to the body, and their unique relationship to the transferential elements of a particular case.

The cases of Ms B and Mr C illustrate the common occurrence for comments about the therapist's body to occur at opening and closing session moments. It is equally common for the therapist to find such comments silencing. I would suggest that this is true for a number of reasons. Firstly, there may be a temptation to return to the 'whole' patient and avoid the 'heat' of the transference. Returning to the relative safety of a therapeutic exchange, and avoiding the directly personal, might feel more comfortable for the therapist. Secondly, if the comment is made as the patient walks into the room, it may feel as though the session has not yet started and the therapist and patient are not yet 'doing the business' of psychotherapy. If the remark is made as the patient leaves the room, there is no time to engage with it since the session is over. Bringing the comment up at another point may feel defensive to the therapist, and they may worry that talking about the comment gives the patient insight into the therapist's hurt feelings. A third reason why such comments may be hard to pick up on is that they may be hurtful, insulting or surprising. Therapists are trained to engage with negative comments about themselves as therapists, but criticisms about them as embodied beings might be particularly difficult to engage with and interpret. Personal comments about the interpersonal interaction, thoughts or attitudes are the everyday products of therapy, but comments about one's appearance may feel penetrative and the therapist may feel less practiced at responding appropriately.

The questions that Mr A asked about my hand brought up strong countertransference feelings. The scar is as a result of being badly hurt in an accident in which I was a victim. It was rather shocking to me, and hard to hear, that someone might think that I had received the injury in the role of an aggressor. The damage had come from outside, and I had no responsibility for it, so when it was viewed through a lens of me being responsible and violent I felt aggrieved and my instinct was to answer Mr A's question defensively. Managing and digesting these countertransference feelings allowed me instead to ask him for his thoughts and fantasies. This led to a useful conversation which would have been foreclosed had I simply answered him directly. It also gave me insight into how he might unconsciously provoke and anger people around him.

While it is true that the therapist's physical appearance is an integral part of the therapeutic setting, it often does not receive the same kind of consideration as other aspects of the setting such as time and money. Perhaps this is because it seems to approach the subject of the personal and of self-disclosure by the therapist. It also reflects a paradox that occurs in the therapy room: the therapist is not a person until the session has started (or at least not one with whom the patient can engage), but once they start the session they are no longer a real person but are instead constituted by the patient's fears, fantasies and projections.

As the vignettes illustrate, patients' comments on the body of the analyst may be a form of symptomatic response which reveal something about the patient's unconscious dynamics, and the analyst's body becomes a site into which these dynamics can be projected. The defence of projection is understood as a failure of mentalization (Grenell, 2008), so the comments and the meanings behind them need to be mentalized by the patients with the aid of the analyst. In this way the patient can begin to take back the projection and be helped to see what is of them in the analyst and what is in fact separate to them.

The short vignettes discussed illustrate the complexity of the therapeutic relationship and the analyst's physical body in that relationship. The therapist's body maintains its impersonal status in order for the patient to keep projecting into it, yet it is simultaneously continuously communicative, and frequently communicates much more than the therapist would like it to. The therapist defends against the patient having any knowledge of her body while the patient remains curious about it. The therapist's body is thus something for the patient to project into as well as to find reality in.

CONCLUSION

The physical body has always been present in psychoanalysis. Indeed, psychoanalysis began with Freud exploring the psychological mechanisms at work in patients who presented with physical illnesses for which no identifiable biological cause could be found (Breuer & Freud, 1893; Gubb, 2010; Rangell, 2000). This was the body of the patient. Despite increasing attention by analysts to the space between the patient and the analyst, the patients' projections and other material are still usually interpreted from a unidirectional perspective. Specifically, they are treated as metaphors or symbols that communicate core aspects about the patient's conflicts and fantasies, and the role of the analyst is to understand these projections and interpret them to the patient. This paper offers a challenge to

engage with the bodies in the therapy room in a different way: by acknowledging, firstly, that there are two bodies in the room and, secondly, that these are inescapably physical bodies which lend themselves to psychic significance. Doing so allows the analyst to be re-embodied. The way in which the patient engages with the analyst's body offers useful information about the therapeutic process.

In order to work with comments or enactments focused on the therapist's body, it is useful to look at the nature of the comment, its timing, and to interpret what it appears to mean to the patient. As with all clinical material, when a patient makes reference to, demonstrates a preoccupation with, or comments upon the analyst's body, it is incumbent upon the therapist to reflect on the significance of the timing of the comment and on what might be going on in the transference-countertransference relationship.

Normal social interaction contains unspoken rules about normative behaviour. These rules tell us how to behave and tell us what we may and may not say. The social injunction around making personal comments – particularly negative comments – about the body might further explain why it is difficult for a therapist to respond. There is shame and meaning attached to our physical appearance. When a patient focuses on the body in this way, it may be an attempt to move themselves out of the discomfort created by the analytic setting. The act of the patient making themselves more comfortable in this way may have the intended or unintended effect of making the therapist less comfortable.

The paper has argued that the body of the analyst always acquires salience, and indeed a special salience, due to the absence of other cues and personal information. Analysts bring aspects of their embodiment into the room without even being aware of these, and are often less aware of the impact of their bodies than of their minds. The frame also inadvertently moves the body out of the room. By paying attention to how patients bring the analyst's body back into the room, the analyst is re-embodied and through that process is able to gain more nuanced insight into the dynamics occurring in a particular therapy.

CHAPTER 8: DISCUSSION

The title of this undertaking, “Minding the Body”, was chosen as it not only raises the issue of the physical body in psychoanalytic practice, but in doing so also includes many of the meanings that the word ‘minding’ evokes both in a psychological sense as well as in common speech, such as ‘taking care of’, ‘being mindful of’, ‘taking into account’, ‘holding in mind’ and importantly ‘giving mental attention to’. The project as a whole is located against a backdrop in which, despite the fact that the body has been fundamental to psychoanalysis from the beginning, in recent years there have been relatively few developments in theories of mental illness that take a route to the physical as well as very little concern with the body of the analyst, both in terms of the analyst’s private experience and as an object of the patient’s own experience. The aim of this study was to address this relative neglect and to research what the clinical implications of paying attention to both the bodies in the therapy room might be.

The questions and explorations addressed in this project need to be considered in historical context and set against the beginnings of psychoanalysis. Since Freud’s early attempts to diagnose and treat hysterical patients who presented with bodily symptoms for which no underlying biological cause could be found, the body has been central to psychoanalysis (Breuer & Freud, 1893). The very possibility of symptoms that are fundamentally mental in origin manifesting in the body, which was suggested in Freud’s work with hysteria, establishes a relationship between the body and the mind, and it can be argued that a concern with this relationship is inseparable from psychoanalysis itself (Breuer & Freud, 1893; Freud, 1893a, 1893b, 1896).

Implicit in this emphasis on the mind and body in relation, as manifest in the clinical challenge Freud encountered in hysteria, is the close epistemological link between theory and practice characteristic of psychoanalysis (Freud, 1893a, 1893b, 1894a, 1905, 1909). It can be, and often has been, argued that psychoanalysis has always been about theorising practice rather than practicing theory. In accordance with the close link between theory and practice in psychoanalysis, this research draws on two fundamental theoretico-clinical constructs: that of mentalization on the side of theory, and the phenomenon of countertransference on the side of practice.

Freud’s early work with hysterical conversions was a particularly vivid example of how unconscious material can take a disguised route to the body, and this kind of

pathology illustrates the essentially analytic notion of mental illnesses that are related to repressed psychological conflicts which eventually emerge in indirect form in the body, and where the origins of the illness remain unavailable to the ego of the patient (Freud, 1894a, 1909, 1926).

Freud described various other forms of psychosoma too, such as hypochondriasis, actual neuroses and psychosomatic illness, and theorised the clear distinctions between the symptoms of these pathologies and their underlying dynamics. He also had precise ideas about which of these could be treated by means of the analytic method and why that was so (Mitrani, 1995; Taylor, 2003). The work in the area of bodily symptoms following Freud expanded and questioned some of the aspects of the Freudian position as well as emphasising new areas of enquiry. An important Freudian view that was questioned was whether or not it was possible to treat other physical complaints, such as those that became known as somatisation, with psychoanalysis (Deutsch, 1939; Ferenczi, 1955; Groddeck, 1977). As theories developed around the origin and genesis of somatisation, the Freudian concepts behind the idea that symptoms have unique and specific meanings related to the particular patient's history, was also debated (Gottlieb, 2003; McDougall, 1974). What these theoretical extensions of Freud's work also highlight is that the distinction between the various types of psychosoma are neither simple nor straightforward and much debate ensued, particularly around differentiating and diagnosing conversion symptoms from those now described as the product of the condition called psychosomatosis.

THE DYNAMICS OF PSYCHOSOMA

The paper entitled "The Sense of Bodily Symptoms" (Gubb, 2010) investigated the specific extension of psychoanalytic practice to include physical symptoms which were not originally considered to be treatable by means of psychoanalysis, using the psychoanalytic method or talking cure. The paper was written against the background of the literature attempting to distinguish, in theoretical terms, a form of diagnostic and classificatory activity which implied that patients belonged in either the category of hysterical conversions or that of psychosomatosis (Carveth & Carveth, 2003; Taylor, 2003, 2008b; Verhaeghe, Vanheule, & De Rick, 2007).

The limitation of this position is that it does not reflect what is observed in the clinical situation. In practice one sees examples of patients who are classical converters, patients who present with vague forms of somatisation, and interestingly, patients who seemed to move from one position to another during the

course of a therapy. These moves occur in both directions: in some cases the patients' presentation changed from one in which the symptom had a less mentalized and symbolic form to one in which the symptom became more symbolic and meaningful. In other cases, usually if the patient experienced a trauma, regression or breakdown, the move occurred in the other direction.

The implication of this shifting in position coupled with the extent to which a particular patient's circumstances influence levels of mentalization combine to suggest that the diagnostic tendency underpinning the theory has been overly constraining, and therefore does not adequately explain what is seen in clinical practice. The paper consequently proposes a continuum on which the two pathologies might be mapped and which reveals different levels of underlying pathology which in turn affect whether there is a particular meaning in a symptom related to the patient's history, while still retaining the central understanding that this psychopathology involves repression of unconscious material. Much of the theorisation in the paper is made possible following the work done on the concept of mentalization and what that has revealed about the underlying psychical mechanisms which link patients' physical symptoms to their relative mentalizing capacity. The mentalization theory also has clinical implications, as it informs an understanding of what the task of treating patients with these symptoms might be.

The clinical application of identifying where the patient lies on this continuum and what their underlying level of mentalization is, is important for treatment as it defines the therapeutic task. Since the way in which a psychosomatic pathology will manifest is related to the patient's level of mentalization, (in that conversion symptoms require a degree of mentalization related to the level of language required for the symbolisation behind the disguised meaning of the symptom) while somatization symptoms do not, and as the patient's ability to mentalize changes during a treatment, so too might the symptom presentation. Consequently, different kinds of interpretive activity may be required at different points in the therapy depending on whether the patient is operating in a more concrete, rigid manner, or if they are able to make links and free-associate to material. If the patient has poor mentalizing and symbolising ability it is best for the treatment to place in a face-to-face manner and to focus on creating the links between the patient's mental activity and their physical responses to that. Assisting the patient in this way to mentalize and symbolize aims to shift their position along the continuum. If the patient has a more well-developed capacity for mentalization, the therapist can make more use of word play and interpretation, in order to allow the patient to make sense of their

symptom and understand its disguised meaning, and in that way allow them to lift the repression and work through the underlying conflict.

Interestingly, while there are contemporary papers which engage with the debate concerning the differences and similarities of conversions and psychosomatic illnesses (Taylor, 2003, 2008b; Verhaeghe, et al., 2007), there are apparently fewer and fewer patients who present with hysterical conversions clinically. Whether this is in fact the case and is a result of different attitudes to sexuality in more modern society as is often argued, or if in fact conversion symptoms are not being recognised in different contexts, is a matter for debate. However, the apparent 'disappearance' of, or concern with, classic conversion hysterias does not mean that attention is no longer paid to other kinds of symptoms which involve both the psyche and the soma.

SCHOOLING PSYCHOSOMATIC ILLNESS

Work in the field of psychosoma has been explored and developed by the well-established Paris School of Psychosomatic Illness since the 1960s. The Paris School is based on the founding work of Pierre Marty, and the theorists belonging to this well-known Paris School maintain Freudian economic principles, focusing on how the patient preserves and discharges their libidinal energy. They argue that if the patient is not able to mentally deal with their libidinal energy by identifying and processing (i.e. mentalizing) the underlying psychic suffering or discomfort, the unbound energy takes a route to the body, but that this route to the body may not be related to specific, identifiable forms of trauma, or to an identifiable developmental history (Aisenstein, 2006, 2008; Aisenstein & Smadja, 2010).

In the psychoanalytic literature published in the English language, the Paris School is the only acknowledged and established school of thought focusing on the field of psychosomatic illness. However a review of contemporary literature suggests the emergence of another group of theorists who generally seems to be writing in a similar way and who thus could be construed as a school, even if they do not yet identify themselves as such. The second paper "Psychosomatics Today: A Review of Contemporary Theory and Practice" (Gubb, 2013a) argues for this second school and names it the Attachment approach. Not surprisingly, the Attachment approach is based on the work of attachment theorists such as Fonagy, Target and Allen and their work on mentalization (Allen, et al., 2008; Fonagy, et al., 2004; Fonagy & Target, 2007). This school is also related to Freudian economic

principles in that it understands somatisation in terms of unmet childhood needs stemming from interactions with caregivers which leave the child unable to manage intense affects and physical sensations. The Attachment approach is also more related to Freudian topographics and developmental theory than the Paris School, as it recognises that the relationship with the caregiver produces internal conflicts and desires, some of which need to be repressed in order to be managed.

The development of the theorisation and treatment of psychosomatic illness appears to be following one of two trajectories based on these two different understandings of mentalization and the levels and forms that it can take. Accordingly, the paper compares and contrasts the two approaches with respect to their underlying theories and treatment approaches, paying close attention to how the school's understanding of the concept of mentalization translates into the task to be completed by the therapist in the room with the patient. The term 'mentalization' was coined by Pierre Marty (1963) of the Paris School who understood it in Freudian economic terms, describing it as the process which is used by the mental apparatus to bind the body's libidinal drives. By contrast, mentalization as understood by the Attachment approach focuses on early experiences with caregivers as well as on affect recognition and regulation (Fonagy, et al., 2004).

Based on their theoretical foundations, each of these schools make proposals about how the therapist should understand their task and how they should engage if a somatising patient seeks treatment with them. The clinical implications of these differences between the schools, while defining the therapist's task according to the particular patient's level of mentalization, interestingly translate into very little difference in the treatment activity. The two schools are also in agreement that the therapeutic task may be required to be adjusted through the process of therapy as the patient's capacity for mentalization is strengthened and deepened.

In summary, contemporary theorisations about patients' bodily responses to psychological events agree that these have psychological meaning and can be treated by means of psychoanalysis. The keys issues in the current literature turn on the understanding that the patient's underlying level of mentalization will affect how much and in what way that patient will somatise. This suggests that it is important to pay attention to mentalization in the therapy room and allow that to inform the therapeutic task. The first two papers presented in the thesis highlight the therapeutic consequences that arise after the therapist identifies different levels

of mentalization and how this affects the treatment of different types of psychosoma.

Since changes in any key ingredient of the practice of psychoanalysis are likely to involve possible theoretical shifts in understanding and vice versa, it becomes important to pose the question of what impact the shifts in both practice and theory coming out of the contemporary theorisations of psychosomatosis might have had on the psychoanalytic theoretical foundations underlying the understanding of the symptomatic body, as well as how this is treated in psychoanalytic practice. In contemporary psychoanalytic practice, and as suggested by the Paris School and Attachment approach, the scope of what can be treated by means of the psychoanalytic method has increased, as well as the understanding of the nature of the therapist's task. The most significant contemporary practice development is the acceptance of the close relationship between psychosoma and mentalization and how that relationship informs the therapeutic endeavour. The therapist's task is now understood to be determined by the patient's underlying level of mentalizing ability and requires that that level of mentalization be enhanced and improved by means of both mirroring and interpretation by the therapist. However, despite these developments, the conceptual foundations nevertheless still allow for the retention of the fundamental conception of psychosomatic illness as an unconscious process underpinned by the repression of psychic material, which can be treated using the psychoanalytic method, importantly, making use of interpretation. It would appear then, that even though there have been significant developments in practice, the metapsychological principles and understandings of somatic psychoanalytic psychopathology are still intact, and in fact little has changed in the understanding of the underlying mechanisms of psychosomatosis as these still closely resemble their early Freudian beginnings (Gottlieb, 2013).

While there might be some variance between different schools of thought between their emphases on economic, dynamic or topographical principles, there is still fundamentally the same understanding of psychosoma and how the unconscious works and how symptoms function in most of the work described and reviewed in this research, as when Freud described the "puzzling leap from the mental to the physical" (Freud, 1917b, p. 258). This is the understanding of psychic energy which is frustrated or not satisfactorily discharged to the object, and when a mental understanding can be applied to this, the discharge can instead be made mental meaning of, and does not need to manifest in the body.

This general acceptance of symptoms of a mental conflict manifesting in physical terms, occurs at the same time as the contemporary emphasis on the importance of countertransference, and this combination of theoretical influences predicts a new and matured understanding of the same conceptual elements of psychosomatic psychopathology being applied to the relationship between the mind and body of the second body in the room: the body of the analyst.

THE SECOND BODY IN THE ROOM

The contemporary embracing of the importance of the countertransference, and specifically more focus on the contribution of the analyst to the form in which the countertransference manifests (Gabbard, 2001), expands the role of the therapist. The expansions in theory around the phenomenon of countertransference have evolved psychoanalytic practice in that the role of the analyst in the unfolding of a psychoanalytic treatment is now understood in an increasingly modulated way, and countertransference is now worked with extensively and is considered to be an irreplaceable tool in psychoanalytic treatment (Gabbard, 2001).However, despite this emphasis on the countertransference in the psychoanalytic literature, there is still insufficient attention paid to the *physical* countertransferential responses of the analyst, and therefore the unanalysed material on the level of the analyst's body is neglected. It is interesting to note too, and crucial to this thesis, that what little attention is paid to somatic countertransference is read outside of the tradition which makes sense of bodily responses as being specific to the particular therapeutic dyad and developing out of the dynamics of that dyad.

In the context of the analyst's expanded role and their contribution to the form of the countertransference, it would seem that it is equally important for the therapist to mentalize any regular physical sensations which they experience in their own bodies in relation to a specific patient in order to understand what those may reveal about what has not been available to the therapist until that point. This will, in turn, lead to the analyst using him- or herself as a psychoanalytic tool in a more nuanced way.

The third paper "Craving Interpretation: A Case of Somatic Countertransference" suggests that what has been learned about the need for the mentalization of physical symptoms in the patient should be applied to the physical responses the therapist experiences to the patient in the therapy room, and by doing so those physical responses will be transformed into the realm of the mental. This proposal

is made possible by the shifts in the countertransference described previously and advocates that these 'signs' which are indicative of preconscious and as yet uninterpreted responses to the patient, and which are not immediately available to the therapist, be made mental and become grist for the analytic mill.

In suggesting that somatic countertransferences have been neglected in theoretical consideration and implying that major attention needs to be paid to interpretive processes that the analyst needs to apply to herself, questions of technique arise with urgency. The first of these arises consequent upon the requirement for the analyst to interpret their somatic countertransference. The interpretation of a somatic countertransference can usefully be developed on the basis of Ogden's notion of reverie (Ogden, 1994b, 1997a). The emphasis Ogden places on making sense of physical responses is a very useful vehicle which the analyst can add to her repertoire in order to make mental those of her responses which were previously unconscious and physical, in order that she may make the best clinical use of the countertransference.

The second question of technique raised is consequent to the developments in the theory and use of countertransference and the debate this raises about the nature of the relationship between the patient and the analyst, as well as opening up a substantial difference in clinical practice from the original Freudian construal and the Kleinian interpretation which followed. When the therapist begins to mind her own body with the view to exploring both the intrapsychic and interpersonal meaning of its responses (even if this meaning is initially partially unavailable to her, and may or may not be disguised), this may result in a different way of engaging with the 'symptoms' of her body and the visibility of these to the patient. This introduces an examination of the positioning of the role of the therapist and how much of her hidden physical responses should explicitly be revealed to the patient. In the case of psychosomatic phenomena which are spontaneously perceivable (and in that sense not able to be hidden) there is a particular implication for therapeutic practice, and the question is then not whether the fact of the physical response should be revealed or not, but instead how to work with that dimension – as discussed in the third paper. Engaging with the patient's response to these visible or audible somatic countertransferences may provide the analyst with a further area in which to explore and understand the dynamics of that particular therapeutic dyad.

While the traditional understanding was that contents of the analyst's unconscious or their preconscious material prior to interpretations were not to be revealed to the patient, the broader intersubjectivist tradition suggests that useful therapeutic gains can be made when the analyst reveals information about their physical responses to the patient even when these are not immediately perceivable (Ehrenberg, 2005; Gerhardt, Sweetnam, & Borton, 2003). This issue of the extent and nature of the analyst's disclosure of personal information and how it affects the patient's involvement in the interpretive process is one of the controversial and intensely debated issues currently confronting contemporary analytic practice (Sugarman, 2012).

The intersubjectivist paradigm advocates the disclosure by the analyst of their thoughts, fantasies and responses (both psychological and physical) in order for these to enter the field of interpretation (Sugarman, 2012). The therapist engaging with the patient in this way fundamentally changes the nature of the psychoanalytic exchange, and the degree and character of the patient's involvement in the interpretive process as it has been conceived of since the beginning of psychoanalysis. It was Freud's (1914) view that the best interpretation is one that is made by the patient himself. However, while this Freudian understanding does include the patient making interpretations about him or herself during the interpretive exchange between patient and therapist, this is not done via an interpretation about the impact that the patient might be having on the therapist.

Even though in some ways the intersubjective extension of this technique could be seen as a reasonably logical move, the position taken in this research is a more traditional one in which the analyst does not disclose personal information. This position is not taken in order for the analyst's anonymity to be preserved in some false way, but in order to retain the important key analytic concept of the importance and use of interpretation. I would also argue that the approach suggested by the intersubjective paradigm may increase the attention paid to the countertransference but with a focus on the more 'real' aspects of the relationship, and may thus edge towards a 'two-way' interaction characteristic of informal conversation. This sort of change in the therapeutic relationship may close down the space for the analyst's body to receive the patient's psychic projections or other manifestations of a cornerstone of the psychoanalytic method, the transference, by filling in the gaps that a patient might otherwise fill with their fantasies.

THE ANALYST'S BODY AS ANALYTIC OBJECT

When the body of the analyst enters the room, whether it be 'accidentally' in a visible countertransference, or if something of it is unavoidably revealed by the analyst, for example by manifest illness or pregnancy, there are implications for practice. An idea traditionally endorsed by psychoanalysis is that the analyst maintains the position of a 'figure' in the therapy room and this is related to the fact that the analyst is seen by the patient as an expert, and it is common for an interaction with an expert to be conducted in an impersonal, professional manner. Psychoanalysis views this impersonal presentation of the analyst to be especially important because of the very personal nature of the exchange, and the therapeutic encounter was therefore intentionally set up to construct the interaction as a professional consultation rather than, for example, a friendly, advice-giving, confessional relationship (van Zyl, 2003). The interpersonal relationship between analyst and patient is of utmost importance to the two parties involved, but it is a relationship unlike any other in that it is particularly one-sided. The analyst does not confess or celebrate the personal in equal measure to the patient as would occur in a friendship (Freud, 1912c).

The establishment of the analyst as a figure is derived from the work of early psychoanalytic theorists who promoted the idea that the analyst should remain neutral, impartial and impersonal in order for the transference to develop and for the analyst to function as a screen onto which the patient can project their conflicts, fantasies and neuroses which are unconscious in origin. It was believed that this was the best way to foster the development of the transference as the analyst's neutrality and anonymity kept any 'real' aspects of the analyst from 'muddying' the therapeutic space (Freud, 1940; Giustino, 2009; Moore & Fine, 1990; Smith, 2003).

The concepts of analytic neutrality and anonymity have recently been the subject of much debate, especially with the emergence of the intersubjective approach to practice (Renik, 2007), and it is within that debate that the paper entitled "Re-embodying the Analyst" (Gubb, 2013b) is located. The paper argues that when attention is drawn to the body of the analyst in the room, the idea of the impersonal, neutral analyst, which has been encouraged since the birth of psychoanalysis, is challenged.

The traditional psychoanalytic perspective was therefore one in which it was the 'figure' of the analyst and the body and mind of the patient which took part in the

treatment. The unconscious parts of the minds of both participants were active during the process and were the objects of enquiry for the analyst. However, all of the developments which have developed the understanding and use of certain elements of psychoanalytic practice have made it possible to now move the embodied person of the analyst legitimately into the arena of analytic practice and allow it to join the customary figure of the analyst.

The fourth paper suggests in contrast to the traditional idea that the analyst should remain only a figure, that the physical body of the analyst will always give clues to the patient about the analyst in their reality as a person, and instead of spending effort attempting to hide these, it may be clinically useful to engage therapeutically with the patient's comments and observations about the analyst's body. It is likely that the body of the analyst will only enter the therapeutic space and affect the impersonality of the analyst after there is either a significant physical change such as due to illness or pregnancy, or if there has been a shift in the transference-countertransference dynamics which has consequently drawn the patient's attention to the analyst's body in a more personal way. The paper proposes that paying attention to the physical aspects of the analyst as they are seen through the eyes of the patient following a physical change or shift in the interpersonal dynamics provides a wealth of information which can then be mined during the treatment. The paper consequently advocates that the body of the analyst as an object of perception and experience of the patient must be allowed to enter the therapeutic space.

It is important to emphasise that what is proposed here is that when the analyst's body becomes explicitly present after such changes, that it is both the figure *and* the embodied person of the analyst, rather than the figure of the analyst alone, that enters the room. This therapeutic approach importantly reinforces the fundamental structure of a psychoanalysis in which the position of the analyst as a figure is not abandoned, and the therapeutic frame still exists, while at the same time opening up a space for an investigation of what the more 'real' aspects of the relationship reveal about the transference-countertransference dynamics.

As the raison d'etre of psychoanalysis is to treat the suffering of patients, it is understandable that the emphasis has traditionally been upon the body of the analysand and that the therapeutic dimensions of the changing body of the analyst have therefore not been sufficiently reflected upon. Further to that, against the background of the analyst being conceived of as an expert who deals in language,

interpretation and the talking cure, the asymmetry of the psychoanalytic relationship comes to the fore, and the body of the analyst may easily be construed as being not for the attention of the patient. However, by paying attention to the body of the analyst as it is experienced by the patient the analyst can add to their therapeutic repertoire and access useful information about the transference-countertransference dynamics at work in the therapeutic dyad.

In summary then, the first two papers of this thesis outlined what procedures could be used to facilitate patients' mentalization of their physical symptoms, while the second two papers advocate that the analyst pay attention to two different ways in which their own body becomes an object of the analysis. The first of these is the suggestion that the analyst brings the same procedures and techniques to bear upon themselves in order to enable interpretation and understanding of their physical responses to a patient as they did to the patients' psychosomatic symptoms, or in other words, that the analyst interpret their own bodily self. The second advocates interpreting the patient's interpretation of the analyst's body.

It was possible to put forward this argument in the second part of the study following the expansion of the notion of countertransference as this has brought the other half of the therapeutic dyad – the therapist – into greater focus than might previously have been the case, and importantly for this research, with a particular focus on the therapist as embodied. The theory of mentalization and its implications for practice also relates the first part of the thesis with its focus on the patient's body, to the second part of the thesis which focuses on the analyst's body, by proposing that the analyst must herself make her own body mental.

The project therefore submits that all expressions of the body in the therapy room – whether in the case of psychosomatic symptoms in the patient or in the case of the 'normal' relation between the analyst and her own body, or the way in which the patient responds to the analyst's body – require therapeutic investigation and interpretation. It further urges that any clinical practice in the area of psychosoma now be written in a way that includes the somatic dimensions of both the patient and the analyst based on the proposition that by paying attention to the two bodies in the room the analyst extends her analytic range which can in turn facilitate deep and lasting therapeutic gains.

The structure of the thesis with two interconnected parts making up a whole, was chosen to reflect a similar relationship in two other areas of psychoanalysis: the first of these is the non-cartesian relationship between the body and the mind, and

the second relates to an appreciation of the fact that that there cannot be a patient without a therapist. The two-part structure of the research therefore accentuates both the setting of the psychoanalytic situation and its two participants, as well as aspects of the two 'parts' that both of these participants bring into a psychoanalytic treatment, namely a mind as well as a body.

In conclusion, this thesis has argued that it is therapeutically useful to mind both the bodies in the room. Giving attention to the patient's physical symptoms and presentation will allow for a deeper understanding of their psychic conflicts and levels of functioning which in turn informs the clinical intervention so that patients might be helped to function with reduced suffering. Minding the body of the analyst allows for the analyst's body to emerge in a way in which it can play a part in therapy, and consequently invites the body of the analyst to enter the room as a tool in analytic practice and in that way as an analytic object (Ogden, 1997a) in and of itself.

LIMITATIONS OF THE PROJECT

Research making use of the methodology used in this study raises four interrelated epistemological considerations.

The broadly qualitative research paradigm is often criticised on the grounds that the findings of qualitative studies cannot be generalised both because of the small number of participants involved and due to the fact that the kinds of claims being made may be very case specific. As described in the methodology chapter, this criticism is true of case study methodology specifically as well as other research methods where small numbers of instances are explored, such as in-depth interviews. The lack of generalisability of this project could be considered as its first limitation. However, the depth and richness of the material produced using that method is also one of its strengths, and was therefore an appropriate research method for this project. The cases used were chosen because they were believed to be typical of the point being argued and were revealing in that very typicality which exemplified points under discussion and/or expanded theoretical positions.

The second and third limitations are related to the fact that this research is specifically clinical in form and has certain aspects in common with the clinical case study research method. Clinical research by definition includes a high degree of data selection and thus raises questions in relation to ethics particularly vividly,

since in clinical contexts there is an imperative to maintain a patient's privacy and consequently issues of confidentiality and recognisability come to the fore.

As a result of the ethical requirement that patients be asked for permission to use their material in the research or for them to have terminated therapy a long time previously, restrictions were placed upon the choice of which patients could be included (as described in Chapter Three). This important consideration necessitated that great care be taken when deciding who to approach so as not to negatively impact any on-going therapeutic processes, and consequently some potential participants were not included even though their material may have been connected to, or useful for, the study.

In this form of research, once appropriate subjects have been selected specific material from within the case needs to be selected. This in turn raises the question of to what extent the material chosen can itself risk a confidentiality breach if it reveals the identity of the patient or in some way makes it possible that they may be recognised. In order to prevent that, some of the identifying details needed to be disguised. This leads to the third possible limitation of the study since, as a result of the disguise, there may have on occasion been some inhibition or distortion in the presentation of the research data. There is therefore a tension between the authenticity and accuracy of the research data as in literal, detailed information, and epistemological cogency in the research. Every possible attempt was made to maintain the integrity of the material and to not disguise any substantive details in ways which would skew or influence the manner in which the material was understood.

The fourth limitation is related to the use of case material from other therapists, and in those cases the researcher took on the position of interlocutor. This may have been limiting in the sense that the material was not known as intimately or in as nuanced a way as it was to the therapist involved. It did, however, allow for the researcher to hold an observing, more distanced, 'third' position which then opened up possibilities for new understandings of the material. Using the material of other clinicians also allowed for a way to extend the use of case material without risking the confidentiality of patients (as described in Chapter Three). The potential limitations of using this research method were mitigated by repeatedly checking the way in which the papers were written up with both the contributing clinicians as well as the PhD faculty.

In all these cases, every attempt has been made to limit these potentially vitiating circumstances

RECOMMENDATIONS FOR FUTURE RESEARCH

In order for the thesis to have focus, the decision was made to draw a single theoretical paradigm even though there is not only one theoretical trajectory around the understanding of psychosoma. The decision was made to choose one strong paradigm, and the classical Freudian one seemed to be the obvious one as it is still widely accepted and was also able to account for the various ways in which the patients and therapists presented. It is acknowledged that broadening the research to include other paradigms might broaden and deepen the work.

An engagement with the field of psychosoma in the wider sense would necessarily involve taking on board some of the newer, more recent research, particularly in the field of neuropsychoanalysis which has particular cogency to the field of psychosoma and is an extension of psychoanalysis, and is very much concerned with thinking, theorising and practising explicitly across the body-mind border.

Both of the authors who were invited to comment on the paper "Psychosomatics Today" (Gubb, 2013a) gave very useful suggestions about other paradigms that work in the field of psychosomatics and which could usefully be combined with psychoanalysis in order to achieve a deeper understanding of the mechanisms involved. Gottlieb (2013) makes the important point that although Freud was skilfully able to map the mind in the early 1900s, it is important that psychoanalytic thought about psychosomatosis keep abreast of the scientific developments of the twenty-first century. There has been a great deal of research in disciplines such as neuroscience and psychoneuroimmunology, and including and integrating learnings from these complementary disciplines into the psychoanalytic tradition would result in a more robust and richer understanding of the field.

Frommer's (2013) commentary on the same paper reviews work in psychosomatosis from a German perspective, and also identifies a split in disciplines. He describes how, for historical reasons peculiar to Germany, psychosomatics and psychoanalysis are two different discourses in that country. He describes the difference between the focus of each discourse: Psychoanalysis appears to be interested in theorising the cause of psychosomatic illness whereas the psychosomatic discourse has abandoned that endeavour because of methodological problems involved in trying to establish causation, and has chosen

to focus instead on how patients cope with their illnesses. He concludes by helpfully suggesting that an integration of these two traditions might lead to a better understanding of the subject but also to better ways to treat patients with psychosomatic illnesses.

Finally, since there is some indication that forms of psychosomatic illness such as hysteria may be diagnosed only under specific historical conditions, and therefore appear or fall out of the diagnostic repertoire, it is possible that such diagnoses may also be influenced by cultural differences. It could be useful to explore the understandings that other cultures have about physical symptoms which appear to have no biological origin if this research is to be developed in the future – especially in the South African context.

CONCLUDING REFLECTIONS

Having very recently read and written about how the analyst's pregnancy affects the therapy in theoretical terms for the final paper, one of the most extraordinarily interesting, and in many ways enriching, experiences of doing this doctoral research was the fact that I fell pregnant at the very last stages of the project and watched with interest the impact that my changing body had on my patients. This event was a live example of the therapist's body entering the treatment room and served to beautifully illustrate and highlight many of the arguments made in this thesis. Of course, the body in pregnancy is a particularly evocative phenomenon and is known to (re)awaken old internal conflicts and painful memories in patients (as discussed briefly in the final paper "Re-embodying the Analyst"). Because pregnancy has such a particular meaning, when the analyst's body visibly changes during a pregnancy, it will evoke different responses in the patient to those that other physical changes in the analyst such as weight loss or gain, or illness might result in.

It was clear that I should expect that my patients would react to the changes occurring in my body, but what was of particular interest was the observation that even though there was a mix of individual responses amongst my patients, in almost all cases the question of my pregnancy had a marked impact on the *manner* in which the patient engaged: almost without exception, my patients began to relate to me in a way that was far more 'personal'.

My growing belly and changing walk were profound and obvious physical changes which made the fact of the pregnancy and the changes it would bring to the therapeutic setting impossible to avoid. They also drew attention to more personal aspects of me such as my physicality and my private life. The curiosity of my patients was piqued regarding my life outside of the therapy room in an intense and profound way, and my patients began to voice thoughts and questions about me in a way that they had not done previously. While this 'push to the personal' occurred across the board, it appeared to me that the reactions fell into three general groupings. These groupings conveyed to me a sense of the modalities in which the patients' perceptions of the analyst could emerge in the transference, and I suggest were related to the patients' internal dynamics as well as to the transference dynamics of the therapy which were at work at the time my pregnancy entered the frame.

The first grouping was patients who demonstrated a more 'benign', ego level response to me and my pregnancy. It was generally true that in these patients, the form the transferences took before my pregnancy was known and manifest, seemed to be much more metaphorical in nature, and the position I held as a 'person' was previously far less verbalised and had certainly functioned much more unconsciously. From the start of their treatments, these patients would anticipate and experience my interpretations and responses as warm, understanding, critical, supportive or unhelpful depending on the transference-countertransference dynamics that were occurring at that point in the treatment, but in most cases, I was their therapist who 'lived' in the practice room and about whose private life they showed little manifest curiosity. In other words, I appeared to hold the role of the figure of my patients' therapist, and our relationship occurred in the realm of the psychic. After becoming pregnant I became more embodied and more of a 'person' in the mind of these patients. They began to ask me direct questions about my marriage, other children I might or might not have, and my views on child rearing. They became much more aware of me as a physical presence and appeared to feel more entitled to comment on my appearance and the size of my belly. Some patients even tried to rub my belly as they walked past me when they entered or exited the room. I noticed a strong pull in myself to engage in a similar way. I was often very tempted to allow myself to be pulled into a personal interaction and to share my joy and excitement (and on occasion, my exhaustion or illness). It was important to hold the frame in those moments despite this desire in my patients (and sometimes in myself) to personalise the relationship. I observed that as the therapy continued in its usual manner that on the whole, this group of patients did not present with much new material or reveal conflicts which were very different from those they were already working with. Although I had become more of a human being rather than simply being the patient's therapist, this shift appeared to be one that the patients were conscious of and could put into words, and it did not have a substantive impact on the treatment.

In the remainder of my patients, the transference neuroses were either significantly intensified or vividly brought to the fore once they became aware that I was pregnant. The pregnancy provoked the return or escalation of the patients' internal, unconscious conflicts and difficulties. In the second group of patients I identified the transferential responses were strongly positive (even erotic), while in the third group they were powerfully negative and attacking, subject to the individual patient's unconscious structures and how these became radicalised as I, as the

person of the analyst, changed shape and emerged more from the impersonal figure that I had previously represented.

The patients who responded with a strong positive transference seemed to be reacting to the strong, life giving and feminine aspects of me as a pregnant woman. Some of my younger, adolescent patients experienced me as a nurturing and understanding mother who was much better than the one that they had. Other patients commented that they were pleased to have a 'role model' who had both a career and a child. Some male patients had fantasies about raising the child with me as their partner, and with some of these men, the transference became quite eroticised. On the whole though, with these patients there was a general increase in the dependency they felt for me, and the impending break in therapy due to my maternity leave was a painful subject.

The group of patients in which my being pregnant provoked profound elements of the negative transference, revealed their hostility in demonstrations of envy, resentment and attack. Commonly it was issues relating to the body, fertility, pregnancy, sexuality and marriage which were central to these patients' pathologies and were frequently raised in the material which they had brought to therapy from the start of their treatments. The negative transference enactments came to the fore in some extremely vivid, dramatic, and sometimes shocking, ways. Some of these patients were too angry with me for becoming pregnant, or found it too painful to watch as my belly grew, and chose to leave the treatment. Others remained in therapy but mocked and attacked me during sessions. These experiences were distressing and difficult for me and I had to work hard to balance my concern for my patient with my outrage and defensiveness regarding my unborn child.

Whichever grouping a particular patient fell in, what was universally true was that working with the material the pregnancy brought up for them usually led to interesting and useful therapeutic advances within the context of the unique dyadic relationship, the patient's interpersonal dynamics and my changing physical condition. The important point here, though, is that this material was only made manifest when I began to emerge as more of a person than simply as the figure which I previously had been.

This experience with my patients highlighted and reinforced many of the thoughts which had germinated and grown through the process of the writing of this doctorate. Most importantly though, it cemented the conclusion which I had already

reached through the research: It has been clear since the very beginning of psychoanalysis that it is crucial to mind the body of the patient. What is now also clear is that it is just as important to mind the body of the therapist.

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APPENDIX I

PATIENT INFORMATION AND CONSENT FORM

KAREN GUBB

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Dear _____

INFORMATION ABOUT PROPOSED STUDY

I am currently completing a doctoral degree (including publication) at the University of the Witwatersrand and would like to invite you to participate in the research. I am writing this letter to provide you with sufficient information about the study so that you are able to make an informed and consensual decision about participating. If there is any information that is not included in this letter, but which you require, or if you require any further explanation about anything contained in this letter, please do not hesitate to contact me.

If you are prepared to participate in the study after reading this letter and the attached informed consent form I will ask you to sign the attached form. I will then give you a copy of that same form for your records.

My area of focus is how the body is used to reinforce and communicate unconscious anxieties, desires and memories in psychotherapy. When you contacted me and asked to enter into therapy with me, you became eligible to participate in the study as I am interested in using observations from my practice to explore ideas and make specific arguments.

The study that I am completing includes case study research using illustrations from psychotherapy to explore specific ideas. That means that I will be including material that came up during therapy sessions to demonstrate and investigate certain features of the topic. I would like your permission to describe some of how our therapy sessions unfolded and to use any relevant content from the sessions, as the data for my research. I will make every effort to assure that you cannot be identified in any material that is published.

I am ethically bound to protect your confidentiality and therefore if I refer to any aspect of the therapy, I will not reveal your identity by disclosing your real name or any details which might identify you. To protect your confidentiality and anonymity further, I will disguise the case material, for example, by including some false information, or by combining features of several cases to create a composite case study.

If you agree to participate in the study, the only requirement is that you complete this form.

The professional services you will receive from me will be the same regardless of whether you choose to participate or not. I am committed to prioritising our therapy relationship at all times and that will continue whether you choose to participate or not. Your participation in this study is entirely voluntary and you can decline to participate at any time without stating any reason. You may also withdraw your consent to be included in the study, without stating a reason, at any time. You will be offered the opportunity to read the report I produce. All names will have been removed to protect the identity of all those who have participated.

I do not believe that there are any direct risks to you if you participate in this study. The possible benefit of your participation in this study is that you will be

contributing to building up the body of psychoanalytic knowledge. I would be completely willing to discuss with you any concerns or feelings that this request or the writing up of aspects of our therapy might bring up and to work with this appropriately in the psychotherapy.

The protocol for this study has been submitted to the University of the Witwatersrand Human Research Ethics Committee (HREC) and written approval has been granted by that committee. Should you require any further information about your rights as a research participant, please visit either the University of the Witwatersrand's website at www.wits.ac.za/Academic /Research/Ethics.htm or the Health Professions Council of South Africa's website at http://www.hpcsa.co.za/hpcsa/default.aspx?id=152. My final thesis for the doctorate will be stored in the Thesis Collection at the Library of the University of the Witwatersrand and some chapters of the thesis will be published in peer-reviewed psychology journals.

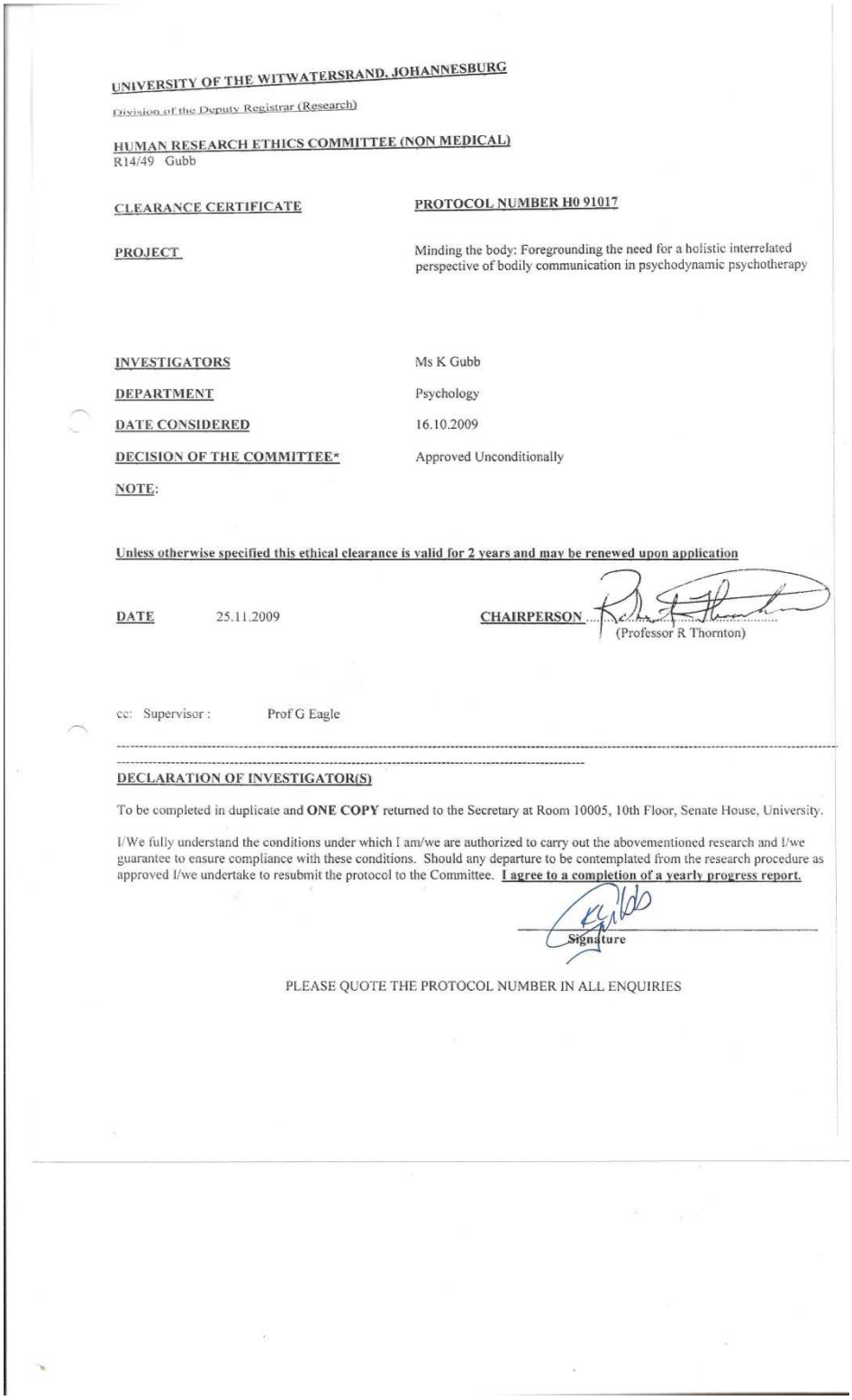
Please feel free to contact me if you require any further information. My contact details are provided in the letterhead above.

Yours sincerely

Karen Gubb

APPENDIX II

ETHICS CLEARANCE CERTIFICATE



UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Gubb

CLEARANCE CERTIFICATE	PROTOCOL NUMBER H0 91017
PROJECT	Minding the body: Foregrounding the need for a holistic interrelated perspective of bodily communication in psychodynamic psychotherapy
INVESTIGATORS	Ms K Gubb
DEPARTMENT	Psychology
DATE CONSIDERED	16.10.2009
DECISION OF THE COMMITTEE*	Approved Unconditionally
NOTE:	

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 25.11.2009 CHAIRPERSON .....
(Professor R Thornton)

cc: Supervisor : Prof G Eagle

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES