

https://dspace.org/

Minding the body : questions of embodiment and the practice of psychoanalytic psychotherapy.

Gubb, Karen Louise

2014-07-23
http://hdl.handle.net/10539/14985

Downloaded from a DSpace repository. https://dspace.org/

The Sense of Bodily Symptoms

Karen Gubb
University of the Witwatersrand

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 (Freud and Breuer, 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 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* (1912) and *The Sense of Symptoms* (1917), 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 (Freud and Breuer, 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, 1917). 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, 1917). 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 and 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, 1894).

In his paper *Types of Onset of Neuroses* (1912) 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, 1912). 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'Uzan (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, Gergley, Jurist and Target, 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*' (pg. 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, 1915).

Using Freud's topographical model of the mind, Luquet (in Bouchard and 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 Bourchard and Lecours (2004) 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 and 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 and 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 and 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 and 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 and Lecours, 2004) where the empty and severely restricted psychic world results in somatisations and re-enactments 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 and 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 and 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 (1923).

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 and 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.

References

Aisenstein, M. and Smadja, C. (2010). Conceptual framework from the Paris Psychosomatic School: A clinical psychoanalytic approach to oncology. *International Journal of Psycho-Analysis,* 91, 621-640.

Allen, J., Fonagy, P. and Bateman, A. W. (2008). *Mentalizing in Clinical Practice*. London: American Psychiatric Publishing, Inc. .

Avila, L. A. (2007). Body and meaning. *International Forum of Psychoanalysis,* 16(1), 43 - 48.

Bouchard, M. and Lecours, S. (2004). Analyzing forms of superego functioning as mentalizations. *International Journal of Psycho-Analysis,* 85, 879-896.

Bouchard, M. and Lecours, S. (2008). Contemporary approaches to mentalization in the light of Freud's project. In F. N. Busch (Ed.), *Theoretical Considerations, Research Findings and Clinical Implications.* (pp. 103 - 129). New York, London: The Analytic Press.

Engel, G. L. (1968). A reconsideration of the role of conversion in somatic disease. *Comprehensive Psychiatry,* 9(4), 316 - 326.

Fonagy, P., Gergley, G., Jurist, E. L. and Target, M. (2004). *Affect Regulation, Mentalization, and the Development of the Self*. London: Karnac.

Freud, S. (1893a). Frälein Elisabeth von R, Case histories from Studies on Hysteria. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume II*, pp. 135-181. London: The Hogarth Press.

Freud, S. (1893b). The psychotherapy of hysteria from Studies on Hysteria. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume II*, pp. 253-305. London: The Hogarth Press.

Freud, S. (1894). How anxiety originates from extracts from the Fliess Papers. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume I*, pp. 189-195. London: The Hogarth Press.

Freud, S. (1905). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII*, pp. 1 - 122. London: The Hogarth Press.

Freud, S. (1912). Types of onset of neurosis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII*, pp. 227-238. London: The Hogarth Press.

Freud, S. (1915). The unconscious. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV*, pp. 159-215. London: The Hogarth Press.

Freud, S. (1917). Introductory lectures on Psycho-Analysis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XVI*, pp. 241-463. London: The Hogarth Press.

Freud, S. (1923). The ego and the id. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX*, pp. 1 - 66. London: The Hogarth Press.

Freud, S. and Breuer, J. (1893). On the psychical mechanism of hysterical phenomena. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume II*, pp. 1 - 17. London: The Hogarth Press.

Gottlieb, R. M. (2003). Psychosomatic medicine: The divergent legacies of Freud and Janet. *Journal of the American Psychoanalytic Association,* 51, 857-881.

Grebow, H. (2008). A tale of two minds: Mentalization and adult analysis. *International Journal of Psychoanalytic Self Psychology,* 3, 16 - 33.

Kellner, R. (1990). Somatizations: Theories and research. *The Journal of Nervous and Mental Disease,* 178(3), 150-160.

Krystal, H. (1997). Desomatisation and the consequence of infantile trauma. *Psychoanalytic Inquiry,* 17(126 - 150), 126.

LeDoux, J. (1996). *The Emotional Brain*. New York: Touchstone.

Lombardi, R. (2008). The body in the analytic session: Focusing on the body–mind link. *International Journal of Psycho-Analysis,* 89, 89–110.

MacAlpine, I. (1952). Psychosomatic symptom formation. *The Lancet,* 1, 278-282.

Marty, P. (1968). A major process of somatisation: The progressive disorganization. *International Journal of Psycho-Analysis,* 49, 246 – 249.

Marty, P. and De M'Urzan, M. (1963). La pensée opératoire. (Trans. title: *Mentalization and action bound thinking*). *Revue française de psychanalyse, 37, 345-356. Republished in 1994 in Revue française de psychosomatique, 6*, 197 - 207.

McDougall, J. (1974). The psychosoma and the psychoanalytic process. *International Review of Psycho-Analysis,* 1, 437 - 459.

McDougall, J. (1989). *Theaters of the Body*. New York: Norton.

Mitrani, J. L. (1993). 'Unmentalized' experience in the etiology and treatment of psychosomatic asthma. *Contemporary Psychoanalysis,* 29, 314-342.

Mitrani, J. L. (1995). Towards an understanding of unmentalised experience. *Psychoanalytic Quarterly,* LXIV, 68-112.

Rangell, L. (1959). The nature of conversion. *Journal of the American Psychoanalytic Association,* 7, 632-662.

Ron, M. (1994). Somatization in neurological practice. *Journal of Neurology, Neurosurgery, and Psychiatry,* 57, 1161-1164.

Sperling, M. (1973). Conversion hysteria and conversion symptoms: A revision of classification and concepts. *Journal of the American Psychoanalytic Association,* 21, 745-771.

Taylor, G. J. (2003). Somatisation and conversion: Distinct or overlapping constructs? *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry,* 31(3), 487 - 508.

Taylor, G. J., Bagby, R. M. and Parker, J. D. A. (1997). *Disorders of Affect Regulation: Alexithymia in Medical and Psychiatric Illness*. Cambridge: Cambridge University Press.

Acknowledgment
I would like to thank my patients for all they have taught me, my supervisor Prof. Susan van Zyl for all her guidance and assistance and Nicola Dugmore for her eagle eyes.

Karen Gubb is a Clinical Psychologist in a psychoanalytic private practice in Johannesburg. She is currently completing her PhD at the University of the Witwatersrand in the area of somatic complaints.