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PSYCHOSOMATICS TODAY: A Review of Contemporary Theory and Practice

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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

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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.

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> 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 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, 1894).

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, 1912). 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 pro-

posed 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, 1926), 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 function-

ing 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 short-circuits 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 (1893) "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, 1915b).

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 sup-

ports 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 nonexistent; 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.[1]

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, 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 (1915b) 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, Gergley, Jurist, & Target, 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, Bagby, & Parker, 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[2] (Griffies, 2010; Kohutis, 2010; Sloate, 2010).

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 psy-

chosomatic 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 gynecological 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 psychologi-

cal 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 behavior without fear of retaliation, overstimulation, or boundary breaches—in other words, to separate and individuate safely (Sloate, 2008; Taylor, 2008a). 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 non-symbolic 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 psycho-

soma 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.

NOTES

1. 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 somatizing 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."
2. 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.

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