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SOMATIC ELOQUENCE:  
Therapeutic Utilization of Countertransference to,  
and Symptoms of, Somatization

by  
MARTHA L. ZLATCHIN

A dissertation submitted to the Graduate Faculty in  
Psychology in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy,  
The City University of New York.

1997

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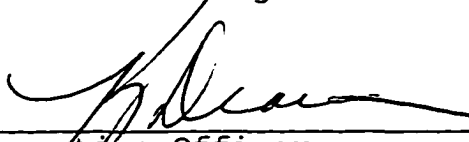
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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

5-13-97  
date

  
Chair of Examining Committee,  
William L. King

5/30/97  
date

  
Executive Officer,  
Kay Deaux

Supervisory Committee:

William L. King, Ph.D.  
Brett Silverstein, Ph.D.  
Paul L. Wachtel, Ph.D.

Outside Readers:

Laurence Gould, Ph.D.  
Herbert S. Strean, D.S.W.

The City University of New York

Abstract

**SOMATIC ELOQUENCE:**  
**Therapeutic Utilization of Countertransference to,**  
**and Symptoms of, Somatization**

by

Martha L. Zlatchin

Advisor: Professor William L. King

This study suggests that while the field awaits further developments in the theory and technique of psychosomatics, clinicians may utilize patients' symptoms and their own countertransference to decrease the current likelihood of therapeutic failure. This study examines somatization, and its accompanying affective disarticulateness in some detail and explores the expectable countertransference issues to each. The scope of countertransference is broadened to include not only expectable practitioners' countertransference but two less recognized forms of countertransference, as well: practitioners' somatic phenomena and clinical language. Additionally, this study proposes a construct of "somatic language" which, it is hoped, will facilitate analysis of patients' somatic symptoms. Finally, this study proposes the full experience of, and detailed analyses of, the broadened scope of counter-

transference to both patient conditions--somatization and emotional wordlessness--as a viable method of locating and accessing somatizing patients' elusive, unconscious, and primarily unsymbolized psychic material.

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To communicate to another  
is to learn what it is we intend,  
for language is not only a medium  
but a resultant as well.

- I. A. Richards

### INTRODUCTION

Having abiding interests and varied experiences in both clinical psychology and hands-on body therapies--i.e. both psyche and soma--the combination aroused curiosity about their interrelationship and thus my interest in somatization. Supervised clinical experience with adults and children, as well as exposure to the clinical, experimental, and developmental literatures, led me to recognize somatization as a complex symptom, the psychotherapeutic treatment of which is often less than successful (e.g., empirical studies of Sifneos, 1973; Nemiah, 1977: clinical work of Taylor, 1987; Krystal, 1988).

Further exploration reveals somatization to be typically accompanied by levels of **affective disarticulateness** (e.g., clinical experience of Wepman, 1988; empirical work of Cicchetti & White, 1990) and of **concrete thinking or a lack of psychological mindedness** (e.g., clinical work of Giovacchini, 1993; McDougall, 1989; Krystal, 1988; Wepman, 1988: empirical work of Nemiah & Sifneos, 1970; Marty & de M'Uzan, 1963).

Although these conditions are noted in the literature, elaboration of their interrelationship is not yet available and would be useful for a better understanding of somatization. Somatization, its accompanying difficulties in verbal expression and concrete thinking, its lack of theoretical consensus (see below), as well as the resulting slow treatment progress and disappointing treatment outcomes, combine to produce complex countertransferential responses (e.g., clinical work of Taylor, 1987; Giovacchini, 1989; McDougall, 1989; Strean, 1988; Karasu, 1980).

It seems apparent that the complicated mixture of clinicians' reactions inevitably contributes to treatment problems. This investigation addresses the countertransference evoked in the treatment of somatizing and emotionally disarticulate patients. Included is a discussion of modes of thinking about somatization which, hopefully, will improve clinical understanding. These may also contribute to improved techniques for treating somatizing patients and for the management and the utilization of countertransference responses to somatization.

The act of writing about emotional disarticulateness and somatization is difficult and has brought some problems in the literature to the fore:

1. Although the affective disarticulateness, or "wordlessness" (Wepman, 1988), of somatizing patients is noted in the literature, it has not been well-investigated; and

2. that which has been written about somatization appears to raise at least as many questions as it answers--there is no consensus regarding the nature and definition of somatic symptoms, their etiology, development, and treatment. For example, some authors posit somatic phenomena as resultants of excesses of excitation expressed at the site of constitutional vulnerability (e.g., Glover, 1949, cited in Strean, 1988); others propose a one-to-one correspondence of symptom to particular conflict--that somatic phenomena represent universal symbols (e.g., Fenichel, 1945, cited in Strean, 1988; Alexander, French, & Pollock, 1968); and yet others believe, and this study suggests, that there exists an idiosyncratic or personal meaning to somatic phenomena requiring patients' associations to allow interpretation (e.g., Strean, 1988; McDougall, 1989; Krystal, 1988).

Some authors (e.g., Dienstfrey's, 1991, reports of numerous empirical and clinical findings) offer various continua indicating somatic phenomena deriving from the "purely" physiological on one end, to the "purely" psychological on the other. Nevertheless, to suggest that either end of this continuum may be solely of one nature or the other, implicitly posits a separation of mind and body. Somatization is better understood as a phenomenon to which the patient's total being contributes--an inseparable psychesoma. Current examples of this view can be found in Bernstein's (1988) laboratory studies investigating the chemical traces of emotion and van der Kolk's

(1996) reports of medical studies demonstrating life-long physiological effects of trauma (even in the absence of physical trauma). Both researches strongly suggest a continuum predicated on the belief that nothing derives entirely from either psyche or soma but always from the whole person's psychesoma: an holistic view.

One of the earliest writers in the field and often referred to as the mother of psychosomatic medicine, Flanders Dunbar (1946), avows that

if. . .there be any dichotomy lurking in the term "psychosomatic" it is [a] . . .projected one, inherent not in the organism observed, but in the mind of the observer and in our methods of observation. . . .When medicine has apprehended the psychosomatic problem and assimilated it, the adjective will be obsolete: *all medicine will be psychosomatic* [italics added]. (pp. xix-xx)

In the last decade, many researchers, writers, and speakers (e.g., van der Kolk, 1996; Pert, 1991, 1993; Dienstfrey, 1991; Bernstein, 1988; Chopra, 1995; Moyers, 1993) have reported laboratory researches indicating various mechanisms of interrelation between the brain and, for instance, the immune system. These recent studies appear to demonstrate two communicatory routes: (a) the hard-wired connections between neural transmissions and lymphocytes and (b) the more generalized endocrine system. Further contributing to the validity of this holistic view, the American Psychiatric Association's, Diagnostic and Statistical Manual of Mental Disorders (DSM, 4th ed., 1994) reports patients diagnosed with Dissociative Identity Disorder (DSM-III, 1980, Multiple Personality Disorder

[MPD]) often display differing physiological profiles for each personality.

Another obstacle to understanding the problems of somatization is the physical isolation fostered by modern life. As increasingly more communication takes place across distances, the body progressively becomes a less accepted, understood, or truly experienced object. Beginning with the advent of telephones ("Reach out and touch someone," AT&T advertisement) and furthered by the computer and cyberspace, it is now possible to meet, make, and converse with new "friends" without the intrusion of, or the presence of, any physical body. The body is becoming obsolete. Increasingly, people work from home offices (a term hardly heard a decade ago), pay bills, and shop for most anything via telephone and computer. Between the popularization of fax machines and computer e-mail, people barely open their front doors to collect their "snail" mail, much less actually leave home. Greater physical isolation from others leads to progressive isolation from our own bodies and those of others. From his clinical perspective of two decades ago, Weiner (1974) believes the increasing reliance of society on left brain function, creates a situation wherein abstract codification of experience dominates and even replaces primary experience. He avers that "today we exist in a heartless, technological culture rationalized beyond all earlier imagining" (p. 46). More recently, drawing on clinical experience, Anzieu (1990) notes that in Freud's day sex was the repressed

part of psychic life but posits that in this era of the third industrial revolution, it is the body that is repressed and physical and affective closeness "is being unlearned" (p. 64).

Although present society expends much time, energy, attention, and money on or about the body, it is this writer's contention that the activities appear obsessional and fetishistic. The attentions paid to the exercise and nourishment of the body seem aimed at its appearance rather than its health and well-being. The body's appearance has become a primary topic of late night television infomercials. The body is frequently both treated and experienced in an objectified manner. It is no longer an intimate part of ourselves--the container of our essence. On the contrary, the package is primary and the contents--heart, spirit, soul, knowledge, emotions, and passions--seem to have become relatively unimportant.

Despite this alienation from our bodies, both ontogenetically and phylogenetically, the somatic expression and reception of meaning is the most early, fundamental, and primitive of all human communication. Phylogenetically, there probably existed a pre-symbolic time in the pre-history of our species (Jaynes, 1976; Pinker, 1984, 1994) wherein adult communication through the language of the body was likely the norm. Ontogenetically, from the moment of conception, the fetus is enveloped in amniotic fluid containing the fluctuating chemical components reflecting maternal physical and emotional states. Infants express their affect in somatic and sensorimotoric

form (clinical work of Krystal, 1978; Schachtel, 1959; Schur, 1955; and empirical work of Piaget, 1974). Infants receive and understand the affective communications of others through their somatic senses (Schachtel, 1959; Stern, 1985). Somatic reception and expression of experience are important components of the lives of both the individual and the species.

It is this primitive and fundamental communication and unity of psyche and soma that underlies the experience of the somatizing patient. However, dynamic psychotherapy, the "talking cure," focuses on patients' psyches and the psychological material which can be verbally expressed. As we acknowledge the pervasiveness of Western Cartesian dualistic thinking, society's progressive isolation from the physical body, and the primacy of verbal formulation in therapists' training, stance, and interpretations as well as in patients' productions, the somatizing patient enters the scene. With somas blazing, evincing their characteristic lack of psychological mindedness and their verbal disability in verbalizing core affective issues, somatizing patients challenge both clinicians and their theories to successful treatment.

Clinical training (e.g., Karasu, 1980; Briggs, 1988), theory (e.g., Karasu, 1980; McDougall, 1989), and experience, as yet, have provided clinicians with few necessary tools for work with somatizing patients. Consequently, treatment of somatization frequently fall short of success. Theoretical deficiencies may derive, in part, from the fact that only in the

last few decades has the field opened to the treatment of those patients Giovacchini (1979) refers to as evincing primitive mental states, many of whom are typically expected to somatize (DSM-IV, 1994). Whether there has been an actual shift in the pathology of patients currently seeking treatment, or an accumulation of clinical contributions enabling present-day clinicians to bring increased knowledge to bear on the subject, is a moot point. In either event, there exists the problem of inadequate theoretical underpinnings for the treatment of somatizing patients.

Clinical experience demonstrates that under particular circumstances, anyone may somatize (e.g., McDougall, 1978, 1989). Its ubiquitous nature makes clinical consideration of somatization and the soma, *per se*, applicable to dynamic psychotherapeutic work with many, if not most, patients. However, without firm theoretical foundations, clinicians are unable to experience necessary support for their clinical work. Insecurities ensuing from theoretical insufficiencies contribute to countertransference issues arising in work with somatizing patients (Karasu, 1980). Many authors suggest that clinicians' countertransference contributes to the lack of treatment success with these patients (e.g., Taylor, 1987; Strean, 1988; Giovacchini, 1989; McDougall, 1989).

While awaiting the further development of the theoretical foundations of psychosomatics and its treatment, this study endeavors to more closely examine somatization, its treatment,

and the countertransference issues apt to arise while working with somatizing patient. It is hoped this work will prove useful. The organization of this study is as follows:

**Chapter One** separates somatization from its implicitly-recognized accompanying affective disarticulateness and concrete thinking. It delineates three apt-to-somatize patient groups that demonstrate a range of emotional wordlessness and concrete thinking: pre-symbolically traumatized patients; 'ordinarily' somatizing patients; and alexithymic patients. Further, it defines the terms delineating those groups.

**Chapter Two** culls both literature and clinical experience for recognized and expectable countertransference to somatization and its accompanying, and co-varying, ranges of wordlessness and concrete thinking represented by the three patient groups proposed in Chapter 1.

**Chapter Three** poses two additional types of countertransference to be considered: clinical language and the somatic reactions of clinicians. It explores reasons for, and possible means of utilizing, all types of countertransference--those proposed in this chapter and those previously examined in Chapter 2.

**Chapter Four** posits a "somatic language" suggested for working with both the analysis of clinician's countertransference and patients' symptoms.

**Chapter Five** offers a discussion of therapeutic persistence in some somatizing patients, the need for patient's and clinician's somatic arousal, and the impact on the transference-countertransference cycle. It closes with a summary of this study.

**Chapter Six** proffers suggestions for future research.

**Appendix A** compiles American-English idiomatic expressions utilizing the body, its parts, and its actions to express affect.

CHAPTER ONE  
SOMATIZATION AND WORDLESSNESS

Introduction

Somatizing patients may be eager to talk, eloquently expressive, interesting conversationalists, and insightful; or, not. When not discussing emotion, they may sound like anyone else; some articulate, some not. However, from clinical impressions (e.g., Wepman, 1988; Giovacchini, 1993; McDougall, 1989), from analyses of language usage (e.g., Overbeck, 1977); and from physiological data (e.g., Cicchetti & White, 1990; van der Kolk, 1996) somatizers show a pronounced tendency to become profoundly disarticulate when it comes to verbally coping with core emotional issues. Wepman (1988) refers to them as the "wordless" patients. For some somatizers, their verbalization difficulties appear only in relation to their own core affective issues; for alexithymics, it generalizes to all emotion, including that of others. Somatizing patients' emotional wordlessness has a different quality from, is on a larger scale, and is more dense and opaque than, the ubiquitous verbal difficulties most patients experience when they approach and attempt to communicate emotionally-charged material. So,

-----

too, is it of a different quality, of a smaller order, and more translucent than the problems patients evince during mutism or prolonged and profound silences. The varying levels of affective disarticulateness are typically accompanied by similarly varying levels of concrete thinking (see below): the two conditions appear to co-vary.

Although the literature has implicitly recognized somatizers' emotional wordlessness, this disarticulateness itself, has not been explicitly explored. Notwithstanding the paucity of empirical data, supervised clinical work and the clinical anecdotal literature appears to suggest the following conclusions:

1. Although the majority of all affectively disarticulate patients somatize more than the general population, not all do.
2. Although the quality and degree of wordlessness vary, somatizers are typically disarticulate.
3. The range of affective wordlessness varies inversely with that of psychological mindedness and positively with concrete thinking. However, levels of somatization appear to vary independently of all.

In other words, the levels of somatization of emotionally disarticulate patients do not appear to be related to the degree of psychological mindedness or concrete thinking, on one hand, or wordlessness, on the other. Additionally, most all somatizers have some degree of affective wordlessness but not all wordless patients are somatizers.

Emotional disarticulateness inevitably contributes to the frustration that clinicians experience and to treatment failures. This chapter discusses these co-occurring conditions--

somatization and wordlessness. Three patient groups are delineated to enable the exploration of these conditions and the recognizable and expectable countertransference reactions to each (see Chapter 2). The groups are: pre-symbolically traumatized patients, 'ordinarily' somatizing patients, and alexithymic patients. The final sections of this chapter define the terms used to organize the three patient groups: "pre-symbolic," "trauma," "'ordinary' somatizer," and "alexithymia."

### The Conditions of Somatization and Wordlessness

#### Somatization

"Somatization," a term coined in 1924 by Wilhelm Stekel (Shorter, 1992), is used to describe a condition wherein physical distress commonly and regularly stands in lieu of conscious manifestations of psychological processes and sometimes of unconscious processes, as well (e.g., McDougall, 1989; Krystal, 1988; Giovacchini, 1989; Taylor, 1987). Robertson's (1988) clinical impression is that somatizing patients' symptoms may be

ailments and behaviors that include organ malfunctions and other conditions in the etiology of which psychological factors play a prominent role; the perpetuation of unhealthy habits and conditions; and unconsciously caused bodily injuries and malfunctions. (p. 80)

Maley (1988) offers a number of possible categories of somatization derived from clinical experience. The following com-

pilation comprises his categories elaborated with additional reading, supervised clinical work, and collegial discussions. This list should not be considered exhaustive nor are the included items mutually exclusive:

1. Physiological responses due to high states of arousal and autonomic imbalance--generalized "stress" responses of the body where the psychic content is not yet clear. Sleep deprivation and disturbances, hyperventilation, overstimulation, and traumatic shock all manifest somatically;
2. Physiologic correlates of grief, anxiety, depression, etc.;
3. "Conversion reactions" wherein symptoms stem from conflicts between the wish to perform an act and its prohibitions or some form of punishment for wanting to or having done the act;
4. Neuromuscular or visceral responses based on the individual's habitual pattern of responding to stress--as in Reich's "characterological" pattern of muscular armoring;
5. Specific somatic symptoms associated with clinically recognized psychosomatic illnesses such as some forms of asthma or arthritis;
6. Body-image distortions or hallucinations from drug reactions or defensive splitting; and
7. Symptoms as indirect communications of an emotional nature that include secondary gains from illness and pleas for help, comfort, attention, contact, control, and/or understanding.

According to the DSM-IV (1994), patients in the following diagnostic categories may be expected to somatize: the Somat-

of form Disorders including Hypochondriasis and Somatization, Conversion, and two of the three Pain Disorders. Additionally, somatization is an expectable symptom associated with Dissociative Identity Disorder (DID) (formerly Multiple Personality Disorder [MPD] in DSM-III, 1980); Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder; and Borderline, Narcissistic, and Histrionic Personality Disorders. Wepman (1988) suggests that individuals of these diverse diagnostic groups are often united by the use of their physiology to express psychic material. Further, the DSM-IV (1994) notes that the etiology of several diagnostic groups listed above is frequently associated with early trauma(ta): PTSD, Acute Stress Disorder, DID, Borderline Personality Disorder (BPD).

During the revision of the DSM-III-R (1987) and the writing of the DSM-IV (1994), there was considerable debate about altering several diagnostic categories (Brett, 1996). Some discussants wished to create a separate axis in order to address the issue of trauma and thereby lessen the pathological view of traumatized patients and better address questions of etiology (e.g., Herman, 1992; Brett, 1996; van der Kolk, 1996). These suggested changes raise complex issues concerning the whole of the DSM nosology (see below, discussion of "trauma").

In addition to individuals' historical and psychopathological determinants of somatization, cultural forces also contribute to the somatic expression of problems: our society

tolerates complaints of physical pain far better than it does those of psychic pain (e.g., Older, 1982). McDougall (1989), from clinical experience, notes that everyone is apt to somatize when typical coping mechanisms are overwhelmed. Somatization may also occur in the absence of overwhelming circumstances: a person experiencing even a low level of an emotion learned as taboo, or simply improper, may somatize rather than experience the particular affect. The omnipresence of somatization becomes even more apparent if one attends to idiomatic American-English wherein the body, its activities, functions, and parts are often employed to represent emotion: e.g., "He's a real pain in the neck," "She's breaking my heart," and "This is really getting on my nerves." (Appendix A supplies a lexicon of similarly somatically oriented idiomatic expressions of emotion.) In the present study, however, despite the ubiquity of somatization, "somatizer" refers only to those persons employing somatization as a regularly occurring primary response to much of their affective experience.

### **Wordlessness**

While most patients experience verbal difficulty confronting core emotional issues, the affective disarticulateness of somatizing patients is more than that. So too is the somatizer's difficulty different from, but less than, the clinical phenomena of mutism or profound and prolonged silences. One of the few clinicians to write explicitly of the affective disartic-

ulateness of somatizing patients, Wepman (1988), dubs the condition "wordlessness." He views it as an incapacity to need, have, or find words to express core emotions. This condition is one in which patients evince a paucity of speech relating to central emotional issues. It is herein considered a disability related to verbally articulating psychological issues in a specific domain.

McDougall's (1989) clinical experience leads her to note that somatizers express psychic problems in their bodies and utilize "an archaic form of mental functioning that does not use language" (p. 10). Somatization stands in lieu of, bypasses, or obviates the later-developing verbal form of symbolic representation and communication. The clinical impression is that this tendency--that somatizers, regardless of level of somatization, are profoundly affectively disarticulate--is a pronounced one (e.g., McDougall, 1989; Giovacchini, 1993; Krystal, 1988; Wepman, 1988). There is also empirical evidence pointing to the same conclusion. Overbeck (1977), studying linguistic productions of alexithymic patients, the most profoundly affectively disarticulate, in psychotherapy sessions compared to those of neurotic patients, found alexithymic patients produced fewer words, utilized fewer modifiers, and created longer and more frequent silences than did neurotic patients under similar conditions. Van der Kolk (1996) reports of studies in which images of brain activity show the Broca's language centers of some traumatized patients actually

"shutting down" as they approach traumatic associations or memories.

When not discussing the realm of emotions, somatizing patients may be indistinguishable from the general population. They may be high functioning and verbally facile (e.g., McDougall, 1989). However, when speaking of affect, their wordlessness might be limited solely to their own core psychological issues or it may encompass all emotion, their own as well as that of others.

The clinical impression is that somatizers' wordlessness typically is accompanied by some degree of lack of psychological mindedness (e.g., Giovacchini, 1989; McDougall, 1989; Krystal, 1988; Taylor, 1987; Wepman, 1988; Libbey, 1996; Ackman, 1996). Alexithymic patients, for example, demonstrate a remarkably profound absence of psychological mindedness that has been labelled "pensee operateire" (researches of Marty & de M'Uzan, 1963) which translates as "operatory," "operational," or "concrete" thinking. The rigidity of thinking, the robotic quality of concrete thinking, is depicted in Taylor's (1987) typical clinical encounter with a somatizing alexithymic patient who

recounted an occasion when he went with a friend to see a movie but was unable to get into the cinema because of a long line. Instead of experiencing and expressing an emotional response to this disappointment, the patient's somatic symptoms increased and he had a dizzy spell which necessitated his returning home. I pointed out that most people would feel frustrated or annoyed and say something like "Damn it!"--whereupon the patient asked, in all seriousness, whether he should think of a few angry

words to repeat next time he encountered a similar situation. (p. 112)

Additionally, alexithymics are generally unable to recognize emotion in themselves and others, and demonstrate an inability even to recognize, or correctly locate in their bodies, the physiological concomitants of emotion (e.g., clinical work of Ikemi & Ikemi, 1986; Taylor, 1987; Krystal, 1988; McDougall, 1989; Giovacchini, 1989).

Reports of poor therapy outcomes with somatizing patients abound (clinical impressions of e.g., Giovacchini, 1993; Taylor, 1987; Krystal, 1982: empirical studies of e.g. Sifneos, 1973; Nemiah, 1973). Somatizing patients' characteristic emotional disarticulateness and lack of psychological mindedness are considered major contributing factors to this therapeutic problem. Although their wordlessness and concrete thinking is widely recognized in the clinical literature, no discussion has been found of the interrelationships of wordlessness and concrete thinking with somatization nor of the dependence or independence of the variance of these phenomena. Therefore, three patient groups have been delineated. These suggest the range of somatizers' wordlessness and what appears to be their co-varying concrete thinking.

### **Descriptions of the Patient Groups**

Diagnostic classification, according to Eigen (1986), can establish persevering stereotypical mind sets about clinical

phenomena that may limit and "delay the investigation of subtle processes that underlie genuine similarities and differences" among them (p. 3). However, so too do they help establish a common ground that "often makes possible meaningful disagreements" (p. 2). Additionally, they provide "maps [that] do not simply capture or impose order; they also express aspects of our encounter with an order we help mediate" (p. 3). Giovacchini (1989) recognizes that "clear-cut diagnostic labels can seldom be applied to actual patients" and "most patients present combinations of features found in various nosologic entities" (p. 93).

These comments about diagnostic classification point to problems encountered in discussions of somatization. The DSM nosology, while perhaps useful for statisticians and the insurance and legal systems, is often inadequate for the needs of clinicians. This problem arises in attempts to address the needs of somatizing patients evincing somatization, affective wordlessness, and concrete thinking. A careful investigation of these symptomatologies is not possible within the frame of the DSM: the question of etiology is substantially ignored; affective wordlessness and concrete thinking are barely mentioned; and somatization is an expected part of the profile of many DSM-IV (1994) diagnostic categories.

In order to account for the conditions of wordlessness and concrete thinking and their relationship to somatization, and to begin addressing questions of possible etiology, I have

delineated three patient groups. By definition, 'ordinarily' somatizing patients are expected to somatize. So, too, are pre-symbolically traumatized patients (e.g., McDougall, 1989; Giovacchini, 1993) and alexithymic patients (Nemiah, 1978; Krystal, 1988; McDougall, 1989), who are not, as yet recognized in the DSM or ICD (World Health Organization's International Classification of Diseases) nosologies. Although the patient groups delineated herein are organized specifically to represent patients likely to somatize, individuals in these groups may be non-somatizers, nonetheless. These overlapping patient groups are formulated to differ with respect to the expected degree of affective wordlessness and concrete thinking that usually accompanies somatization of any level. The patient groups in this study are delineated below.

**Pre-Symbolically Traumatized Patients:** are expected to be disarticulate only about core issues and not to be particularly concrete. Verbally, this group may appear as the general population, ranging from eloquent to inarticulate. However, when dealing with core emotions they become wordless (Cicchetti & White, 1990; van der Kolk, 1996). When wordless, their recognizable psychic angst often speaks eloquently of frustration in the face of their inability to verbally express keenly experienced but amorphous emotions. Infant memory research (e.g., Nadel & Zola-Morgan, 1984; Schachter, 1996; Bauer, 1996) indicates that people, of any age, generally are unable to ex-

plicitly remember that which is not verbally encoded. This accounts for the period of normal development prior to 5 years of age, or so, that is referred to as "infantile amnesia." However, Schachter (1996) postulates what he calls "implicit memory" to account for the memory traces of amnesics and of events occurring prior to the attainment of symbolic competence. In such instances, patients may act on knowledge that is attained as a consequence of an event but be unable to explicitly remember the event, itself. So too are they apt to experience feeling tones and their somatic accompaniments that are attached to these only-implicitly remembered events.

Therefore, unable to verbalize that which occurred before the achievement of symbolic competence, often the emotions of pre-symbolically traumatized patients loom darkly without coherent images, clear form, or words. Despite their wordlessness, they generally are aware of and able to experience the full range of affective life. Although much less concrete in their thinking than the other groups in this study, pre-symbolically traumatized patients, when dealing with their core affect, may be somewhat more concrete than the general population. This group often seeks but cannot find the words for feelings they acutely and actively experience. They may be psychologically minded, insightful, and even aware that their somatic symptoms are directly connected to their immediate affective experiences. However, since traumatized before acquiring functional symbolic verbal language, when confronting

emotions connected to, or associated with, precipitating occurrences, these patients are apt to experience profound wordlessness. This pre-symbolically traumatized group typically comprises a preponderance of females (Finkelhor, 1984; DSM-IV, 1994; Seeman, 1995; Yonkers & Gurguis, 1995; Toner, 1995; Zanarini, 1997). (See Chapter 4 for a further discussion of Gender and Behavior.)

**'Ordinarily' Somatizing Patients:** are expected to demonstrate wordlessness ranging somewhat more widely than core issues and accompanied by seemingly co-varying degrees of concrete thinking. Having an awareness of much of their affective lives with the exception of the most salient core material, this group may be psychologically minded and insightful about other than their central issues. However, when wordless, they are unable to recognize their affective material, its absence, or their lack of verbal ability to express it. Their somatic reactions are usually experienced as coming from outside themselves thus often leading them to feel besieged. Eventually, when, during therapy, a link is established between an episode of somatization and their unconscious emotional lives, the connection is rarely generalized and soon forgotten. When the next episode of somatization occurs, there is little ability to remember, even when reminded, and they therefore are unable to apply any of what they "learned" from previous episodes. Additionally, they evince little angst when in the throes of their wordless-

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ness. Again, although every person can and does somatize, the term "somatizer" is reserved to describe only those individuals for whom somatizing is the primary and habitual mode of response to emotional stress. Expectable membership in this group, too, is weighted toward the female population (DSM-IV, 1994). (See Chapter 4, Gender and Behavior.)

**Alexithymic Patients:** are a rarity. They are considered to be generally wordless about emotion, whether core or not, their own or others, and also are expected to be profoundly concrete thinkers. This group is the most profoundly wordless of the three patient groups presented herein. Their emotional disarticulateness is likely to extend to every aspect of affective life and they often are unable to recognize evidence of emotion in others as well as in themselves. Although alexithymics may evince tears or angry outbursts, rather than experience sadness or anger directly, if they recognize emotion at all, they usually do so by deducing it from the reactions of others. An example might be:

I notice that people are backing away from me. I must be yelling. Therefore, I must be angry. I wonder about what? (Patient communication)

Further, alexithymics are frequently unaware of the physiological concomitants of emotion. However, if they happen to note a physiological response to emotion, it is unlikely they will be able to specifically or accurately locate it in their bodies. This group also is the least psychologically minded, the

most symbolizingly impaired, the least able to use metaphor, and the most profoundly concrete. Alexithymics best exemplify that which Marty and de M'Uzan (1963) have called "pensee operationaire" or concrete thinking. Giovacchini (1989) believes these patients are not so much psychologically conflicted, but rather they are constitutionally unable to deal with affective life. The extent of their wordlessness, concreteness, and lack of connection to their bodies have led some to conclude that alexithymia is a cognitive disturbance (e.g., Sifneos, 1973; Nemiah, 1977; Taylor, Bagby, & Parker, 1991). Although anyone may resort to alexithymic-like behaviors if stressors with which they are forced to cope are severe enough (e.g., empirical work of Taylor, 1984; Hendryx, Haviland, & Shaw, 1991; clinical work of Wise, Mann, & Hill, 1990), the present study is not addressing this state dependent, sometimes transient phenomenon. Herein, the term "alexithymic" is reserved for individuals manifesting alexithymic symptoms as a relatively consistent predominating trait that pervades the individual's entire life (clinical work of Langs, 1978). The alexithymic patient group is weighted toward the male population (researches of Hyypa, Lindholm, Kronholm, & Lehtinen, 1990; Smith, 1983; Blanchard, Arena, & Pallmeyer, 1981). (See Chapter 4, Gender and Behavior.)

### Definitions of Terms

This section defines the terms that are used to label the patient groups formulated for this study. The first group comprises pre-symbolically traumatized patients and the first two terms defined are "pre-symbolic" and "trauma." Since the second group is formed of 'ordinarily' somatizing patients, the next term is "'ordinary' somatization." The third group is alexithymic patients and thus the last term defined in this chapter is "alexithymia."

### Discussion of "Pre-Symbolic"

"Pre-symbolic" is used herein to describe a normal phase of infant/child development that spans the period from birth until the attainment of symbolic competence; the pre-requisite development for functional linguistic competence. The infant/toddler traumatized at, or whose development is disrupted at, this level is apt to become the adult clinicians describe variously as: "non-symbolizing" (e.g., Libbey, 1996); "pre-mental" (e.g., Giovacchini, 1989); "lacking the capacity for symbolization" (McDougall, 1974); or "lacking the capacity to mentalize" (Fonagy, 1991). Fonagy defines the capacity to "mentalize" as the achievement of a representation of mental events, or the capacity for symbolization, specifically of one's own mental states and those of others.

Although trauma occurring at a later stage, of sufficient proportion to overwhelm even a competent symbolizer's ability

to cope, also may result in adults unable to symbolize, that is not how the term "pre-symbolic" is employed herein. In instances of later trauma, the inability to symbolize may be limited wherein solely the event, issues surrounding it, and its sequelae remain unsymbolized. However, if the individual is vulnerable and/or the trauma sufficient, the inability to symbolize may generalize and become a characterological condition (Krystal, 1988, clinical work with Nazi holocaust survivors who developed "secondary" alexithymia [see last entry in this chapter]). Although this scenario may produce a similarly symbolizingly impaired adult, it is the trauma prior to a normal developmental phase, trauma to the developing infant/toddler, that is meant by the term "pre-symbolically traumatized."

The following details related terms and their use within this study:

**pre-symbolic**; denotes any level before the attainment of symbolic competence;

**symbolizingly impaired or challenged**; describes a relative inability to utilize symbolization. It will be noted whether it is a pervasive trait or isolated incident, and if known, it also will be noted whether it is the result of early or later trauma; since the ability to symbolize is one of gradients, "non"-symbolizing is not used except within a citation;

**un-symbolized**; refers to material that has, for whatever reason, not been encoded in symbols. It may refer to material

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never symbolized or that which is awaiting symbolization. If it is known as to whether it is likely to become symbolized, it will be noted.

Balint (1968), from empirical research and clinical work, describes a level of development and a level of experience commonly referred to as pre-Oedipal, pre-genital, or pre-verbal. When serious discrepancies arise between the infant's needs at this time, and the ability of the environment to meet those needs, the resulting deficits produce what Balint calls the basic fault--"basic" because it lacks the organization of intrapsychic conflict. Relationships characterized by this level of experience are dyadic in nature, and are more elementary and primitive than Oedipal. For the purposes of this study, the most important part of Balint's basic fault construct is that adult language is often useless (at best, misleading) when employed by and with patients at the level of the basic fault; words do not always have a consensual or conventional meaning. According to Balint, this level of experience is so basic that its

influence extends widely, probably over the whole psychobiological structure of the individual, involving in varying degrees both his mind and his body. In this way the concept of the basic fault allows us to understand not only the various neuroses (perhaps also psychoses), character disorders, psychosomatic illnesses, etc., as symptoms of the same etiological entity, but also--as the experiences of our research into general medical practice have shown--a great number of ordinary "clinical" illnesses as well. . . . [The force driving this level] is neither of instinct nor of con-

flict, not something dammed up for which an outlet must be found, rather something that's missing. (p. 22)

It is the construct of the "basic fault," the understanding of that condition as one engendered by deficiency, and the quote above describing the profundity of the effects of deficits arising from that stage of development, that is proposed herein to be consistent with the problems confronting adult patients of the pre-symbolically traumatized group in this study. However, the most salient aspect, the one required to elucidate this present work, is that at the time of the accrual of deficits, these patients were, as yet, unable to employ the process of symbolization. It is suggested herein that patients in this group are wordless because the problems with which they struggle coincide with the period of life before the acquisition of symbolic functional language; from the time before the attainment of symbolic competence. Therefore, the focus of this work and the term defining this group, remains "pre-symbolic."

### Discussion of "Trauma"

A discussion of psychic trauma is essential to this study for two reasons: (a) it is half of the definition of the pre-symbolically traumatized patient group and (b) the DSM-IV (1994) diagnostic categories in which somatization is expected to occur include trauma among the likely precipitating events for several of them (DID, PTSD, Acute Stress Disorder, BPD, and

Narcissistic Personality Disorders). Additionally, clinical experience has led others to posit trauma as a major cause in the development of antisocial (Terr, 1991) and schizoid personality diagnoses (Khan, 1963).

The definition of psychic trauma employed herein, comprises several aspects. The prospective point of view, is represented, but only in a limited manner. In other words, although there are many definitions of psychic trauma (it appears every major theorist has one), it is impossible to create a compilation of specific events that would be agreed upon as likely to be experienced as traumatic. Thus, the prospective discussion is, necessarily, limited. Recently, much has been written of the expectable psychic sequelae to events individuals have experienced as traumatic (e.g., Davies & Frawley, 1994; Pearlman & Saakvitne, 1995; van der Kolk, McFarlane, & Weisaeth, 1996). Mention is also made of the enduring physiological changes resulting from psychological trauma. It is the presence of the characteristic sequelae that suggests that, at some point in their histories, individuals were traumatized; the events must be deduced from their derivatives. This is the retrospective viewpoint that receives emphasis in this study. The last part of the definition of psychic trauma discusses Khan's (1963) construct of "cumulative trauma."

This study does not address questions concerning particular types of trauma: e.g., neglect or abandonment; witness to or recipient of physical abuse; molestation, incest, or other

sexual abuse; single shocks, repeated stresses, or long-standing ordeals; etc. Nor does it enter into debate over whether or not any particular form of trauma results in long-lasting detrimental effects. Rather, its focus is those survivors of some sort of early trauma who seek psychotherapy because they experience long-lasting detrimental effects pursuant to whatever traumatic experience(s) they have endured. It is predicated on the general current consensus that the infant's/child's reactions to the caregiver and environmental failures that constitute trauma depend upon the constitution of the infant and the timing, nature, perpetrator, intensity, duration, and repetitiveness of the trauma, as well as events following its occurrence that ameliorate or compound its impact.

The following abbreviated historical account of conceptualizations of early trauma is derived from Davies and Frawley (1994, pp. as noted below). From the classical or Freudian perspective, early trauma's pathogenic action is primarily intrapsychic, caused by reactivation of and regression to earlier intense sadomasochistic fantasies stemming from exposure to the primal scene (p. 18). The ego-psychological perspective incorporates the unconscious meaning of the event(s), as does the classical view, and additionally stresses the extent to which the ego is overwhelmed and rendered nonfunctional by the excessive stimulation inherent in early trauma (p. 20). The object-relational perspective takes into account the incapacitation of the ego and the psychic helplessness, and adds a fo-

cus on the betrayal of the child by one or more important early objects (p. 22). The self-psychological perspective, like that of the object-relationists, underscores the relational aspects of trauma, however, with the specific focus on the profound disturbance of the intersubjective field of the child (self) and the caregiver (self-object) as that which renders an early occurrence traumatic (p. 23). It is the contention of Davies and Frawley (1994), and of this writer, that the pathogenicity of early childhood trauma derives from all of the above and probably more.

Pearlman and Saakvitne (1995), utilizing a meta-analysis of numerous empirical studies of trauma and its sequelae, combined with their clinical experience and their own empirical researches conducted for the development of a scale to measure the effects of trauma, offer a definition of trauma and a comprehensive description of the sequelae of trauma. Although their work focuses on the effects of childhood sexual abuse, their detailed definition of trauma and their description of its sequelae, are similar to those of others (e.g., Davies & Frawley, 1994; van der Kolk, et al., 1996) dealing with a more generalized construct of trauma. However, since Pearlman's and Saakvitne's definition is organized in a more structured format, theirs provides the foundation for this definition and discussion.

Recognizing that each individual's unique experience impacts in differing ways, Pearlman and Saakvitne (1995) posit

any event or on-going condition that meets either of the following criteria should and must be considered traumatic:

1. the individual's ability to integrate affective experience is overwhelmed, or
2. the individual experiences a threat to life or bodily integrity. (p. 60)

They go on to indicate that all individuals who have endured events or conditions that meet the above criteria of trauma will experience negative changes in various psychological realms. These sequelae are expectable shortly after trauma and may last a lifetime. The following psychological aspects expected to be negatively altered by trauma are adapted from Pearlman and Saakvitne (1995, pp. 61-74) and are augmented as indicated.

Frames of reference or habitual ways of understanding self and world, including spirituality, are virtually always negatively altered by trauma. This includes the ways individuals relate to and interpret their own experience. The frame of reference is so fundamental to individuals' perceptions and interpretations of life experience that any alteration of it is inherently disorienting and stressful.

Self capacities which modulate affect and maintain benevolent inner connections with self and others, are often seriously disturbed by traumatizing events or conditions. Self capacities are the inner capabilities that allow individuals to maintain a consistent, coherent sense of identity, connection to others, and positive self-esteem. These self capacities de-

velop through the process of internalization of early interpersonal experiences. If all goes well, developmentally,

this secure relationship becomes the haven from which young children draw their confidence in their capacity to control external events. . . .It is also the retreat to which the child withdraws for soothing and comfort when that omnipotence is challenged or thwarted by experiences of failure and frustration. (Davies & Frawley, 1994, p. 46)

If all does not go well, and children are raised in a malevolent or dysfunctional environment, the resulting adults are apt to have underdeveloped self capacities.

Ego resources, the inner capacities necessary for negotiating the interpersonal world and meeting one's own psychological needs, are also likely to be distorted by trauma. These functions develop through similar experiences to the self capacities and include intelligence, willpower and initiative, the abilities to be introspective, strive for personal growth, and take perspective (the latter ability includes empathy, sense of humor, and wisdom). Ego resources also include the abilities to foresee consequences, establish mature relations and boundaries, and make self-protective judgements. Typically, trauma survivors are more able to identify and meet the needs of others than themselves. Often, these patients have competent false selves (Winnicott, 1960a) that may enable them to excel at many endeavors, but hides from view the pain and devastation. Even empathic and skilled observers may miss it; this is an expectable potential therapeutic pitfall.

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Psychological needs and cognitive schemas The psychological needs, shaped by early experiences of gratification, frustration, reinforcement, and association, and which in turn shape later experiences of the same, are not necessarily consciously held. Although all psychological needs are likely to be affected by trauma, Pearlman and Saakvitne (1995), through extensive literature reviews, clinical work, and empirical study, have identified the five needs, manifested toward self and others, that are most susceptible to damage pursuant to trauma: safety, trust/dependency, esteem, intimacy, and control. The most serious damage is inflicted on whatever needs the infant/child was attempting to meet at the time of the precipitating trauma.

Cognitive schemas (Piaget, 1971) comprise the conscious and unconscious beliefs and expectations about self, others, and the world. Schemas are organized according to central psychological needs. Patients' cognitive schemas are disrupted and changed to conform to their childhood realities; their schemas did not develop as they might have had they escaped early trauma. For example, children who may have originally been optimistic, as survivors of real disasters or traumas are likely to become adults who live life unconsciously expecting disaster.

Memory is also deeply affected by the impact of trauma. Individuals' memory of traumatic events commonly involves fragmentation and dissociation of five aspects of the complex experi-

ence. The continuities of the **verbal**, the **imaged**, and the **affective** narratives are seriously disrupted. Distorted memory may be reflected in dissociated **bodily sensations** of reexperiencing the trauma and may also be reflected in unconscious reenactments within later **interpersonal relationships**. Discontinuities within and isolation among the elements of somatic, affective, verbal, imaged, and interpersonal narratives of trauma are reported to be associated with intrusions or explosions of incomprehensible and intense affect, flashback, or panic attack (according to Pearlman's & Saakvitne's extensive researches, 1995).

Pearlman and Saakvitne's (1995) discussion focuses on the memory of the trauma, *per se*. However, traumatized people, tending to utilize the defenses of repression and dissociation to a greater extent than the general population (clinical experience, Hedges, 1994; empirical study, van der Kolk & McFarlane, 1996; van der Kolk, 1996a), demonstrate a tendency toward a learned generalized style of dissociative thinking and memory and a resulting decreased ability to learn from experience. This behavioral phenomenon is supported by laboratory studies reported by van der Kolk (1996) whose findings indicate that the increased levels of norepinephrine and endogenous opioids that traumatized people commonly display, interferes with effective memory processing, memory consolidation, and the storage of experience in explicit memory, which com-

bine to interfere with the process of learning from experience: "global memory impairment" (van der Kolk, 1996a).

**Biochemicophysiological effects of trauma.** Since brain, mind, and body are inextricably linked, biochemical and physiological changes can be expected to accompany the various psychological alterations triggered by psychic trauma. Van der Kolk (1996) refers to this intertwined phenomenon as "a cascade of biobehavioral changes" (p. 218) that follows in the wake of trauma. His empirical data illustrates the long-term changes that trauma inflicts.<sup>1</sup>

**The biochemical alterations include:**

- profound and persistent alterations in stress hormone secretion;
- stimulation of ascending amine projections;
- panic attacks and flashbacks precipitated by medications that stimulate autonomic nervous system (ANS) arousal (e.g., lactate, yohimbine);
- multiple drug sensitivities;
- alterations in neurohormones (decreased resting glucocorticoid levels, decreased secretion in response to subsequent stress, and increased concentration of glucocorticoid receptors in the hippocampus; and decreased serotonin function);
- alterations in neuroendocrines (increased excretion of catecholamines [i.e. norepinephrine and epinephrine];

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-alterations in corticosteroids (increased numbers of lymphocyte glucocorticoid receptors proportional to the severity of the PTSD symptoms; blunted cortisol response to subsequent trauma; and increased endogenous opioids in response to danger)

**The physiological changes** include: structural and activity abnormalities seen on images of the limbic system (overly active amygdala and suggested loss of cell mass in the hippocampus) and activity "shut down" of Broca's system during stress; a lowering of the threshold of stimulation; hyperkinesis; tremor at rest; flexor changes in muscles; urinary incontinence; gastric distress; general state of hyperarousal--increased heart rate, skin conductance, and blood pressure; alterations in EEG findings; flashbacks precipitated by acoustic startle stimuli; and numbing, dampening, shutting down of emotional, acoustical, and other systems to avoid circumstances of increasing stimulation. In other words, the brain's ability to regulate many activities is seriously compromised by trauma.

**The psychobiological impact** of trauma, the behavioral enactments of the physiological and biochemical alterations, include the DSM-IV (1994) PTSD criteria of persistent symptoms of generalized increased arousal, difficulty falling and/or staying asleep, irritability and/or angry outbursts, hypervigilance, exaggerated startle responses, the physical experience of reliving the traumatic event(s), and the yet greater physi-

ological reactivity when exposed to specific reminders of the event(s).

In addition to the DSM material, van der Kolk's (1996) data indicate probable physiological causes of the behavioral difficulties trauma victims experience with: attention, concentration, distractibility, and memory; the ability to distinguish and select relevant data; the ability to assess and distinguish potential gratification and danger; the ability to release the fight-freeze-flight tension after a challenge is over; the "1,000 mile stare" that typically accompanies hypervigilance; the ability to meet and explore new situations without becoming disorganized; involuntary preoccupation with traumatic memories; and attempts to dampen a tonic state of hyperarousal which result in shutting down, numbing of affect, and a markedly decreased involvement in everyday life. Due to the hyperactivity of the amygdala and the lowered activity of the Broca's area of PTSD patients, they tend to "experience emotions as physical states rather than as verbally encoded experiences" (van der Kolk, 1996, p. 233) and may be "physiologically prevented from translating. . .experience into communicable language" (p. 234). In general, the biochemicophysiological alterations sustained by PTSD patients, frequently lead to traumatic sensations revived as physiological affect states and somatic sensations that, left untreated, are "timeless and unmodified by further experience" (p. 232) and cannot be reported in words.

Historically<sup>2</sup>, psychoanalytic thought has distinguished between traumata caused by single blows from the environment (either from natural occurrences or individuals) and those caused by accumulations of stressors and strains. The first mention of the phenomenon is Breuer's and Freud's (1893) construct of "summation" wherein, "a series of events, none of which on its own would have a traumatic effect, may in concert produce" trauma (cited in Laplanche & Pontalis, 1973, p. 467). Kris (1956) notes a "traumatic strain." Khan (1963), building on these conceptualizations, discusses "cumulative trauma."

Cumulative trauma suggests that the infant may not experience trauma at the time of, or in the context of, each environmental or caregiver failure but that there exists a cumulative effect, a stressor, that "operates and builds up silently throughout childhood right up to adolescence" (p. 301) that in retrospect must be viewed as traumatic. The breaches of the stimulus barrier (Freud, 1920) that Khan (1963) has in mind are

qualitatively and quantitatively different from . . .  
 . gross intrusions by . . . [a caregiver's] acute  
 pathology [but rather the result of maladaptations]  
 . . . to the infant's anaclitic needs. (p. 290)

[They constitute a partial breakdown of the caregiver's stimulus barrier role wherein] the intrusion of her personal needs and conflicts . . .  
 characterize her failure in respect of her role as  
 . . . protective shield. (p. 295)

That is to say, the fit between an infant's needs, a caregiver's capacities, and environmental demands, is insufficiently good to protect the infant from trauma (Escalona, 1968; Bal-

int, 1968). This lack of fit may be due either to congenital (i.e. the infant's need is unusually difficult to meet, as in physical disability) or environmental factors (i.e. the caretaker is unable to cope with demands made by combined stressors due to inadequacies of the caregiver or the severity of life's demands). The effect of this trauma is a "strain" that "does not so much distort ego development or psychosexual evolution as *bias* it" (Khan, 1963, p. 291).

Khan hopes that his conceptualization of cumulative trauma may replace such

incriminating reconstructions as bad, rejecting or seducing mothers, as well as such anthropomorphic part-object constructs as "good" and "bad" breast.  
(p. 192)

His efforts to depathologize the causes of trauma, are joined by the more recent efforts (e.g., Herman, 1992; Brett, 1996) to depathologize survivors of trauma and their symptomatologies. In an effort to have the results of trauma both recognized and depathologized, Herman offers the diagnostic rubric "complex trauma reactions" (p. 120) which would include Somatization Disorder, BPD, and DID. Herman's construct would both address etiology and eschew the characterologically defective pathologized view of patients. Brett, a member of the DSM-IV (1994) Advisory Subcommittee on PTSD, taking a similar stance, strongly suggests the DSM develop a separate axis for stress disorders to include DID, grief reactions, adjustment disorders, and a variety of characterological adaptations. On the other hand, Terr (1991) does not contest current diagnostic

constructs. She wishes to underscore the role early psychic trauma plays as a major etiological determinant in many diagnoses (e.g., BPD, DID, Antisocial and Narcissistic Personality Disorders), and encourages the psychological community to not lose sight of the devastation trauma leaves in its wake. However, reminding us that the forces that create childhood trauma are external, Terr joins the move to lift blame from its victims and to depathologize their ensuing problems.

There are many problematic issues concerning the varied conceptualizations of childhood trauma. Although well beyond a definition sufficient for this study, two must be mentioned to do justice to, and avoid over-simplifying, a complex issue. Unfortunately, however, there is space for little more than mention.

1. The role of "truth" and fantasy within the therapeutic narration of trauma is a heatedly debated topic. It is currently centered around the issue of "false" memories of abuse. Like Diamond (1989), I believe the two need not be opposed but instead, in psychotherapeutic treatment, may, and should, be utilized in concert. Diamond views real traumatic events as imbued with libidinal significance. This view enables both patients and practitioners to understand the events and their reception, internalization, representation, and consequences as a multifaceted totality.

2. The question of external causation and underlying character structure leads to important questions of diagnosis. Gunder-

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son and Sabo (1991) take considerable care to demonstrate that PTSD diagnoses are predicated on external causation (and an un- or depathologized view of the patient) and BPD diagnoses are predicated on the problems of the underlying character structure (patient pathology). Inherent in this issue is the question of the consequences of depathologizing the manner in which trauma survivors and their problems are viewed:

(a) Externalizing trauma enables survivors to feel better about themselves and to believe it was bad luck, primarily, that caused their horror. This goes a long way toward addressing patient issues of good and bad introjects, good and bad selves, identification with aggressors, identities, etc., as well as their ability to place their histories in the past and go on with life.

(b) Maintaining the construct of the internal aspects of trauma leaves survivors feeling tainted with their "badness" that permitted this horror to happen to them. This is not a small consideration since it has far-reaching effects on patients: their very identities are involved.

(c) There, too, is the question of whether there are any diagnostic categories that can be said to entirely omit the role of environment and thereby be solely products of congenital constitution and character. If not, what is to be accomplished by shifting the etiological focus of only trauma onto external forces? Might the whole of the DSM diagnostic system

need to be depathologized? Perhaps the construct of pathology itself needs to be depathologized?

Needless to say, answers to these concerns cannot be proffered here. However, in consideration of both--reality and fantasy; nature and nurture--I believe, as does Diamond (1989), the answers must be sought not in irrevocable dichotomies but rather in an ever-increasing sophistication with which considerations of their interplay are approached: in the dialectic tension between "fantasy and memory, experience and its internal representation" (p. 430).

Turning to the question of recovery from psychic trauma, some believe that it is not only possible but that it can be an impetus for growth--whatever doesn't kill us will strengthen us. Moore's and Fine's (1990) definition posits that trauma of the well-defined and acute sort, as opposed to the less obvious, enduring, and accumulated sort, may sometimes engender a "strengthening of the ego, improved adaptation, and accelerated development" (p. 199). Khan (1963), speaking of "good enough" but human and therefore expectably erring caretaking, suggests that the ensuing difficulties

are corrected and recovered from [in] the evolving complexity and rhythm of the maturational processes. (p. 298)

However, discussing cumulative psychic trauma, Khan believes that, although

the ego can survive and overcome such strains, exploit them to good purpose, manage to mute the cu-

mulative trauma into abeyance, and arrive at a fairly healthy and effective normal functioning, it nevertheless can in later life break down as a result of acute stress and crisis. . . [It can result in schizoid character disorders] which have become the more frequent type of patient in our practice. . . . [although the impingements were] at the time neither gross nor acute. (pp. 300-1)

Balint (1968) notes that basic fault patients struggle with deficiencies from early childhood that, from his descriptions, appear tantamount to pre-symbolic cumulative trauma. About recovery from the basic fault, he indicates that

an instinctual need can be satisfied, a conflict can be solved, [but] a basic fault can perhaps be merely healed provided the deficient ingredients can be found; and even then it may amount only to a healing with defect. . . (p. 22)

If this discussion of trauma were continued, it would arrive at the important topic of the "invulnerable child." Although this subject is relevant, it is well beyond the scope of the necessary definition for the present study, and so this entry must end here.

### Discussion of "'Ordinary' Somatizers"

This chapter opened with a discussion of the condition of somatization that defined the term as it is used throughout this study. The present discussion aims to clarify the nature of the particular group of somatizing patients whose levels of wordlessness and concrete thinking generally lie between those of the pre-symbolically traumatized patient group and those of the alexithymic patient group; the group of "'ordinary' somatizers." The term 'ordinary' is used to indicate that the ex-

pected level of somatization, although varying independently from that of wordlessness, is typically not of the dramatic nor of the life-threatening sort. Although not spectacular nor likely to require hospitalization, this 'ordinary' level of somatization may cause considerable pain and debilitation, nevertheless.

Clinical experience with somatization runs a wide gamut. At the extreme, somatization is seen as a full blown psychiatric disorder in which physical symptoms and the search for their medical treatment substantially disrupt patients' abilities to function. So too, there is a middle level wherein some patients experience isolated somatic disorders in which psychogenic factors are presumed to play major roles in their cause and maintenance (e.g. some types of asthma and arthritis). Lastly, is the low level at which many patients experience somatic distress, of some sort, during emotionally difficult periods. It is the middle and low end of this range of somatization that defines the 'ordinary' somatizing patient group formulated for study herein.

Within the low end of the somatization scale, there is also a range. At the high end of that are the patients who experience extreme to mild muscle or gastrointestinal cramping; extreme to mild headaches; or ordinary twisted ankles, stubbed toes, and cut fingers, etc., at any stressful drop of a hat. They may or may not be hypochondriacal and obsess over each symptom as a portent of physiological doom. Their symp-

toms may be ongoing or episodic in nature. Patients may have the same symptom during each episode of somatization or may develop new ones. During an episode the somatized symptoms may remain the same, appear as new ones, appear in different places on the patient's body, etc. Somatization is frequently unpredictable as to the specific nature and degree of somatic symptoms. However, the timing of their occurrence is less unpredictable--they will occur as psychic stress rises. The low end of the range of this low end of the somatization gamut includes patients who are not particularly hypochondriacal and who experience a general low-level of physical symptoms or a periodic, not particularly frequent, middle level of physical symptoms.

In defining this group particularly, and in discussing somatic symptoms generally, this study does not offer distinctions between symptoms the medical profession can identify and treat and those they cannot. When a doctor is unable to discover a cause for a patient's symptom it can result from different scenarios and there is no way to determine which of the following is the case. It is possible that:

1. a medical problem exists but was missed by the doctor due to lack of expertise;
2. the physical problem that the symptom heralds has not progressed sufficiently for the present level of medical technology to discover it, but, given time, it will develop from a

subclinical symptom to a full-blown medically diagnoseable problem; or

3. the symptom is primarily psychogenic, not yet affecting physiological structure or process, and is, indeed, mostly "in the patient's mind."

Since the distinction cannot yet be known, any attempt at making the judgement is omitted from this discussion. However, as the clinical picture of somatization becomes clearer, and as guiding theories evolve, it may become possible to better know whether a patient with a physical problem does or does not fit the new and better-delineated clinical profile of a somatizer. So, too, may future advances in medicine help to better distinguish among patients' physical symptoms.

### Discussion of "Alexithymia"

As yet, the diagnostic construct of alexithymia has not gained admittance into the standard nosologies (DSM-IV, 1994; ICD-10, 1992). A relatively rare disorder, it has been observed in medical and psychotherapeutic clinical practice with classic psychosomatic disease patients since the late 1940s (MacLean, 1949). Later, it was understood to be a symptomatological component of only some psychosomatic disease sufferers and that was found among non-somatizing patient populations, as well (Smith, 1982). Responding to its most salient feature, Sifneos (1973) named it alexithymia; from the Greek, meaning "no words for feelings."

The clinical picture of alexithymic patients, derived from both empirical and clinical data, typically includes:

- somatization (all authors writing about alexithymia);
- possibly being able to label feelings but little ability to elaborate beyond that (all);
- little ability to recognize emotion in others (all);
- profoundly concrete thinking ("pensee operateire," Marty & de M'Uzan, 1963), approach to life is rigid, literal, nonintrospective (Giovacchini, 1989), and a lack of psychological mindedness and insight (McDougall, 1989);
- utilitarian speech, focused on minutiae, containing little affect or color, and marked by a paucity of fantasy (Nemiah & Sifneos, 1970); use of words as if they are symbolic expression of psychic states but that lack underlying feeling (Giovacchini, 1989); and a generalized paucity of verbal output (Overbeck, 1977);
- few dreams and only of the secondary process sort (Nemiah & Sifneos, 1970), with few exceptions containing only explicit archaic mental content or the day's residue (Taylor, 1984);
- a lack of awareness of most somatic sensation of emotion (Ikemi & Ikemi, 1986; van der Kolk & McFarlane, 1996);
- inability to locate the somatic site of emotional sensation, if aware of it, at all (Nemiah, 1978; van der Kolk & McFarlane, 1996);
- bodies and faces appearing wooden and stiff, with little gestural and expressional fluidity (Nemiah, 1978; Krystal,

1979);

- relationships, in general, and with clinician, in particular, are either markedly dependent or aloof (Lesser, 1981; Fonagy, 1991; Modell, 1976, 1980);
- a considerable degree of social conformity comprising an "as-if" quality (McDougall, 1974);
- some substance abuse (Krystal & Raskin, 1970); and
- some anhedonia and an inability to care for self (Krystal, 1982; van der Kolk, 1996).

Alexithymic patients enter treatment feeling disaffected or are referred by medical doctors who have become frustrated by their failed efforts to treat the somatized physical problems. Clinical experience indicates that alexithymics are not characterized by despair, depression, or even frustration. Rather they display a constriction of affect markedly dissimilar to that of depressives in that it is unaccompanied by hopelessness and despair (Giovacchini, 1989) or much psychic distress (Taylor, 1987). Self-reports include feeling: hollow or empty; unable to experience emotions as others do; dissatisfaction with relationships; unable to understand other people; and a pervasive sense of being different and an outsider (McDougall, 1978, 1989; Giovacchini, 1989). Most 'ordinarily' somatizing patients referred by medical professionals for dynamic psychotherapy to treat their somatic problems experience difficulty believing or imagining it may be useful;

they are likely to be skeptical and adopt either a "wait-and-see" or a "prove-it" attitude (Karasu, 1980). However, alexithymic patients are so concrete that they often become openly confused by a referral for mental treatment of physical problems (Giovacchini, 1989).

Although this patient group is sometimes labelled "alexithymics" (e.g., Krystal, Sifneos, Nemiah, Marty, de M'Uzan, Ikemi & Ikemi, Taylor), in the current literature, they are frequently described under various other labels, as well:

- McDougall initially refers to them as the "anti-analysands" (1974), later, she discusses them as alexithymics (1982a, 1982b), and currently, as among the somatizing conditions (1989).

- Libbey (1996) refers to them as "non"-symbolizing patients.

- Giovacchini (1979) and Ogden (1989), although employing the term alexithymia, also include them among patients suffering from primitive mental states.

- Many (e.g., Kernberg, 1975; Giovacchini, 1993; Fonagy, 1991) describe them under the diagnostic rubric of BPD.

- Winnicott (1963) describes them among those suffering from privation within the early maternal matrix.

- Balint's (1968) description of many basic fault patients may include alexithymics, as may

- Eigen's (1986) description of many psychotic core patients.

The etiology of the disorder is under debate. Freyberger (1977) postulates two sorts of alexithymia; primary and secondary. The definition of, and research data for, each type is as follows:

Primary alexithymia wherein individuals are born with the disorder and it is thought to be caused by physiological brain anomalies that cause a defect in the cognitive processing of emotion. These researches are products of empirical testing. Data employing imaging of live, or post-mortem investigation of, brain physiology of known alexithymics appear to be unavailable. To date, there is no conclusive evidence for any of the following brain anomaly theories.

MacLean (1949) - posits that the bodily expression of emotion, the typical somatization of alexithymics, is an "organ language" made necessary because the neocortex does not receive affective data and therefore finds direct and immediate expression through the body.

Nemiah (1975, 1977) - augmenting MacLean's thesis, posits a blockage between the limbic system and the neocortex in which somatic signs are normally interpreted and given symbolic representation.

Hoppe (1977) - noting the marked similarities of clinical presentation of alexithymics and patients whose brains were surgically "split" to control intractable severe epilepsy (wooden presentation, having to deduce their emotions, and operatory speech and thinking), postulates a "functional commissurotomy" wherein the left and right sides of the neocortex are unable to achieve adequate communication, possibly due to a blockage of the connecting corpus collosum. This hypothesis is receiving the most attention of the physiological etiological research reported in the last decade (PsychLit database, 1994). (However, remembering that the majority of alexithymics somatize, the fact that studies of the "split brain" patients make no mention of a similar tendency may mitigate or vitiate this hypothesis.)

### A combination of primary and secondary etiology

Ikemi and Ikemi (1986) - posit that alexithymia is not so much a newly-discovered disorder but rather a newly-forming one. They believe that it is a response to an increasingly greater modern industrial societal emphasis on left-brain functions to the increasing exclusion of right-brain functions. (This view is consistent with that of Anzieu's [1990] perspective on the repression of the body [Introduction to this study]). Ikemi and Ikemi believe alexithymia to be a result of changes in brain function. However the functional alterations are not thought to stem from congenital physiological anomalies, but to be the functional consequences of experience.

Secondary alexithymia wherein individuals develop the problem as a result of psychic trauma occurring either early or later in life. The nature and the level of trauma(ta) necessary to cause the disorder vary according to the stage of the individual's development at the time of the traumatic occurrence and the individual's constitution.

E.g., the clinical experience of Winnicott (1963b), McDougall (1974, 1982a, 1982b) and Giovacchini (1989, 1993) lead them to posit severe privations in the earliest maternal matrix as a major cause of alexithymic characteristics. In these instances of early trauma, its occurrence precedes the infant's development of desomatized emotional responses (clinical and empirical work, Schur, 1955 and Krystal, 1978).

E.g., Krystal (1979, 1982, 1991) through a combination of empirical research and clinical observation, has discovered numerous cases of alexithymia among child and adult survivors of the Nazi holocaust. Later and similar research with American veterans of the Viet Nam war appears to sustain the view of alexithymia as a sequel to overwhelming trauma (Hyer, Woods, & Boudewyns, 1991). In these instances of later trauma, the individual's emotional responses which had become desomatized, under the impact of severe trauma, become resomatized (clinical and empirical work, Schur, 1955 and Krystal, 1978).

With the exclusion of the later-in-life trauma theory, all the etiological theories posit the existence of children destined to become adult alexithymics. To date, searches for literature that could be thought to describe the childhood clinical

picture of conditions that will become alexithymia in adulthood have proven unsuccessful. This might be due to the fact that adult alexithymics often display such a high level of social conformity (McDougall, 1978, 1989) that, as children behaving similarly, they simply are not referred for treatment.<sup>3</sup> Whatever the etiology of alexithymia, some authors believe it to be an affective-cognitive disturbance (e.g., Taylor, Bagby & Parker, 1991) comprising defects in cognitive processing of emotion wherein affect is poorly regulated and either remains somatized or becomes resomatized (Schur, 1955; Krystal, 1978).

The following research related to differential diagnoses of alexithymia, unless otherwise noted, is based on empirical data.

Hysterical patients: Alexithymic patients' absence of affect and fantasy, and its co-occurrence with physical symptoms does not constitute a similarity with hysterics' repression of fantasy elaboration or production of conversion symptoms (McDougall, 1974). With the exception of conflict-laden areas, the hysteric has a rich fantasy life and experiences a broad range of emotions (Nemiah, 1973). In contrast, the alexithymic has no access to psychic elaboration of emotions and, therefore, undifferentiated affect is somatically discharged (clinical experience of, e.g., McDougall, 1974). Neither does the hysteric lack words to describe the emotions they experience. Recent research suggests that hysterical features such as egocentricity, exhibitionism, and sexual provocativeness are unrelated to alexithymia (Keltikangas-Jarvinen, 1990).

Obsessional patients: Despite the rigidity of carriage, constricted emotional life, and dull recitation of details, the obsessional patient can produce fantasy and their isolation of affect is both amenable to therapeutic intervention (Nemiah, 1973; Lesser, 1981) and is often limited to the conflict-laden areas, thus distinguishing the obsessional from the alexithymic.

Depressive patients: Although alexithymia may occasionally occur with depression, recent research indicates it is not a function of depression (Haviland, Hendryx, & Cummings, 1991;

Wise, Mann & Hill, 1990a; von Scheele, Nordgren, Kempf, Hetta, 1990). As mentioned earlier, the constricted emotional profile of alexithymia typically does not contain psychic angst, despair, hopelessness, or even frustration (clinical experience of, e.g., Giovacchini, 1989; Taylor, 1987).

Schizoid patients: Despite the similarities of constricted affect and aloofness, clinical experience appears to indicate that schizoid patients are more able to experience, name, and elaborate upon emotion, when they choose to, and generally are more able to form and maintain relationships than are alexithymics (e.g., Giovacchini, 1989; McDougall, 1989; Taylor, 1987).

The recent alexithymia research, from a search of in excess of 200 articles from 1988 to 1994 (PsychLit, 1994), comprises the following:

About 25% of the recent literature concerns empirical considerations of somatic issues including substance abuse, eating disorders, chronic and/or psychogenic pain, rheumatoid arthritis, hemodialysis, AIDS, cancers, lung conditions (asthma, emphysema, bronchitis), and digestive track disorders (Crohn's disease, colitis, duodenal ulcers).

40% of the recent articles address scales, tests, and research directed at measuring, describing, and defining alexithymia. Among others, they include the: Toronto Alexithymic Scale (TAS), MMPI Alexithymic Scale, Beth Israel Hospital Psychosomatic Questionnaire, Schalling-Sifneos Personality Scale, Alexithymia Provoked Response Questionnaire, Rorschach Test, Drawing Completion Test, Visual Stimuli Test, and Parallel Visual Information Processing Test. There has also been investigation of the quality and quantity of speech utilized by persons diagnosed with alexithymic features.

About 10% of the recent work empirically explores the etiology of alexithymia, from other than the psychodynamic perspective. This research concentrates on the functional commissurotomy hypothesis of etiology; i.e. alexithymia represents a lack of linkage of the left and right brains. One branch of this investigation continues the comparisons with split brain patients; the other addresses brain laterality, including creativity and other right-brain functions.

The remaining approximately 25% of current research addresses alexithymia's psychodynamic and clinical aspects including its relation to: PTSD, depression and other affective disorders, solace, anxiety, ego defensive styles, psychosomatic medicine,

and treatment considerations. This research stems from both empirical and clinical experience.

Although alexithymia is not yet listed in either DSM-IV (1994) or ICD-10 (1992), the current literature issues from more than twenty countries. 80% originates in the U.S., Canada, Italy, France, Germany, Finland, India, Spain, and Japan.

A perusal of the above literature indicates that epidemiologically, alexithymia occurs world-wide and does not appear to correlate with intelligence, level of education, age, or socioeconomic status. As yet, its prevalence is unclear. However, data exists that indicates that alexithymia is more prevalent among males (Blanchard, Arena & Pallmeyer, 1981; Hyypä, Lindholm, Kronholm & Lehtinen, 1990; Smith, 1983). The gender skew may relate to several disparate considerations:

1. Many cultures exert pressure on males to maintain strict control of emotional expression (Krystal, 1982).
2. There is empirical data indicating the male brain is less plastic (reported by Taylor, 1984) and therefore less able to find alternate routes around possible physiological blockages to communication, whether from the limbic system to the neo-cortex or between the left and right hemispheres.
3. The literature indicates a greater occurrence of learning disabilities among males (DSM-IV, 1994) which may be related to the higher incidence of left-handedness among males reported in education literatures, as well (Small, 1982). These laterality phenomena also may correlate with the functional commissurotomy and other brain anomalies hypotheses of the etiology of alexithymia.

The considerable research surrounding alexithymia encourages hope of achieving improved treatment outcomes. However, alexithymic patients still present complex issues of countertransference (Chapters 2 and 3) and treatment (Chapter 4).

1

### Chapter Summary

The conditions under investigation--wordlessness and somatization--have been described. The reviewed literature indicates data suggesting that the conceptualization of somatizing patients grouped to demonstrate the ranges of wordlessness and its co-varying concrete thinking might usefully be those delineated for this study: the group of pre-symbolically traumatized patients representing the low end of the range; the group of 'ordinarily' somatizing patients constituting the mid-range; and the group of alexithymic patients comprising the high end of the range. The last sections of this chapter defined the terms "pre-symbolic," "trauma," "'ordinary' somatizer," and "alexithymia" as the terms are employed in this study. The following chapter defines "countertransference" for this study; examines expectable countertransference reactions to the wordlessness of each patient group; and finally, examines anticipated clinical responses to somatization.

### Chapter One Notes

1. Those readers interested in the details of the enduring biochemical and physiological changes wrought by trauma and the intricacies of their relationship to behaviors, are referred to van der Kolk's (1996) compilation and discussion of empirical data in: The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In B.A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body, and society (pp. 212-241). New York: Guilford Press.

2. For a concise and learned review of the psychoanalytic history of psychic trauma, see Khan's (1963) article: The concept of cumulative trauma. The Psychoanalytic Study of the Child, 18, 286-306.

3. It is interesting to note that although both the primary alexithymia theory and the early traumatic secondary alexithymia theory posit a condition for which one would expect to find some childhood evidence, I have been unable to discover any empirical or clinical literature that appears to address anything that could be thought to be the appearance of childhood alexithymia. Since I do believe that alexithymia exists and, that, for some patients, it stems from the earliest of times, the lack of any child data is quite puzzling. As mentioned in the text, it is perhaps due to the extreme degree of social conformity alexithymics evince in adulthood (McDougall, 1989) that keeps them from being referred in childhood. Chapter 6 (Future Research) offers several suggestions responding to this question.

. . . the analyst is prepared to wait till the patient becomes able to present environmental factors in terms which allow of their interpretation as projections. . . . Sometimes the analyst needs to wait a very long time.

- D. W. Winnicott

## CHAPTER TWO

### COUNTERTRANSFERENCE

#### Introduction

The first section of this chapter tenders a brief history of "countertransference" and a definition of the construct as employed in this study. The following two sections offer the expectable countertransferential pitfalls apt to arise in response to each of the patient conditions: affective wordlessness and somatization.

#### The History of Countertransference

Natterson (1991), offering a succinct outline of the history of the term, posits four positions in its development. In the main, these approaches developed sequentially and each has its proponents among current practitioners. A brief overview of the models is presented herein.

**First Model:** As originally described by Freud, countertransference is a destructive phenomenon that threatens treatment.

Its prevention, through the analyst's own analysis, is strongly recommended. Should it occur, however, its rapid detection and elimination are required and, if necessary, analysts must return to treatment. Freud initially viewed transference as a hindrance to the patients' primary task--that of free association. Similarly, Freud saw analysts' countertransference as an obstacle to their ability to perform their primary task: sustaining evenly-suspended attention (Racker, 1968). Over time, Freud (1923a) altered his view of transference and came to understand it as "the most powerful therapeutic instrument" (p. 247). A similar transmutation of countertransference was left to others to initiate and effect.

**Second Model:** Countertransference is seen to be neurotic and potentially damaging if not analyzed, and eliminated as some say, or reduced and controlled, as others understand it. Although potentially problematic, it is believed to occasionally provide therapeutic understanding of basic importance, adding markedly to the process and progress of treatment, provided it is rigorously analyzed.<sup>1</sup>

**Third Model:** Countertransference is viewed as a normal and inevitable phenomenon. Every therapist has many both expectable and idiosyncratic responses to every patient. These responses play a fundamental part in the shape and course of every treatment. Countertransference provides opportunities to learn more about the internal lives of patients and practitioners, as well as the interrelationships between patients

and therapists; and the interrelationships between their internal lives.

A **fourth model** is evolving presently in which some authors address what they perceive as a need to go beyond the concept of countertransference entirely and utilize constructs of intersubjectivity to discuss interactions between therapists and patients. Proponents of this model differ from each other as to how they define countertransference (either as in model one, two, or three) but appear to feel that the construct is not particularly useful to them no matter how defined.

Each of these four positions has its own adherents among current practitioners. With the advent of each new approach, those preceding, albeit perhaps with decreasing numbers, continue development. Though not rigidly separated, these models serve as useful constructs through which to view the history of the concept of countertransference.

There appears to be only one point of consensus among today's practitioners: careful analysis of countertransference is necessary. Supporters of the first position would analyze it in order to expunge or prevent it; adherents of the second position would seek to control and to possibly even utilize it; advocates of the third position would work it for all it can possibly provide by way of greater understanding and increased empathy. No matter how clinicians of the fourth position define countertransference, they, too, agree that when it occurs, its analysis is requisite for good treatment.

Although there exists this sole point of agreement, the literature is rife with points of difference, not only between followers of different positions but also among proponents of the same model. Almost all of the original points of difference are still discussed. The main question currently afoot within and among varying schools concerns methods and techniques of utilizing countertransference. Subsumed under that, is the controversy over whether, how, and under what circumstances, therapists should disclose countertransferential material to their patients (Mitchell & Black, 1995). However, this issue is beyond the scope of the present study.

#### **Definition of Countertransference for the Present Study**

This section defines countertransference as it is used herein. Management, resolution, and utilization of countertransference reactions encountered in work with somatization and wordlessness are presented in Chapter 3. The following elements define countertransference for the present study:

1. Countertransference, as defined by some third-position writers, is ubiquitous and refers to all attitudes, thoughts, associations, feelings, and behaviors of clinicians toward their patients.

All the therapist's responses contain countertransference elements. . . Everything [therapists]. . . experience contains, in varying degrees, elements from all levels of. . . [their] psyches. (Giovacchini, 1989, p. 20)

2. Countertransference encompasses clinicians' "professional attitude," which includes empathy, courtesy, and friendliness. When empathy is lost, or fails to evolve, careful analysis of countertransference issues can help to (re)establish it.

3. The presence of countertransference is expectable and not indicative of practitioners' pathology, but rather their humanity.

4. Countertransference contains both "real" and "distorted" perceptions of and reactions to patients, patients' material, and treatment.

5. "Negative" and "positive" are employed to describe poles of affect involved in the countertransference. The terms do not denote its utility, since, with rigorous analysis, all countertransference is deemed useful, and without it, both "negative" and "positive" countertransference are potentially damaging to both treatment and patient.

6. Countertransference is to be observed, analyzed, and utilized to pre-logically understanding one unconscious with another (Tauber & Green, 1959).

7. Countertransference, whether "homogeneous" or "idiosyncratic" (see below), "positive" or "negative", based on "real" or "distorted" perception, when not analyzed is apt to be problematic and when well analyzed may prove of great value.

Giovacchini (1989) draws a distinction between "homogeneous" and "idiosyncratic" countertransference responses. Homogeneous countertransference reactions are those that most psy-

chodynamically trained therapists would experience under similar situations.<sup>2</sup> Although they contain a minimum of clinicians' infantile elements, homogeneous countertransferences can sometimes, nonetheless, can be quite disruptive. This is particularly true of homogeneous countertransferences to primitive mental states. "Idiosyncratic countertransference" refers to those reactions peculiar to individual practitioners and not to those most clinicians would experience under like conditions. Idiosyncratic reactions usually contains more infantile elements than homogeneous and, as a result, are more commonly substantially disruptive. However, despite their considerable disruption, idiosyncratic reactions may still "lead to precious insights and resolutions with work" (Giovacchini, 1989, p. 25).

He further explains that therapists may have widely varying responses to any particular type of patient. Reactions depend on the varying character structures of practitioners. These countertransferences, however, are not necessarily considered idiosyncratic since therapists' responses may be rooted in the particular ways their character structures have interpreted societal forces. Specific contents of those disturbances are the idiosyncratic part of even the most homogeneous countertransference responses. Most situations comprise combinations of both homogeneous and idiosyncratic types of countertransference and the distinction between the two is imprecise, at best.

In sum, Giovacchini (1989) suggests that although homogeneous countertransference reactions are those most clinicians would experience, it does not mean these reactions are not often disruptive to treatment. And, although idiosyncratic reactions are usually quite disruptive it does not mean they cannot be valuable when analyzed. Lastly, he believes work with patients who present primitive mental states frequently entails countertransference responses that are primarily homogeneous and yet are particularly disruptive.

Therapists' motivations for entering the field of clinical psychology play a role in both idiosyncratic and homogeneous reactions to working with any individual patient, group of patients, or particular symptomatology. Little (1951) suggests there are two childhood reasons for becoming a clinician: curiosity and reparation. Among adult motivations, a common denominator is practitioners' expectations they will feel useful, competent, and make life better for the patients they treat (Giovacchini, 1989). When patients do not improve, when treatment does not progress, bogs down, seems interminable, or terminates prematurely, this fundamental expectation--of being competent and able to make positive contributions--is threatened. The curiosity and reparation of which Little wrote, are thwarted. Racker (1968) sees the lack of treatment progress as frustrating therapists in two important needs: (a) for patients to like, respect, depend on, and value them and (b) for

their colleagues' approbation. Racker believes obstruction of these needs leads to serious countertransference responses.

Compounding the problem, treatment impasses and failures created by unanalyzed countertransference pose further countertransferential difficulties. Similarly to Racker, Giovacchini (1989) characterizes these as potential threats to therapists' professional self-representations, and, as such, among the most major and disruptive countertransference difficulties. The degree of disruption is partly due to the fact these threats are seldom recognized and if apprehended, it is only after substantial disruption has been created. Another factor contributing to the degree of disruption invoked by threats to therapists' professional self-representations is that infantile parts of therapists are involved greatly in these instances and therefore fundamental aspects of both the clinician and treatment are apt to be disrupted.

Although therapists are products of their own pasts, as Giovacchini (1989) says, this study does not deal with countertransferences emanating from

special sensitivities and vulnerabilities but rather with the commonalities of sensitivities and vulnerabilities found in most therapists. . . . [I]nsofar as there are some similarities in analysts' backgrounds, there may be certain predictable reactions to patients that should be made explicit. (p. 159)

Thus, the focus is on therapists as products of their common pasts--their training and their society. The countertransferential observations discussed in following sections are phen-

omenological and might be engendered by a variety of projections, psychic states, and defensive postures emanating initially from either practitioners or patients. As Giovacchini (1989) suggests, in this study, therapists' responses will be painted in

broad strokes that hopefully will give shape to those countertransference reactions considered homogeneous and potentially useful in facilitating the therapeutic alliance. (p. 58)

Disruptive countertransferential experiences are generally not recognized as they initially occur and are apt to be in full swing before apprehended (Giovacchini, 1989). It takes time and work to determine their nature, what aspects of patient and therapist are involved, and the impact they have had on practitioner, patient, and treatment.

Examining countertransference issues evoked by each condition separately, creates an artificial dichotomy, albeit, for purposes of this study, a necessary one. The following section presents homogeneous countertransference reactions to patients' wordlessness, the section following, presents those to somatization. These sections focus on expectable and homogeneous countertransferential difficulties arising in treatments with pre-symbolically traumatized, somatizing, and alexithymic patients. (Discussion of the utilization of countertransference is presented in Chapter 3.)

### Expectable Countertransference to Wordlessness

As discussed in Chapter 1, "wordlessness" is used to describe a condition wherein an experience has not been adequately symbolized and therefore cannot be verbally expressed. The symbolization difficulty may result from traumatic occurrences overwhelming either mature or developing symbolization processes or failure within the early maternal matrix. Wordlessness results from differing etiologies, it presents and is experienced differently by patients in each patient group in this study and thus evokes differing responses from clinicians.

Herein is represented the available literature addressing homogeneous expectable countertransference reactions to wordlessness and the results of supervised clinical experience and discussion with colleagues. However, as mentioned earlier, as yet, there is not much written on the subject and there is a wordlessness about wordlessness. Fortunately, the literature is undergoing a current expansion--a growing interest in both the primitive mental states (e.g., Mitrani, 1996; Ogden, 1989; Giovacchini, 1979, 1989, 1993) and trauma (e.g., Share, 1994; Hedges, 1994; Davies & Frawley, 1994; Scharff & Scharff, 1994; Pearlman & Saakvitne, 1995; van der Kolk, McFarlane, & Weisaeth, 1996; Herman, 1992).

In this investigation of wordlessness and the countertransferences evoked by it, it would serve to first note, as does McDougall (1989), that since its inception psychoanalysis

has privileged the role of language in the structuring of the psyche and in psychoanalytic treatment. (p. 10)

The primacy of verbal formulation is apparent in the development of the individual from infancy on (consider the excitement over baby's first word); in the history of dynamic psychotherapy and the "talking cure"; in graduate and post-doctoral course work; in didactic analysis; in supervision; in most productions of most patients; and in interpretation, as well as most other therapeutic interventions. Those trained verbally to work verbally with verbal productions of verbal patients may become more than a bit frustrated by frequent encounters with "wordless distress."<sup>3</sup>

### **Pre-Symbolically Traumatized Patients**

Although typically occurring with somatization, this section focuses solely on the wordlessness of pre-symbolically traumatized patients and their therapists' countertransferences to it. As mentioned earlier, pre-symbolically traumatized patients may be quite verbal about everything save their core issues. However, when wordless, recognizable psychic angst usually speaks eloquently of frustration over their inability to express keenly experienced but amorphous emotions. Unable to verbalize that which happened before symbolic competence, emotions loom darkly without clear form, without coherent images, and without words. Winnicott (1963?) describes how this may occur: the original trauma is a

fact that is carried round hidden away in the unconscious. The unconscious here is not exactly the repressed unconscious of the psychoneurosis, nor is it the unconscious of Freud's formulation of the part of the psyche that is very close to neurophysiological functioning. Nor is it the unconscious of Jung's . . . world mythology. . . . In this special context the unconscious means that the ego integration is not able to encompass something. The ego is too immature to gather all the phenomena into the area of personal omnipotence. (pp. 90-91)

The following passage, written by a pre-symbolically traumatized patient nearing termination of a very long but successful treatment, offers partial testimony to its success. It was her therapy that enabled her to finally link words to her experience of inexpressible emotion which had characterized its beginning:

How lonely to have feelings weighing heavily,  
thoughts obscurely circling,  
locked in archaic darkness.  
How lonely to know life is useless  
and have no words to sculpt that form.  
How lonely to look for help  
and be unable to say for what.  
How lonely to sit with someone who cares but  
who does not understand what I cannot say.  
(Patient communication)

Although pre-symbolically traumatized patients often do not believe it themselves, clinicians usually perceive them as victims of their trauma: what happened to them occurred usually before they had attained symbolic competence--before words. There is nothing an infant or toddler could possibly be held responsible for in causing their trauma, whatever it may have been; there is little, if any, possible patient-agency in the emotional sequelae. Pre-symbolically traumatized patients struggle to grasp what they do not understand but can vaguely

sense. They experience their problems, often repeat them, but frequently have no memory of the trauma(ta). There are not words with which to symbolize what has happened, and often continues to happen. Without linguistic symbols, their attempts to communicate their plight to themselves or others, fail. Unless able to provide other than linguistic symbols and be fortunate enough to work with a therapist able to read the somatic symptoms, they experience difficulty making known the nature of their prison and the requisites for release. The wordlessness of pre-symbolically traumatized patients does not appear to suggest resistance. Rather, it suggests that they are unable to find words (Winnicott, 1963?) to depict their amorphous, primordial sensations (Giovacchinni, 1989) no matter how much they may want to.

Therapists working with such patients may feel thrust or drawn into the maternalistic position by several forces:

1. Patients without symbolic representation for their most salient emotional material, wordless like infants, leave therapists with but one tool to utilize for understanding--the same tool as a mother with her infant--pre-verbal, pre-logical attunement (D. Stern, 1985).
2. The evident psychic pain, the struggle to grasp, remember, symbolize, and communicate what is happening and has happened, impact on therapists. Their patients' pain, frustration, and palpable distress may pressure clinicians to respond protectively (Winnicott, 1963?; Giovacchinni, 1989).

3. Patients traumatized before attaining symbolic competence, retain elements of early stages of development which tend to evoke the complementary maternal responses from their therapists (Giovacchini, 1989).

Clinicians gripped by these pushes and pulls toward the maternal position may find themselves falling prey to various feelings, thoughts, and overt behaviors. These include over-protective feelings and even actions; finishing sentences or filling in blanks their patients cannot; reading into and making assumptions about what they see and hear in session. D. Stern (1985) suggests caregivers create and/or distort their infant's reality by their unconscious interpretations and responses to their infants' non-verbal, non-symbolic behaviors. Patients, sometimes as wordless as infants, cede to therapists that same potential power: the possible creation or distortion of realities. Admittedly this dynamic can occur in work with verbal patients. However, pre-symbolically traumatized patients are often unable to find words with which to counter clinicians' misapprehensions; their own understanding of their feeling is too amorphous to gather into words.

Pressures toward the maternal position may compound difficulties and cause therapists to become vulnerable to related countertransferential potentials, as well. While empathy for these innocent victims is generally abundantly available, patients' difficulties symbolizing and verbalizing their psychologically most relevant material often lead to slow or hardly

visible treatment progress. Each dyadic member may be frustrated by impasses: patients have not been understood and remain locked alone with nameless emotions; therapists have not been able to understand that which has not been put into words.

Fenichel (1939) suggests people are apt to be angered by that which frustrates them. Maroda (1994) notes attempts to maintain empathy towards patients while experiencing negative feelings about their symptoms and behaviors--their psychopathology--are difficult to accomplish and perhaps harmful. She believes therapeutic attempts to keep anger focused solely on pathology may lead to creation or concretization of conceptual duality: parts of patients that want to relinquish their psychopathology and parts that do not. Although at times theoretically useful, Maroda (1994) cautions that in clinical practice the "weakness in this formulation is that it never really permits integration of the whole person" (p. 2).

Thus the scenario becomes one in which therapists are angered and frustrated by their patients' lack of progress. The anger and frustration may be at themselves or toward their patients. Efforts to gain control of their feelings may lead clinicians to construct defenses. The patient, as symbol of the problem, may be either warded off or attacked, in either event, the result may be their revictimization (Pearlman & Saakvitne, 1995).

Pre-symbolically traumatized patients' material is often dominated by primary process and thus apt to be disturbing to the therapist (Giovacchini, 1989). He notes that to the

degree that much of the patient's self consists of infantile introjects, he is casting the analyst in the role of an emotionally significant and usually traumatizing person of the past (Loewald, 1986). The assumption of such a role is usually ego-dys-tonic for the therapist, but he may not recognize the nature of the patient's projections. Consequently, he reacts as if a foreign body has been pushed into his psyche, and the experience can be painful and disconcerting. Rather than being able to analyze the interaction, such therapists, because their vision is obscured by disruptive feelings, may construct defenses to regain their equilibrium. (pp. 177-8)

Countertransference reactions may be responses to projective identification wherein clinicians provide containers for patients' perturbing and therefore rejected affects or aspects of self (Tansey & Burke, 1989). When working with pre-symbolically traumatized patients those rejected elements may lead practitioners to feel threatened, terrified, devalued, objectified, ignored, and hated (Davies & Frawley, 1994). Although clinicians are still responsible for whatever responses they have to induced feelings, as mentioned above, nevertheless, their countertransference to their patients' rejected elements may lead them to behave in ways that attack or distance their patients (Crespi, 1986). The consequence of either response is the abandonment and the revictimization of patients (Pearlman & Saakvitne, 1995). This, then, potentiates guilt born of blaming victims; guilt over involvement, unintentional as it

is, in the creation of and participation in circumstances resulting in their patients' revictimization.

Additional ramifications of succumbing to maternal countertransferences exist. Some pre-symbolically traumatized patients seem to initiate a quest wherein they compulsively seek that which they most fear to find. With these patients, the therapist's attempts to protect them, to act upon the maternal countertransference, pose particular threats to treatment. As a result of the occurrence of trauma(ta) at an early age, the developing egos of these patients were overwhelmed and, thus, emotionally unable to process and experience the occurrence(s) (Winnicott, 1963?). As adult patients they may repeat aspects of the event(s) in order, finally, to process and, thereby experience, for the first time, what happened. Often, such patients existentially dread abandonment, disintegration, fragmentation, breakdown, death, or annihilation; they dread the return to primitive agonies (Winnicott, 1963?; Giovacchini, 1993; Crespi, 1986).<sup>4</sup> Both their fear and their search continue until the *"thing feared has been experienced"* (Winnicott, 1963?, p. 92). Consciously or not, they seek to determine if their therapists can refrain from attempts to make it better, make it go away, protect them from it, and minimize or mitigate it in any way.

Winnicott (1963?) believes patients on this quest require therapists who can stay out of the way and simply tolerate the horrors and massive regressions. If able to find such clini-

cians, Winnicott believes these patients will do the rest themselves. They will approach and experience for the first time that which actually occurred so many years before. Both Giovacchini (1993) and Winnicott (1963?) appear to understand that maternalistic wishes to alleviate suffering; to interrupt or abort regression may well be efforts to gratify therapists' own needs and will unnecessarily prolong patients' needs to regress and/or destroy the treatment. Practitioners succumbing to the maternal countertransference may communicate that their patients' horrors are unendurable to their therapists and so, essentially and unwittingly, abandon their patients to isolation within unending and unendurable horrors.

In sum, psychodynamic psychotherapy with pre-symbolically traumatized patients opens therapists to numerous pushes and pulls toward a maternal countertransference position which may lead to further problems:

1. Therapists working with the pre-symbolically traumatized have, to a degree greater than with other patients, the onus of the ability to create or distort their patients' reality.
2. The empathy pre-symbolically traumatized patients elicit from their therapists may be overshadowed by frustration and anger resulting from slow treatment progress. Defensive attempts to cope with that anger may lead therapists to unwittingly revictimize their patients, adding feelings of guilt to the already complicated countertransferential mix.

3. Pre-symbolically traumatized patients develop transferences that often include viewing their therapists as important early abusive objects. Therapists may unconsciously erect defenses to ward off this particularly ego-dystonic role. These defenses also may unwittingly revictimize their patients.

4. Lastly, the wish to protect patients from further pain or horror may lead clinicians either to infantilize them and thus promote unnecessary regressions or to try to alleviate suffering and thereby prolong or abort necessary regressions.

#### 'Ordinarily' Somatizing Patients

'Ordinarily' somatizing patients enter treatment with somatic disturbances--it is the very definition of this group. Their symptoms may be small or big, prosaic or exotic, inconsequential or dangerous, medically diagnosable and treatable or not. Typically unable to verbally represent affect-laden psychological issues, they unconsciously utilize their somatic symptoms for expression.

Unlike pre-symbolically traumatized patients, 'ordinarily' somatizing patients do not appear to be frustrated, struggling, or experiencing psychic pain in response to their verbal inability. Also unlike the pre-symbolically traumatized patients, for 'ordinarily' somatizing patients it is as though emotions that are unexpressed verbally are also unfelt; as though there is an absence of internal pressure for expression. Perhaps the material has already been expressed (both

communicated and put out) in the somatizer's physiology and so the internal pressure for expression has been pre-emptively alleviated. Alternatively, since the material was never symbolized and therefore never entered the psyche, perhaps it simply is not available for verbal expression. It may be that their psychological material remains somatized and never attains the desomatized state that customarily occurs in normal early development (Schur, 1955; Krystal, 1978).

In contrast to alexithymics' wordlessness, which extends to almost all emotionally-related material, 'ordinarily' somatizing patients usually can experience affects remaining outside the realm of conflict and attaining symbolization: they have a consciously-experienced affective life. In contrast to the pre-symbolically traumatized, who experience their core emotions and frustration over their inability to verbalize them, 'ordinarily' somatizing patients appear to be unaware of their missing emotional experience or the absence of its verbal representation. That is to say, 'ordinarily' somatizing patients fall between the pre-symbolically traumatized and the alexithymic patients on the continuum of affective experience and on the continuum of emotional wordlessness.

In treatments of somatizing patients, verbalized material that normally taps therapeutic skills is rarely forthcoming: core issues usually are verbally unavailable as are the affects relating to them. Altenberg (1988) notes

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the somatizing patient doesn't talk or think 'psychologically'. . . often 'lacks insight'. . . [and] doesn't seem to be introspective. (p. 95)

McDougall (1989) indicates there is an

unavailability of affect, [a]. . . lack of imaginative capacity, and difficulty in verbal communication. (p. 11)

The resulting patient productions commonly lack richness and resonance.

The material present in abundance with 'ordinarily' somatizing patients, overtly verbalized or internally obsessed over, is physiological. When verbalized, therapists may experience it as an onslaught. Patients' bodies, physical symptoms, and concerns about both, are all too available. Although practitioners may recognize their patients also feel assaulted by their own bodies and symptoms, therapists' patience and empathy are apt to be sorely tested nonetheless. The sometimes seemingly unending verbal bounty about somatic complaints is material clinicians typically have little training for decoding, understanding, or interpreting.

For example, Marie Cardinal, a seriously somatizing woman, in desperation, chose psychoanalysis when all medical attempts to control many years of profuse and continuous uterine bleeding had failed. Remembering that few verbal links typically join somatizers to their fantasy lives or symptoms, her (1983) book, The Words to Say It, could only be written after successful treatment. As Cardinal began her analysis, her blood stood in lieu of words, unconscious emotions, and in-

sight; only her physical symptoms were available to herself and her analyst:

Prostrate as I was, withdrawn into my own universe, how to find the words which would flow between us? How to construct the bridge which would join the intense to the calm, the clear to the obscure, which could span this sewer, this river filled with decomposing matter, this treacherous current of fear, that separated the doctor and me, the others and me? (p. 3)

Her body issues forth the "river of decomposing matter" comprising the "sewer" to be spanned. Her body is that disgusting substance standing between her innermost self and the outside world. Her body is out of control, it festers, poisons her, shames her, and frightens her. It expresses and contains feelings that remain encoded and hidden behind wordlessness and blood.

Somatizing patients are often referred for psychotherapy only after repeated and frustrating attempts at medical treatment (Cardinal, 1983; Ingrassia, 1996). Physicians, as well as family and friends, lose patience over the numerous complaints for which there is often no medical evidence or treatment. Cummings and Bragman (1988, statistics gathered in a large San Francisco health maintenance organization [HMO]) indicate that

in testimony before the United States Senate (Cummings, 1985), it was reported that . . . patients who are experiencing emotional stress generally find "an unsympathetic or uncomprehending ear" when they attempt to discuss their distress with their physician, and quickly begin to translate their problems into physical symptoms for which they receive a great deal of attention in the form of x-

rays, laboratory tests, prescriptions, and return visits to the physician. (p. 109)

Cummings and Bragman believe somatizers develop physical symptoms after recently failed efforts to find a sympathetic ear for their psychological concerns. Although the present study addresses a different set of somatizers, or a different definition of somatizers--those developing somatization pursuant to early life events--Cummings' and Bragman's conclusions as to the attitudes confronting somatizers and the emotional comfort derived from medical attention, nevertheless pertain to this discussion. Based on clinical experience, many practitioners (e.g., Karasu, 1980; Altenberg, 1988; McDougall, 1989) observe that somatizing patients who accept their physician's referral to psychotherapy nevertheless often believe they are consulting the wrong professional and that they should seek a better medical doctor instead of consult a psychotherapist.

The stage set, somatizing patients bring their physiological ailments and their concerns about them to psychotherapists who commonly have little training for dealing with somatic symptoms and may even share the belief that their patients are consulting the wrong professional. Understandably, therapists may fear they will be of little help to their somatizing patients. Patients' attitudes often convey like messages--despite attending sessions, they typically expect little benefit from either treatment or therapist (McDougall, 1989).

For therapists who believe somatizing patients belong to physicians, who have opted not to treat them, somatizing pa-

tients who enter treatment without mentioning their physiological concerns present an additional problem (McDougall, 1989). Eventually they mention their symptoms: either as the reason for entering treatment but waiting until they felt comfortable; or casually, as an aside, with indifference, as though everyone has somatic problems. In either case, when somatization arises only after treatment has begun, those therapists who ordinarily do not work with somatizing patients are confronted with an unwelcome surprise, and are likely to feel blindsided and even duped.

In whatever manner 'ordinary' somatizers are referred to treatment and whether therapists knowingly accept them or do so unwittingly, their wordlessness presents its unique set of potential countertransferential problems. In contradistinction to the "belle indifference" of hysterics to physiological conversion symptoms, somatizers present a "belle indifference" to the psychic world of core affects.

The treatment of somatizing patients constantly involves therapists in phenomena for which they typically have little training--physical symptoms. Karasu (1980) describes the situation:

Unfortunately, most training programs fail to provide experience in the treatment of psychosomatic illnesses. This, compounded with insecurities from limited knowledge in the field itself, creates an unfavorable condition from the beginning. . . . [A practitioner must have confidence in his work, must be relatively sure of] his theoretical frame of reference, his goals to be accomplished, their fea-

sibility, as well as how he will go about performing his therapeutic task, i.e. his techniques. Unfortunately, psychosomatherapists are handicapped in all of these areas. (p. 264)

The following phenomena can be expected to occur in limited forms with 'ordinarily' somatizing patients. Practitioners experiencing these following in great degree are probably working with alexithymics rather than 'ordinary' somatizers. McDougall (1989) notes if somatic phenomena become part of the

patient's analytical associations, they tend to reveal little or no language links with underlying fantasy. . . . Moreover, many years may be required before the language links can be forged. (p. 10)

'Ordinary' somatizers seldom use language about core affects, metaphor, curiosity about and play with unconscious meanings of their somatic phenomena. They don't play the game right, they don't follow the rules, they don't use the game pieces--the therapist's skills. It is not that these skills are rejected, rather they are ignored. Outright rejection might be easier for clinicians to tolerate since it implies a therapeutic intervention "touched" the patient and was then actively pushed away. However, with many somatizing patients, interventions just do not touch them. Either interventions float off into the ether leaving little or no trace of their passing, or they just lie there, lumpishly, between patient and therapist. With their best offerings evaporating or moldering, therapists may feel demeaned by this disuse of their expertise. Hedges (1994), from clinical work, notes that when

an analyst repeatedly reaches out to someone and is not responded to. . . . it tends to activate his or

her own most primitive experiences of reaching out to mother and not finding her there. (p. 274)

Feeling and being ignored may feel like a "chronic narcissistic blow to the therapist's interpretive power" (Karasu, 1980, p. 270) and lead to defensive withdrawal into boredom and somnolence (Giovacchini, 1989). Similarly, Hedges (1994) notes that defense may include a clinician's wish to maintain

the relationship on a superficial level [and to deflect the target of the transference to the past or outside the analysis] . . . to protect themselves from their own regressive trends [stirred by being ignored]. (p. 274)

Somatizing patients often believe psychotherapy and therapists will be of little use. Even those clinicians initially believing they can be helpful, after protracted and seemingly unproductive labor, may change their minds and unconsciously adopt their patients' belief that treatment may of little help.

These circumstances can lead practitioners working with these patients to experience guilt arising from concerns about insufficient training; insufficient available theory; inability to break through "la belle indifférence" to the world of affects; and maintaining patients in treatment when it is unclear that therapists and/or treatment will be helpful. This state of affairs heightens self-doubts and may threaten clinicians' professional self-representations (Giovacchini, 1989).

With little verbal affective material from somatizing patients to assist therapists to make routine trial identifications with them (Fliess, 1953; Libbey, 1996), and with few indications of psychic pain or struggle to arouse it, empathy

itself may be thwarted. Potential countertransference feelings (Karasu, 1980; Libbey, 1996) include boredom, helplessness, impotence, confusion, rejection, defeat, inexplicable anger, enormous fatigue, claustrophobia, as well as guilt and self-doubt. Without the vital parts of both dyadic members available to fuel them, treatments are likely to lose momentum, go flat, and become sterile cognitive exercises.

Fenichel (1939) notes, "whenever one is blocked in any piece of work to which one is devoted, one always becomes angry" (cited in Racker, 1968, fn. p. 121). As treatments with somatizing patients lose momentum and become mired, clinicians may feel it is not only the situation and patients' difficulties that have thwarted treatment, but that somatizing patients themselves have thwarted both the therapy and the therapist. Although this is an expectable reaction to a frustrating situation, therapists may become uncomfortable feeling angry at their patients. Karasu (1980) notes that angry therapists may defensively reframe their anger and deliver "belittling statements of an aggressive nature either in the guise of attacking defenses or of interpreting affective distance" (p. 269).

In addition to believing therapy will be of little help, somatizing patients hold another attitude apt to affect their therapists. The 'ordinary' somatizers' level of things-are-what-they-are cognitive style is but a tiny sample of alexithymics' concrete thinking. And yet, as small as this sample

may be, practitioners who repeatedly bump into this "concrete" wall nevertheless may find themselves unwittingly influenced by their patients' belief systems. After some time they may realize that they have unconsciously abandoned their own beliefs about their patients' symptomatologies and inadvertently accepted their patients' concrete view. (See Chapter 3 for discussion of utilizing these and following countertransference issues.)

### **Alexithymic Patients**

As noted in Chapter 1, although alexithymics may be verbal about much, when trying to speak of affect, they have "no words for emotions"--the direct translation of the term from the Greek (Sifneos, 1973). Of the three patient groups herein, alexithymics are the most wordless. Unlike that of the pre-symbolically traumatized and 'ordinary' somatizers, the wordlessness of alexithymics is not confined to emotion-laden or conflicted areas of mental life; it encompasses most all affective areas. Their self-reports include: hollow or empty feelings; the inability to experience emotions as most others do; dissatisfactions with relationships; feelings of not understanding other people; and pervasive experiences of being different from others and an outsider (McDougall, 1979; Giovacchini, 1989).

Clinical experience indicates alexithymic patients evince minimal psychic distress (e.g., Taylor, 1987) and appear rigid

and stiff with little gestural and expressional fluidity (Nemiah, 1978; Krystal, 1979). Bodily disconnection, deeper than physical rigidity, is demonstrated by empirical findings indicating alexithymic patients are often oblivious to inner physiological stimuli, generally, including those that herald, accompany, or follow emotion: e.g., alterations in heart rate, respiration, temperature; changes of muscle and organ tension; queasiness; dizziness; and perspiration (Krystal, 1988; Taylor, 1987; Giovacchini, 1989; Nemiah, 1978). Those alexithymic patients able to recognize and experience physiological components of emotion, sense them only vaguely and are unable to locate somatic sites of sensations (Nemiah, 1978) or to interpret their meaning (Krystal, 1988; McDougall, 1982b). Most experience bodily phenomena globally, if at all. If aware of a gastrointestinal signal, for instance, they may be unable to determine whether they are hungry, need to void bowel or bladder, or are about to burp. Clinical literature indicates that while alexithymics may be able to experience sexual arousal and orgasm, they commonly are unable to experience the normally ensuing auras of comfort, security, and pleasure (Robbins, 1993). This characteristic lack of alexithymics' bodily connection has been termed "alexisomia" (Ikemi & Ikemi, 1986).<sup>5</sup>

The qualitative linguistic style of alexithymic patients is also stiff and wooden. It is remarkably concrete, non-symbolic, and matter-of-fact and lacks imagination, metaphor, and psychological insight. Although the linguistic style of alex-

ithymics may resemble that of 'ordinary' somatizers, it is only as a mountain resembles a molehill. As McDougall (1982b) warns, "the therapist must not be fooled by the devitalized use of vital words" (p. 387). Alexithymic patients, usually conventional and conforming to social standards in the extreme (McDougall, 1989), may have the correct lyrics but the music is always jarringly incongruent or absent.

The rigidity of thought, the robotic quality of concrete, operatory thinking (Marty & de M'Uzan, 1963) is palpable in McDougall's (1978) reference to their study wherein patients were being questioned about circumstances that appeared to be closely connected with the onset of serious psychosomatic illness. Although each was found to be not depressed, not psychotic, not psychopathic, nor in shock, McDougall (1978) notes

one is struck by the flattened affect and. . . unusual detachment.

- [his mother in hospital gravely wounded, was asked] "What kind of woman is your mother?"--"Well, she's tall and blond"

- [her parents killed in the same accident as her fiance, was asked] "What was your reaction as you learned of the death of you fiance?"--"Well, I thought I'd have to pull myself together."

- [both his victims seriously injured in hospital, was asked] "Were you upset when you ran over this woman with the baby?"--"Oh, I was insured against third party accident." (p. 359-60)

In addition to the qualitative, the quantitative aspects of alexithymic patients' linguistic style are similarly sparse. A study of language occurring in individual psychotherapy sessions demonstrated that somatizing alexithymic patients, as compared to neurotics, spoke less, were less spontaneous in

speech production, used fewer modifiers, and were silent more often for longer periods of time (Overbeck, 1977, cited in Taylor, 1987).

Their wordlessness opaque and profound, emotional silence deafening, alexithymic patients do not appear to struggle to express affective phenomena, but rather seem unaware of the very existence of all emotion; their own and others. The alexithymic probably knows the words for emotions but is unable to apply them meaningfully (Taylor, 1987; McDougall, 1989; Krystal, 1988; Nemiah, 1978). The problem is not primarily a lack of language for emotion, but rather one of having "no access to genuine feeling" (Wepman, 1988, p. 194). Thus, they possess little or no ability to elaborate emotion beyond the possibility of labelling them. At best, fantasy life is seriously constricted (McDougall, 1989). The wordlessness of alexithymia suggests a discussion about affective life, in an unknown tongue, without labels for emotions, held with someone Giovacchini (1993) believes to be constitutionally unable to experience feelings.

Interpretations made to alexithymic patients tend to fail for two reasons. Following from the discussion of "privation" as part of the etiology of secondary alexithymia (see Chapter 1), alexithymic patients are unable to incorporate gratifying phenomena (Winnicott, 1963b) therefore they experience little impact from therapeutic concern, interest, empathy, insight, and interpretation. Additionally, alexithymic patients are

unable to make use of symbolism (clinical experience of Ackman, 1996; researches of Fonagy, 1991). Therefore, interpretations of defense, transference, or the past as reenacted in the present, will fall on uncomprehending ears and often be experienced as evidence that the alexithymic patient's plight is beyond comprehension and thereby beyond help and/or that the therapist is incompetent and/or insensitive.

Rycroft (1968) suggests "the technique of psychoanalysis presupposes that the analyst, the analytic situation, and the words used in analysis are all symbols" (pp. 59-60, cited in Taylor, 1987, p. 110). Taylor (1987) notes that the concrete cognitive style of alexithymics provides clinicians with few analyzable derivatives and their characteristic lack of emotional experience allows for a limited capacity for relationships. His clinical experience leads him to believe alexithymics' lack of relatedness precludes both transference material to analyze and a therapeutic alliance. Without imagination, play, fantasy, capacity for metaphor, relatedness, much evidence of emotion and practically no words for it, and the important ability to symbolize, it is readily understandable that many clinicians believe dynamic psychotherapy with alexithymic patients is unlikely to succeed (e.g. Sifneos, 1973; Nemiah, 1978).

Although alexithymic patients are often considered untreatable, some believe it possible. Those who believe psychotherapy with alexithymic patients is in the realm of pos-

sibility, do so with cautionary provisos. Krystal (1982) believes treatment may be accomplished but only with mildly afflicted alexithymics of the "secondary" type--those without a functional commissurotomy (see Chapter 1). McDougall (1982a) also believing it possible, warns of the need to respect their defensive systems. Taylor (1987) is cautiously optimistic, as well. Giovacchini (1989) believes the alexithymics' present day lack of relatedness replays their early object relatedness and thus is tantamount to transference. However, the alexithymic's cognitive style seriously limits the potential therapeutic use of that reenactment. The above writers posit the necessity of beginning treatment with many educative or behavioral interventions in order to make possible any later and enriched dynamic psychotherapy.

Krystal (1979), drawing on clinical experience, informs those willing to take the challenge that work with alexithymics is highly repetitive and takes many years. He offers the following suggestions for initial therapeutic work. Physiological and behavioral signs of emotion need to be indicated repeatedly so patients can recognize them and, albeit with effort, begin to connect them to each other. Sometimes affective labels need to be learned and then connected to physiological and behavioral components of emotion. This recommended emotional education may enable alexithymic patients to begin experiencing genuine emotion and to forge verbal links to them. Without it, the contents and meanings of their emotions

cannot be explored. In even successful treatment, progress will be protracted and slow. Alexithymic patients require much patience.

Those writers whose clinical experience lead them to deem psychotherapy possibly useful for alexithymic patients, nevertheless frequently find the work laborious (e.g. Giovacchini, 1993; Krystal, 1989; Libbey, 1996; McDougall, 1978, 1989; Ackman, 1996). The homogeneous countertransferential responses to work with alexithymic patients include boredom, somnolence, tension, and frustration (Giovacchini, 1989; Libbey, 1996). Taylor (1987), noting the same, suggests that the defense of

withdrawal is not necessarily neurotic but [quoting Modell, 1976, p. 287] "a human reaction to the patient's state of nonrelatedness." In fact, when these countertransference responses are experienced. . . they usually indicate . . . primitive mental functioning [of patients] with its associated alexithymic characteristics. (p. 110)

Although meant to reassure clinicians in the throes of countertransferential responses to the wordlessness of alexithymia, Taylor's comment may provide cold comfort.

Giovacchini (1989) considers some homogeneous countertransferences to be existential crises. He believes them to be precipitated by patients' projections of their inner sense of emptiness and devalued self-representations onto their therapists. According to Giovacchini, therapists are likely to respond with anger, anxiety, agitation, and usually with considerable disruption. In the same vein, Fonagy's (1991) experience leads him to note that analysts

may also find themselves internalizing the lack of mental functioning of their patients, involuntarily abandoning the capacity to attribute emotion through imagination. . . (p. 651)

At these times therapists may unconsciously abandon their own beliefs about their patients and their symptomatologies. They unwittingly come under sway of their patients' concrete and unsymbolic beliefs: somatic symptoms are solely physical and without symbolic content; transference does not exist; and occurrences in their patients' lives really are entirely the result of outside forces. Since these induced and unconscious beliefs fly in the face of all their clinical training and experience, therapists under their sway frequently are led to question their own "reality" and to feel as though they are going or have gone crazy (Libbey, 1996).

Somatizing alexithymics are barely connected to their bodies and so differ from 'ordinarily' somatizing patients who are often overly involved with their bodies and ailments. Although treatment of somatizing alexithymic patients is rife with frustration, the work does not usually arouse in therapists the societally-condoned temptation to blame patients for their problems or the slow pace of treatment, as is more common with 'ordinarily' somatizing patients. Neither do alexithymic patients commonly evoke a maternal countertransference as do the pre-symbolically traumatized patients. Alexithymic patients evince little psychic angst, struggle, or genuine relatedness and so, at least initially, there is little availab-

le with which to form a maternal countertransference or even empathize.

Giovacchini describes his feelings about an alexithymic patient whose concrete maternal transference included the belief that his therapist would conduct his treatment so that it would be either a total success that cured him or a failure. At the time of this description, Giovacchini was proving to be most unsuccessful. His patient was unable to accept interpretations that essentially asked him to recognize his transference, understand its symbolism, and accept some responsibility for his treatment. Giovacchini (1989) felt that

To represent the failing mother in treatment as a therapist was an acceptable therapeutic phenomenon, but to be a failing therapist in the present, without any connection to the past, upset the analytic setting. Actually, rather than being perceived as symbolically failing him, the patient created a concrete reality that intruded into my psychological perspective and disrupted it . . . [I]t . . . ran counter to the professional ego ideal, which values making successful interpretations that lead to creative integrations. (p. 69)

McDougall (1978), working with patients she terms anti-analysands, avers

even if my analysand shows no trace of . . . fantasy, I on the contrary am filled with odd ideas, with a wish to act out, change something, anything to get us out of the rut. But then if I were to act upon these ideas I in turn would become an **anti-analyst!** The structured protocol that protects my patient from my violence toward him also keeps me in my role of analyst. Thus I resist the temptation to throw away the analytic relationship--but what next? I must also resist the temptation to fall asleep! (p. 219)

If the reader presently feels there is little likelihood of forming connections with alexithymic patients and that dynamic psychotherapy is impossible, this section has successfully aroused a sample of the homogeneous countertransferential responses encountered by therapists treating alexithymic patients. Although, like the above-listed authors, this author believes the work possible, it was felt important to deliver the often hopeless and helpless flavor of the expectable countertransference reactions. (There is hope, Chapter 3 addresses utilizing these responses.)

#### **Expectable Countertransference to Somatization**

As discussed in Chapter 1, "somatization" describes a condition wherein bodily distress stands in lieu of conscious manifestations of psychological processes and sometimes in lieu of unconscious processes, as well. This section is a compilation of homogeneous countertransference reactions to somatization derived from supervised clinical experience, discussions with colleagues, and current literature.

In English-speaking North America, somatization is usually not met with empathy. When the phrase, "it's in your mind" is delivered or heard, it often carries a note of dismissal, even contempt. Society doesn't tend to view somatizers as victims but rather as persons wholly or partially responsible for the creation of their symptoms and problems. They may even be

viewed as manipulators or malingerers. The sufferers, their suffering, and their ailments are often dismissed with a combination of impatience, anger, and disgust. They may be viewed as creating unnecessary drains on medical care resources; as bottomless pits, wasteful of money, time, and medical expertise. Psychotherapists, as products of this society and its views, even when conscious of their feelings, often find it difficult to expunge the influence of society's condemnatory perceptions and may, unwittingly, convey similar messages.

Dynamic psychotherapists working with adults are often undertrained to deal with communication that doesn't employ words symbolically; after all, psychotherapy is the "talking cure." Somatic symptoms and bodily communications, are alien and often confound and frighten therapists. Karasu (1980) notes physically ill patients constantly, actually, and theoretically challenge clinicians, their knowledge, and the relevancy of psychological material and psychological interventions to their illnesses. Karasu suggests that although neurotics may also question their therapists, he believes neurotics more generally accept explanations, respond well to doubts about treatment, and tolerate interpretation. Returning his comments to somatizing patients, Karasu continues:

Since the therapist is under such attack . . . these patients typically pose a threat to his self-esteem and self-confidence, and tax his patience. Very few therapists are willing or able to survive such an experience. (p. 264)

McDougall (1989) observes that psychosomatic phenomena are often beyond analysts' understanding and it frequently constitutes a disruptive narcissistic

affront [leading some] . . . to feel that psychosomatic problems should be dealt with elsewhere . . . [and that their] efforts should be confined to that which is psychological and capable of being expressed in words. (p. 11)

To recapitulate, it is impossible to anticipate the appearance of symptoms in the beginning of any treatment. Somatizing patients sometimes enter treatment without mentioning somatic difficulties (McDougall, 1989). Since somatization is beyond the ken of so many therapists, since working with somatizing patients is often frustrating, since somatic symptoms may become life-threatening and therefore frightening, and since somatization conceptually can be so tidily relegated to physicians, some therapists opt not to work with somatizers. Not surprisingly, those are the clinicians who feel blindsided when somatic symptoms erupt or are mentioned only after treatment has already begun.

Once practitioners are at work with somatizing patients, as with all patients, countertransference issues are bound to arise. Although there has been a recent increase in interest in mind-body interaction or unity (e.g., Moyers, 1993; Kepner, 1993; Dienstfrey, 1991; Kramer & Akhtal, 1992; Rossi & Cheek, 1988; Damasio, 1994; Ornstein & Sobel, 1987; Rossi, 1986; Weiner, 1992; Shorter, 1992, 1994) and work with somatizing patients (e.g., Erskine & Judd, 1994; Giovacchini, 1993; Wilson

& Mintz, 1989; Goodman, 1994; Taylor, 1987; Griffith & Griffith, 1994), the metapsychology of psychosomatics has yet to be written (e.g., Karasu, 1980; McDougall, 1989). Less yet has been written explicitly addressing the expectable countertransferences in work with patients' somatic symptoms as separate from their linguistic and cognitive styles.

Supervised clinical work and discussions with colleagues have led to the organization of the homogeneous countertransferential material evoked by somatization around three issues: illness, dying, and death; intimacy; and primitivity. This section follows that organization.

### **Illness, Dying, and Death**

Being in the presence of physical illness can be difficult to endure. It is a reminder of mortality and vulnerability: a portent of things to come. Work with the symptom of somatization can threaten the therapists' trust that they will continue to coexist peacefully with their own bodies. It raises or intensifies the specter of potential or existing physical frailties. Obviously, if clinicians have personal or familial histories including serious illness or recent deaths, their fears of bodily breakdown or death will be considerably increased and even more apt to inform the treatment.

There are instances of somatization wherein physical ailments are produced primarily by psychic means: requiring no

physical trigger to produce sickness and even death (e.g., irritable bowel syndrome, uncontrollable hypertension, and some forms of diabetes and asthma). Without conscious awareness, somatizing patients can wreak considerable physiological havoc on themselves. Since, under certain circumstances, everyone is apt to somatize, therapists' cherished hope that their body will not turn on, and betray, them can be seriously threatened as they witness physical degeneration in their somatizing patients.

If a psychotherapy patient has a physical illness without apparent psychogenic components, the therapist can be comforted by the knowledge that there are medications, medical doctors, and medical treatments to deal with the somatic disturbances. In these instances, the role of their therapists is clear: to help patients explore their general psychological reactions, issues, and concerns as well as those to their physical illness, particularly. These same issues become less clear when patients' physical ailments are psychogenic in origin. In that case, clinicians face discomfoting questions with few answers: What is the nature of the therapist's role in the treatment of the patient and the physical symptoms? Since the symptoms are physical, are they in the purview of a psychotherapist? If so, how so and to what extent? How are they to be handled? Can it be known, with any certainty, that the symptom is not a result of a physical disease process that has yet to be detected? Since the cause is psychic, the dis-

ease is in their purview but how should clinicians proceed? The metapsychology of psychosomatics that should provide answers to these questions is yet to develop. Further complicating matters, standard professional training offers little preparation for grappling with these questions and this treatment task.

Clinical response to these questions runs a gamut. On one end, some practitioners opt to not work with patients who are somatizing, if at all avoidable. Others may attempt to ward off the question by referring physical ailments to physicians and, further, trying to deny the possibility of a psychic component to the symptoms (Strean, 1988). Yet others, recognizing that although somatic symptoms may be life-threatening ailments, they are, nonetheless, psychologically engendered and, therefore, within the domain of dynamic psychotherapeutic concern. Strean (1988) suggests therapists are then confronted with patients

having bodily symptoms which should be one's concern but which one is not affecting . . . much, if at all . . . [This] can puncture the therapist's narcissism and diminish his or her self esteem. (p. 68)

On the other end of the gamut of clinical response are practitioners accepting somatization to be within their professional purview, but who take their responsibility too far. According to Strean (1988) those clinicians recognizing

the mind and body are in constant interaction and few human events when appraised can eliminate the contributions of . . . [either] the psyche . . . [or] the soma (p. 71) . . .

may feel a responsibility to alleviate physical suffering or even to save lives. This may lead them to overestimate what they, and psychotherapy, can, or should, attempt to accomplish and thereby fail to refer patients in a timely fashion for appropriate medical consultation and care. Karasu (1980) cautions therapists to recognize that it is not their role to treat physical illness, no matter how psychogenic in origin.

Freud (1910b) warns analysts against entertaining ambitions to cure. Although therapists' standard training and experience prepare them to guard against that pitfall in psychological matters, resisting the ambition to cure in the realm of somatic symptoms may be more problematic. As Strean (1989) notes, people tend to become anxious about concerns of health, dying, and death in the presence of physical illness. Quoted in another context, Giovacchini's (1993) example of a dramatically somatizing patient, bears repetition at this juncture:

It was . . . painful for me to see him suffer so intensely and there was a strong urge to do something to help him feel better. (p. 91)

Clearly, concerns about health, pain, dying, and death exert considerable pressure to relinquish treatment frames and move toward nursing stances. These circumstances may lead clinicians to become involved with questions of physiological management regarding choices among medical personnel and procedures (Strean, 1988). They voluntarily or involuntarily may be drawn into researching medical treatments and directing, or

even directly participating in, physical patient-care responsibilities.

Additionally, therapists may unconsciously fear internalizing their patients' somatic processes. They may fear that they themselves will either become ill or seriously somatize. Several factors contribute to this feared possibility:

1. The potential for somatization exists in us all (McDougall, 1989). Commonplace experiences of "butterflies" in the stomach in anticipation of an important event, attest to that fact as do many idiomatic American-English expressions (See Appendix A). Consciously or unconsciously, the work with somatizing patients may remind clinicians that under similar circumstances, serious somatization could befall them, as well.
2. Therapists may experience somatization in their own bodies as a result of working with somatizing patients (McDougall, 1978). Authors differ as to how this phenomenon may occur.

a. Wilson's (1989) clinical experience leads him to note that psychosomatic patients, employing projective identification, can induce psychosomatic symptoms in their therapists. This process can be viewed in differing ways, e.g.: as one in which therapists provide containers for the psychic material patients are, as yet, unready to contain; or patients unconsciously are trying to, in any way they can, make what is happening to them understandable to their therapists; or a combination of the two. However it may come to pass, the emotion or the somatic response that is induced, obviously belongs to

the clinician, nonetheless, and, hopefully, the clinician assumes responsibility for it.

b. Another mechanism of therapists' somatization, offering a more active view of the practitioner, may be that it occurs pursuant to their routine trial identifications with patients (Libbey, 1996; Fliess, 1953).

3. Patients can sometimes die of psychological concerns expressed in somatization (as noted before, e.g., uncontrollable diabetes, asthma, hypertension). Through normal trial identifications, clinicians may establish an internal sense of connection to their somatizing patients. When their patients' somatization increases, the fact somatization can kill may cause clinicians to become quite frightened of losing their patients to death. Young children threatened with parental loss identify with their parents, and even with parental physical or emotional illness, in the hopes of preserving the threatened connection (Freud, 1917). Therapists, unconsciously employing this primitive mechanism for coping with threatened loss, may become concerned about their own potential for succumbing to illness or somatization.

Therapists may experience apprehension about their own physical health in response to any one of the above factors. To make matters more difficult, all of these processes could hold sway at any time. Clearly, under that condition, clinicians' countertransference experience is apt to be intense and escalate considerably beyond apprehension.

Yet another concern for clinicians is that under the duress of participating in a dynamic therapy approaching core psychic material, somatizing patients typically experience marked exacerbations of somatic perturbation (e.g., McDougall, 1989; Strean, 1988; Krystal, 1988; Taylor, 1987; Nemiah, 1978). As McDougall (1989) notes:

In attempting to attack any awareness of certain thoughts, fantasies, or conflictual situations apt to stir up strong feelings of either a painful or an overexciting nature, a patient may . . . produce a somatic explosion instead of a thought, a fantasy, or a dream. (p. 11)

Somatization may become life-threatening. Practitioners working with somatizing patients face a substantial quandary: a double bind. Proceeding with treatment, continuing to help their patients uncover and confront problems, will likely result in increased somatization potentially threatening their patients' health and even their lives. Seeking to maintain somatization at manageable levels, therapists may decelerate treatment, restrict treatment goals, or both. The strategies of retreat, which may not even successfully reduce somatization, may lead therapists to question their competence.

Neither choice--retreat nor advance--is particularly compatible with what Racker (1968) describes as clinicians' "professional selves." On one hand, dynamic psychotherapy practitioners are not supposed to cause physical suffering. On the other, they are expected to help patients explore their psychic lives. Clinicians may doubt the feasibility or the ethics of continuing treatments that make so little progress and car-

ry such potential risk. This double bind may threaten therapists' professional selves and arouse concerns over treatment failure. They may grow concerned that they will lose the approval of their patients and their professional peers (Racker, 1968). It is possible, too, that the countertransference reactions may escalate to those which Giovacchini (1989) terms "threats to professional self-representations," which, as discussed earlier, he deems to be among the more devastating and disruptive countertransferential reactions clinicians face.

As noted, when somatization becomes serious, patients may die. Therefore, this last section investigates possible countertransference parallels between the literatures of work with patients suffering serious physical illnesses or dying and the work with life-threatening somatization. Further, since somatization is psychogenic (caused by an aspect of self), it was thought that grave somatization may usefully be examined as unconscious suicide and an investigation of homogeneous countertransference reactions to suicidal patients might prove fruitful, as well. Efforts to find parallels in the literature have met with some success, and the following may prove useful in considering possible parallels of countertransference responses between the work with serious somatization and the work with dying and suicidal patients.

**Work with dying patients:**

1. In writing of their work with the terminally ill, Schwartz and Karasu (1980) note that

we all live lives deliberately ignoring the anticipation of our own death as well as the deaths of those we love. (p. 281)

They note that one of the major difficulties inherent in the work is to be "reminded constantly of our own mortality" (p. 293). These issues certainly apply to the work with somatizing patients, particularly those who are gravely ill.

2. Eissler (1955) believes that work with dying patients necessitates therapeutic partial identifications in order to span the widening gulf created by dying and to provide a usable treatment. However, he cautions that the identification must not be total and must not lead to the evolvment of anxiety in the therapist for

part of the therapist's ego must remain free of identification. . . . If the therapist's own fear of death is considerable, he will either recoil from even a partial identification or become anxious, if not depressed. In both instances [s/]he is bound to harm the patient. The calm with which [s/]he bears the experience of a partial [identification] is . . . to make it possible for the patient to establish a therapeutic relationship which is at all usable. (p. 249)

Gravely somatizing patients may also require treatment that includes similar identifications with them. Therefore, it would seem that corresponding difficulties may arise and like precautions be required.

3. Schwartz and Karasu (1980) note that when working with dying patients they sometimes develop feelings of embarrassment engendered by their own better health. Similar emotions cer-

tainly may pertain to clinicians working with physically ill or gravely somatizing patients.

4. Schwartz and Karasu (1980) and Eissler (1955) write of experiencing embarrassment when unthinkingly mentioning the future or speaking encouragingly. Although their somatization may be reversed and so there may be a future for the gravely somatizing patient, some have somatized since childhood and have never enjoyed good health. This may limit their ability to consider a future any more pleasurable than the present.

**Work with suicidal patients:**

1. Suicidal patients consciously seek self-inflicted and self-intended cessation (Shneidman, 1980). Although gravely somatizing patients not apt to be conscious of the same processes, unconsciously both may be at work.

2. Shneidman's (1980) goal in work with suicidal patients is not to make them feel better, rather, it is a more primitive one: to keep them alive. He lists a series of techniques therapists can employ toward that goal. Although the same goal certainly pertains to seriously somatizing patients, none of the techniques he enumerates is applicable. Since similarly clear-cut techniques have yet to be formulated for somatization, clinicians working with somatizing patients may flounder and feel that both they and their theoretical underpinnings are insufficiently sophisticated to help their patients.

3. Shneidman (1980) believes the work with highly suicidal patients differs from other psychotherapies in that

the tranference [sic] . . . and the countertransference . . .--especially those positive feelings of affection and concern--can legitimately be much more intense and more deep than would be seemly or appropriate (or even ethical) in ordinary psychotherapy where time is assumed to be endless and where it is taken for granted that the patient will continue functioning in life. (p. 308)

This intense potential exists for clinicians at work with seriously somatizing patients, as well.

That this investigation into the literature has not proven more fruitful should not foreclose further explorations into possible parallels between expectable countertransference reactions to seriously somatizing patients and to patients who are physically ill, dying, threatening suicide, or who have succeeded at suicide. Despite the fact that little has been written of these parallels, it is suggested herein that they exist and that future researchers may find this soil fertile.

### Intimacy

Most somatizing patients, particularly alexithymics, do not usually accept therapeutic interpretations for the first few years of treatment (Wilson, 1989). As mentioned in the discussion of countertransference to wordlessness, interpretations are not rejected as much as they are unheard, as though they never occurred. It is as though the clinician, in the patient's psyche, doesn't really exist (Fonagy, 1991). This "nonexistence" means the patient is unable to be "touched" by their therapist. Necessarily protracted beginning work with

most somatizing patients is thus often marked by a lack of intimacy.

The literature on somatization contains a sort of unacknowledged controversy concerning the goal of patient insight into unconscious meanings of their somatic symptoms. There are various arguments against this goal.

1. Cummings and Bragman (1988) founded a center to offer psychotherapy to the heaviest medical facility utilizers in a San Francisco HMO. Sixty percent of the patients selected displayed no diagnosable physical illness and were therefore considered to be somatizers. Their center was founded on empirical research that

demonstrated that one session of psychotherapy, with no additional visits, could reduce medical utilization by 60% over the following 5 years and that there was a 75% reduction in medical utilization over a 5-year period for those patients receiving two to eight psychotherapy sessions. (p. 109)

The psychotherapy sessions were specifically designed to avoid making any connection between patients' physical distress and their psychological concerns lest their patients become defensive and reject treatment.

2. In another vein, and, as noted previously, the chance of seriously exacerbated somatic symptoms increases as patients approach core emotions. Additionally, Wepman (1988) argues that work with somatization is

work in which insight is not always necessary, is often useless and [actually] may be undermining. (p. 194)

Further, although Strean (1988) and Karasu (1980) do not avoid insight they indicate there are many practitioners who believe that psychological insight into the meanings of the somatic processes may overwhelm the frail defenses of somatizing patients and engender psychosis.

Countering, Karasu (1980) indicates that while exacerbation of physical symptoms is likely and a possibility of increased psychological perturbation exists, he states emphatically there is "no data at all to demonstrate that the psychological deterioration that may occur will lead to psychosis" (p. 275). Unfortunately, he provides no data to bolster his conclusion. Although McDougall (1978) does note that some somatizers experience psychoses, she avers it is usually well into analysis, accessible to further treatment, and of short duration. Although not directly entering the controversy, many others (e. g., Krystal, 1988; Giovacchini, 1993; Taylor, 1987) proffer copious clinical anecdotal material illustrating no avoidance of patient insight, some eventual successes, and no precipitated psychoses.

As do many clinicians working with the general patient population, as well, all the above authors (Wepman, Krystal, Strean, Karasu, McDougall, Taylor, and Giovacchini) avoid leading their somatizing patients toward insight. However, Giovacchini (1993), Krystal (1988), and McDougall (1989) clearly follow their patients, apparently believing some will arrive at insight into the psychological nature of their som-

atic ailments. Perhaps it is this very belief that enables insight, and even offers some protection against psychosis.

Patients who have attained insight have also achieved a necessary intimacy: they have been emotionally "touched" by the therapeutic environment, therapists' interpretations, and their therapists. The attainment of insight, the achievement of being "touched" indicates an acceptance of the beginnings of a working alliance: a further intimacy. Absence of emotional "touching," as described earlier, may lead therapists to experience work with somatizing patients as demeaning them and their skills by dint of disuse; as rejecting and/or erasing them; as thwarting treatment and/or themselves; and as threatening their professional self-representations.

However, just as therapists are apt to be concerned about a lack of emotional intimacy, so, too, may they become concerned about the development of a differing sort--a physical intimacy born of words. The English-speaking North American culture tends to be one in which social physical touch is generally eschewed (Montagu, 1971). Societal norms tend to proscribe physical touching, permitting it only under specific and prescribed circumstances of privacy and familiarity (Older, 1982). As somatizing patients learn to accept verbal interpretations and respond to them as emotionally "touched" by them, therapist and patient alike may experience the open discussion of the specifics of the body and somatic symptoms as

another kind of intimacy. It is one of "physically touching" the body with both words and thought (F. Stern, 1994-6). Some therapists and patients may consider this "verbal physical touching" to be a valuable and productive part of treatment. However, others may experience it as threatening: as taboo and as occurring outside socially and even clinically prescribed boundaries.

The unconscious forces apt to play roles in the formation and maintenance of psychosomatic symptoms include their utility as defensive structures, as vehicles for secondary gains from illness, and as possible means of communication. Patients also may use symptoms to meet other unconscious needs including desires to be held (F. Stern, 1996), be comforted and soothed (Fenichel, 1945), be caressed, bond with the therapist, exhibit themselves and be noticed.

Mitchell (1988), while disagreeing with classical Freudian views that shun gratification of patients' infantile wishes or impulses, provides a succinct and useful description of it. He notes that

Freud saw the analytic process in terms of renunciation; by bringing to light and renouncing infantile wishes and illusions, healthier and more mature forms of libidinal organization become possible. (p. 189)

Again, in Mitchell's (1988) conception of the Freudian view,

if patients' infantile wishes are gratified, they will become further entrenched rather than transformed into memory and renounced. (p. 141)

Therefore, when "verbal physical touching" occurs, concerns about gratification of patients' wishes may well arise.

Practitioners thus may question the utility, propriety, and consequences of intimacy that develops as a result of opening the body and its language to clinical investigation. As these issues become a focus of therapeutic dialogue and as experiences of "verbally physically touching and being touched" ensue, therapists may become concerned that discussions of these issues may cross social boundaries; produce unfamiliar, and therefore threatening, sorts of intimacy; indicate unconscious collusion with their patients' quest for gratification of infantile needs; and somehow cross therapeutic boundaries.

Finally, sexual concerns, differing somewhat from those surrounding intimacy, warrant separate mention. As indicated earlier, words can touch intimately both as emotions, and also intimately as "verbal physical touching." Normal therapeutic transference identifications, employed with somatizing patients, may lead therapists to experience intimacies with patients' bodies, body parts, body sensations, and "body memories" that are different from the expectable concomitants of psychotherapy. As such, these may lead to unexpected sorts and instances of sexual arousal; ones with which clinicians may be unfamiliar and may, therefore, find threatening.

In cases of pre-symbolically traumatized patients, there is considerable statistical evidence that they suffer from Borderline or Narcissistic Personality Disorders with precipi-

tating traumata of childhood sexual abuse usually perpetrated by a trusted adult (empirical studies from the late 1980s and early 1990s cited by Paris & Zweig-Frank in their report of their own study, 1997; additional empirical studies cited in Pearlman & Saakvitne, 1995). In these instances, patients often fuse caring and sexuality. Chu (1992), from clinical experience, notes these patients may, consciously or not, put themselves in situations of revictimization in their efforts to actively master passively expressed trauma. Crespi (1986), also from clinical experience, notes the therapeutic relationship can reactivate symbiotic longings in these pre-Oedipal patients and cause them to become

intensely involved with the analyst and to demand reciprocity as a means of warding off feelings of abandonment, depression, and disintegration. This involvement may take on a sexual form [a more adult form of fusion] . . . to disguise its dependent nature, the infantile roots of which would make them intolerable to the patient. . . .In addition, these patients tend to be concrete, and, because of their tenuous hold on reality . . . demand that things be "real," particularly the relationship with the analyst. . . . [I]t is difficult for them to . . . talk about . . . [their needs and fantasies] rather than live them out. (p. 87)

Fonagy (1991) notes in treatments with patients unable to symbolize, "the 'as if' nature of the transference" (p. 651) is lacking and leads to situations in which the projection of the internal world onto therapists is "for real." There is no Winnicottian (1971, 1971a) "play space." He notes

the absence of mentalizing function . . . leads to a tendency to "act out" [\*] the transference because the ability to decouple mental representation from reality is vulnerable or absent. (p. 651)

[\*] It is believed that in the above quote, Fonagy employs the term "to act out," in the non-psychoanalytic sense meaning "to enact." It is suggested herein that he does not mean to contrast it to the psychoanalytic "act in" since he is discussing transference which is, by psychoanalytic definition, unconsciously "acting in."

Additionally, Crespi (1986) notes that when these symbolizingly impaired patients are in the grips of an idealized transference, their desire to be

loved and admired, to be chosen by or fused with the idealized object may take a sexual form. To re-experience the early narcissistic needs underlying their wish for the analyst's love, would be frightening and humiliating and this may be defended against by acting out sexually. Feelings of entitlement, and the threat of loss of self-cohesion cause such patients to become demanding as well as highly seductive in their attempts to elicit the needed response from the analyst. (p. 88)

Crespi (1986) also notes that sexually abused patients may regard the sexual seduction of their therapist as a vindication of their childhood abuser by proving "the analyst to be no better . . . at maintaining the taboo" (p. 88). Wachtel (1981), discussing the concept of transference from a Piagetian perspective, sheds some light on the possible mechanisms of this phenomenon and others like it. From clinical experience, he posits a continuum of patient response within the therapeutic relationship from reactions based primarily on "distortion," the transference reactions, to those resting more solidly on "reality." He posits that the more "distorted," or transference reactions, are processed more through assimilation into existing schema and are experienced as recapitulations of childhood experience. However, when patients

more "realistically" respond to the differences between their past relationships and their present therapeutic one, when more attuned to "reality," they are utilizing a lesser degree of assimilation and a greater degree of accommodation.

Extrapolating from Wachtel's (1981) formulation, patients able to recognize "real" differences between their therapeutic relationship and their childhood experience, have changed expectations to accommodate their existing schema to better conform to their new "reality." Accommodation requires more from a patient than does assimilation. It asks them:

1. to note the existence of something new that does not easily assimilate into existing schema--that their therapist is unlike adults from their history;
2. to alter expectations and world view, to expand their schema to contain new data--they can now entertain the possibility that all adults are not abusive nor exploitative; and
3. following from the preceding tasks, to confront their feelings towards those original experiences that formed their initial schema--in this case, their childhood abuser. In other words, if all adults are not as the original object, then the original was not just doing what all adults do but was truly flawed and actually did mistreat the patient.

In Crespi's (1986) scenario above, patients pressuring their therapist to behave similarly to their childhood abuser, have difficulty accomplishing these accommodating tasks, and are continuing to rely more heavily on assimilation. Crespi

posits two additional transference scenarios that can also be understood within the Piagetian frame suggested by Wachtel (1981). Each scenario may exert powerful pressures on clinicians. Pre-symbolically traumatized patients may identify with their aggressors and attempt to seduce their therapist as they had been seduced. Or, they may attempt to test their therapist, hoping to force them to set limits and become the protector unavailable in childhood.

Clinicians facing these transference scenarios from their regressed patients are likely to react with potent countertransference responses. Crespi (1986) notes that in response

early symbiotic and narcissistic needs . . . and incestuous longings become restimulated in the analyst. . . . [and in addition to defensive responses,] the analyst may find herself . . . pulled toward the patient and becoming entranced by . . . intense feelings of specialness, of love and understanding, of need and intimacy, and of sexual desirability . . . the patient offers. This, as Freud (1915) points out, can be quite hard to resist. (pp. 90-91)

These transference phenomena exert forces on therapists; initially for the maternal caretaking role and eventually for sexual contact (Gabbard & Wilkinson, 1994). Somatizing patients seeking to meet their needs, consciously or not, may demand their therapists vitiate the therapeutic frame. As Davies and Frawley (1994) note

The fact that sexual encounters with therapists are most often reported by adult survivors of childhood sexual abuse (Kluft, 1990) bespeaks the power of transference-countertransference pressures to enact rather than symbolize. (p. 177)

However, therapists successfully maintaining treatment boundaries and thus frustrating patients' efforts to meet their own needs, may be faced with patients who become infuriated. Gabbard and Wilkinson (1994), from clinical experience, suggest clinicians desiring to avoid this, may be tempted to relinquish the frame and to foster, instead, an idealizing transference, with its attendant pitfalls.

Concurrently, therapists may be inspired to maternal, paternal, or rescuer countertransference responses to patients' victimhood. Giovacchini (1989) notes strong parallels between the maternal matrix and work with patients suffering primitive mental states. He posits clinicians spurred by desires to compensate patients for past horrors or protect them from further damage, may evince a desire to

form an emotionally nurturing bond with the patient . . . [However, to create that bond, the therapist] may break the therapeutic boundaries, breach the frame, and destroy the relationship. . . . [This sort of] therapist usually believes that trying to meet most of the patient's infantile needs is part of a technically ideal therapeutic endeavor. . . . On the surface, these therapists seem to be dominated by concern for their patients. (p. 141)

It is suggested herein that the therapists of whom Giovacchini writes have misinterpreted Winnicott's (1952, 1956) "holding environment" to mean unconditional love and soothing. An important point has been omitted--both Winnicott and Giovacchini believe the treatment/maternal matrixes require titration of sufficient frustration and disillusionment to enable patients/babies to grow (Giovacchini, 1989; Winnicott, 1952).

In that vein, Winnicott (1952) encourages caregivers to frustrate their baby's id, but cautions them against frustrating their ego.

To recapitulate, the forces that may combine and lead to discomfoting sexualized countertransference include:

1. discussions of the body which may lead both dyadic members to experience an emotional as well as a "bodily" sense of verbally "touching and being touched";
2. sexually abused patients' transferences comprising confusions between caring and sexuality exert powerful forces toward potentially eroticized maternal countertransferences;
3. therapists' early symbiotic and narcissistic needs and incestuous longings may become restimulated and cause therapists to become attracted to their regressed patients' offers of specialness and love;
4. therapists' fantasies of rescuing from and/or compensating for patients' past horrors create potentials for crossing therapeutic boundaries; and
5. therapists' efforts to avoid their patients' disappointment and rages by fostering idealized transferences exert a like force.

Searles (1979) recognizes when therapists feel thwarted in efforts to help patients, their unconscious therapeutic omnipotence may lead them to seize upon any available method including sexual involvement with their patients. Little (1951)

acknowledges the potency and the ubiquity of clinicians' libidinal impulses. She indicates therapists' fears of their own id impulses are the primary force causing countertransference responses to become destructive to treatments. Therefore, clinicians adept at handling fears of their id impulses as well as the impulses themselves, are most likely to avoid finding

themselves crossing one boundary after another as they descend down the "slippery slope" toward sexual contact with their patient. (Gabbard & Wilkinson, 1994, p. 119)

The transferential and countertransferential forces exerting pressures on practitioners' sexual thoughts and impulses having been presented, discussion now turns to contributions classical metapsychology makes to this discussion. Whether or not one considers oneself a classicist, Freud's thinking is an enduring and pervasive influence. Thus clinicians' attitudes, and, thus, countertransference, consciously or not, are still permeated with his views. Freud (1916-17) exhorts society to

undertake as one of its most important educative tasks to tame and restrict the sexual instinct . . . for with the complete irruption of [it] . . . educability is for practical purposes at an end. Otherwise the [sexual] instinct would break down every dam and wash away the laboriously erected work of civilization. (pp. 311-312, cited in Mitchell, 1988, p. 75)

Once again quoting Mitchell's (1988) lucid recapitulation of that with which he takes exception, within Freud's theory of sexuality, later to become the basis for Freud's drive theory,

sexuality is difficult to integrate with other dimensions of interpersonal relations because it is a

vestige of man's primitive origins, of his early days as a precivilized protohuman, as well as of the prehuman ancestors in his phylogenetic development as a species. Thus Freud regards what is distinctively human and special in mankind as a tenuous overlay upon a rapacious, bestial core, which is only with great difficulty brought under the control of civilized motives. (p. 74)

Lastly, Mitchell believes that in Freud's system, "sexuality . . . is the crucial link to our animal past" (p. 73). Mitchell's linkage guides our discussion toward the countertransference issues revolving around the primitivity of somatization and the emotions contained or expressed therein.

### Primitivity

Somatic expression is the earliest form of human communication. It is primitive in both phylogenic and ontogenic senses of the word. Whether somatic communication is gestural, involves the sensorimotor apparatus, or is somatization, it harkens back to the most primitive times of both species and individual. As a current species living in "civilized" society, adult human beings are expected to communicate symbolically with words.

Not only is somatization a primitive mode of expression, but the content of that communication is also primitive. McDougall (1989) conceptualizes psychosomatic symptoms as "primitive pathologies that have failed to achieve psychic representation" (p. 4). It can be expected, then, that emotions contained within those pathologies are primitive, as well.

The Platonic-Christian view of man was as a "chip off the divine block gone astray" (Mitchell, 1988, p. 73). With the advent of Darwinian evolution, man was viewed as having ascended from the beast rather than having fallen from grace. This position informs both Freud's vision and the scientific zeitgeist of his time. Again, Mitchell (1988) succinctly depicts the idea he counters as he says Freud understood that

just as lower organisms evolve into higher forms of life, bestial sexual and aggressive impulses are transformed into the entire array of civilized activities. (p. 74)

Further, that Freud saw "civilization . . . always as a . . . counterfoil to man's bestial nature" (Mitchell, 1988, p. 75).

In The African Queen (Agee and Huston, 1951), the classic movie set in 1915, Rose Sayer (Katharine Hepburn), a very British spinster, sister of a slain African missionary, says to her slovenly, hard-drinking rescuer, Charlie Allnutt (Humphrey Bogart), "Nature, Mr. Allnutt, is what we are put in this world to rise above." Antiquated as this statement may seem at the close of the 20th century, society has not changed so very much. The word "primitive" still connotes that which civilized peoples have risen above. "Primitive" is still understood as "uncouth," "unevolved," "untamed," and "uncivilized." Societal views are pervasive, and clinicians' unconscious reactions to primitive modes of expression of primitive emotions bespeaking primitive pathologies are apt to be similarly tainted.

Freudian metapsychology is rife with similar views. Although some clinicians consciously reject the classical position, they may still be swayed, albeit unconsciously, by its underlying biases. For good or not, the then-revolutionary and still powerful zeitgeist of that stance continues to influence much contemporary thought. Mitchell (1988) presents some views of primitivity propounded in classical metapsychology:

The [individual's] past which Freud believes . . . to be encased within the id, is an array of bestial desires. Civilized man lives always in the tension between his social existence and his primitive past, which is alive in him as a powerful motivational core. . . [S]ocial existence represents a reclamation project, operating on borrowed territory, with the continual threat of being overrun once again by primeval, instinctual forces. (p. 76)

Mitchell later says that in classical metapsychology,

human experience is portrayed as a struggle to negotiate between the claims of *body-based* [italics added], asocial psychic tensions and the demands of social reality. (p. 134)

And, just in case the point is not yet clear, Mitchell (1988) also says that

"primitive" impulses bubble up from the id, a "cauldron full of seething excitations" (Freud, 1933, p. 73), [and are worked over by a] secondary" process concerned with adaptation to external reality, to fuel "higher" functions. (p. 73)

Freudians view the human condition in continual danger of being overrun by body-based, primeval forces. Somatizing patients have yet to attain "secondary" process leaps to "higher" functions in the arenas of their somatized symptoms. The verbal links to primitive pathologies have not been forged. Their therapy thus presents continual demands upon both pa-

tients and practitioners to attend to, or expend energy avoiding, the very body threatening to breach the dam of civilization. It is inevitable that practitioners' unconscious experience of this threat is potently present in and informs their work with somatizing patients.

Giovacchini (1989) posits that much of the material produced by primitive mental state patients is so early, so amorphous, so primary process in content, that countertransference evoked by it is usually in full play before therapists become aware of it. To make matters worse, there is rarely ability, certainly for patients and often for clinicians, to translate it into the language of secondary process. Eigen (1986) posits the ubiquity of a "psychotic kernel" and that Freud implicitly understood that

the human psyche is rooted in the same type of world the psychotic lives in, that in some sense, psychotic experience has a certain primacy. (p. 5)

Eigen establishes his point by noting Freud's use of psychosis as metaphor in discussion of the unconscious, id, libido, primary process, dreams, hypnosis, falling in love, man's relation to both army and church, and man's quest for power. Clinicians not sufficiently fortunate to explore their own psychotic kernels in their own analyses, and to approach and explore their own primitive selves, may experience the primitivity of their patients' somatic communications as alien. They may doubt their ability to understand and utilize it for treatment. So too may they fear, or experience, engulfment by the

primitive, early, untamed, nature of somatic expression and/or their contents: the primitive unprocessed emotions and pathologies. Whether or not therapists work with their primitive-state patients with the semblance of a map from their own analyses, as Giovacchini (1989) notes,

The feelings that are absorbed and form the basis of the countertransference are very primitive and, as such, can be painful to bear. (p. 195)

### Chapter Summary

The first section presented four conceptual models from the history of the development of the construct of countertransference. Focused primarily within the third model, elements comprising the definition of countertransference employed herein are described. The adaptation of Giovacchini's (1989) concept of homogeneous countertransference places this study of countertransference phenomena, and the clinician, within a societal frame.

The second section presented homogeneous countertransferential responses to the wordlessness of three patient groups. Pre-symbolically traumatized patients were seen to evoke a maternal countertransference position; somatizing patients elicit a societally-condoned dismissiveness; and alexithymic patients pull for a variety of withdrawal responses and, sometimes, a sense of going crazy.

The third and final section presented homogeneous countertransference reactions to somatization. Grouped into discussions of three issues, they revolve around clinician's concerns about illness, dying, and death; the absence and presence of various intimacies; and the primitive nature of both the somatic form of communication and its psychic contents.

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## Chapter Two Notes

1. Many, if not most, theorists involved in the development of the second and third models of countertransference are women (see Appendix B). It would add to our understanding of the history of countertransference if a study investigated how that transpired. Also of interest is the impact on these groundbreaking analysts of their consistent adherence to the convention of employing the male pronoun referring to the analyst.

2. Giovacchini's "homogeneous" countertransference concept has similarities to Winnicott's (1947) concept of "objective" countertransference. However, Winnicott's construct was not used as the basis of the definition for this study because it contained many elements of the classical "analyst pathology" model of countertransference from which this study attempts to separate.

3. "Wordless distress" refers to both distress experienced without words for expression and distress caused by having no words.

4. Both Winnicottian patients on the quest and Giovacchini's (1993) patients appear to resemble Balint's (1968) description of the basic fault: despite their failures in treatment and despite the observation that adult language is not useful in their therapeutic communication, basic fault patients appear to have the conviction something can be done and appear ready to do whatever is necessary to achieve successful therapeutic results. Further, Balint (1968) suggests that their

profound suffering, absence of cheap pugnacity, and an unshakeable determination to get on makes these patients truly appealing. . . . [As a result, the therapist] finds it rather difficult to maintain his usual attitude of sympathetic, objective passivity; in fact, he is in constant danger of subjective emotional involvement. (p. 19-20)

5. Alexithymic patients characteristically divorced from or devoid of both affect and internal physical sensation raise a thought about the word "feelings" (W. King, 1996). Generally causing linguistic confusion, "feeling" is used to denote both phenomena. This linguistic confusion (at least in English) may indicate connections between these phenomena in alexithymic patients that warrant investigation beyond the scope of this study, and beyond those begun by Darwin (1872/ 1965) and followed by Knapp (1963).

### **CHAPTER THREE**

#### **UTILIZING COUNTERTRANSFERENCE**

##### **Introduction**

This chapter opens with the suggestion that, in addition to the expectable homogeneous countertransference to somatization and affective disarticulateness (proffered in Chapter 2), two additional clinical responses be considered as potential countertransference, as well: clinicians' somatic phenomena and clinical language. The chapter closes with a discussion of the utility of all forms of countertransference and the particular importance of employing its full experience and detailed analysis in the treatment of emotionally wordless somatizing patients.

##### **Additional Countertransference**

In addition to countertransference responses previously examined, it is suggested that there are less recognized phenomena that may be considered countertransferential, as well. Although these phenomena arise in work with all patients, they are presented from the perspective of the work with emotionally disarticulate somatizing patients. First, the somatic phen-

omena that clinicians experience while at work may represent unconscious responses to patients and/or treatments; and even when they do not, can prove useful. Second, the clinical language used with and about patients subtly influences practitioners' unconscious attitudes. Each is presented as a form of potential countertransference and, as such, requiring and deserving of both full awareness and full analysis.

### Clinicians' Somatic Responses

Darwin (1872) detailed observations that led him to conclude that people cannot be said to feel emotion without experiencing the physiological accompaniments of affect. Further, as anyone else, therapists may somatize. Periodically practitioners recognize that their own somas become involved during the course of their work. McDougall (1978) notes that when working with her "gastric patients"--those with psychosomatic gastrointestinal disturbances like ulcerative colitis--both she and her patients often are aware of audible noises from her bowels. More specifically connected to the point of this section, Bollas (1987) suggests that the

analyst's countertransference [is] a complex registration of [both] the psychical and the somatic . . . (p. 198-9)

As a first step in clinicians' exploration of their own somatic phenomena, it is worth noting any physical occurrences while at work with patients--e.g., becoming sleepy; getting hiccups, a muscle cramp, or a stomach ache; developing gas; or

experiencing normal allergies more intensely. Further, practitioners, already trained to maintain an intentional ear open to the inner workings of their minds, may consider becoming more explicitly aware of the inner workings of their bodies. Combining awareness of the soma's import and intentional observations of its workings may permit discovery of possible meanings contained in their own somatic phenomena. If insights are reached, they are apt to be first about the patient, then the process and dyad, and lastly, clinicians' selves. This order approaches from that which is the least apt to be defended to the most, thus, it is most likely. If, however, these explorations disclose no useful data and come to naught, well then, "sometimes a burp is just a burp!"

However, when somatic phenomena tend to recur while sitting with one particular patient, or arise around a constellation of issues, then it is important for practitioners, as Bollas does, to consider the body and its phenomena specifically as part of countertransference. Now no longer viewed as "a burp, is a burp, is a burp," it is time to become explicitly investigative and as particular as one is with more recognizable countertransference responses: e.g., Why this physical reaction? Why at this time? What is happening in the clinician, session, dyad, treatment? Why does this reaction occur with this patient or when these issues arise? etc. Clinicians' physical reactions that occur between sessions, most probably represent issues belonging to themselves, alone, ra-

ther than to the dyadic field or to the patient. The exceptions are when clinicians sense, with a sort of pre-logical consciousness, or "gut" feeling, that the somatic phenomena are somehow connected to a specific patient.

Should these attentions to their own somas fail to yield specific data about their patients, the treatment, or themselves, therapists may have gained something substantive from their efforts, nevertheless. From within themselves, first-hand, clinicians will have experienced what it is to focus on their soma, the sense of attention paid to their own bodies, and begin to understand what their patients may feel when, in turn, they attend to their patients' somas. In other words, that which clinicians have not had the opportunity to learn in society, in training, or in their didactic analyses, cannot be transmitted to their patients. However, informed of its existence and its potential utility, they can explore, for themselves by practicing on themselves, the experience of attendance to the soma.

The reader wishing to pursue this phenomenon further is referred to Gendlin's (1981) philosophical manual of experiential psychology<sup>1</sup>, Focusing, in which he offers innovative exercises designed to provide readers/experimenters with first-hand experiences of listening to their bodies. (Cornell [1996], a student of Gendlin's, offers a more recent manual that is more easily accessed.) Gendlin's knowledge of, and respect for, both intellectual and "gut" understanding is evi-

dent as he teaches the fusion of the two to create consciousness of a subliminal knowledge, or "body knowledge" (Gendlin, 1981) comprising the brain/mind and the soma. This knowledge has some similarities to Bollas' "unthought known" in that when first experienced through the suggested exercises, it is felt to be familiar, as having been "known," but not in an intellectual manner. Of the unthought known Bollas (1987) avers

This is a form of knowledge that has not yet been dreamed or imagined because it is not yet mentally realized. . . . and yet it may permeate a person's being, and is articulated through assumptions about the nature of being and relating. (p. 246)

Therefore, that which Gendlin teaches is not an "aha" experience since that is typically a response to an intellectual recognition of something already thought, or almost thought. Gendlin avers that it is a physical knowing and refers to it as a "felt sense" that he suggests can only be apprehended through what he calls "focusing through-the-body." Perhaps it is better described as an "ooh," or even a "wow," experience.

### **Clinical Language**

As earlier (Chapter 2), Freud initially believed patients' transference and clinicians' countertransference to be similarly serious hinderances to psychoanalytic treatment. In time, he recognized transference and its analysis as the most potent therapeutic tool. Although he died still believing countertransference a destructive phenomenon to be avoided and banished from the consulting room, currently there are many clin-

icians who consciously believe that countertransference is omnipresent, cannot be banished, and may be useful. However, the classical view is enduring and pervasive. As such, despite conscious belief to the contrary, there are discrepancies between theoretical commitment and actual practice (Hamilton, 1996) and many current practitioners feel (as opposed to believe) countertransference is best removed from the playing field. The process by which conscious theoretical beliefs are undermined by unconscious echoes from the perhaps repudiated classical position affects other clinical phenomena, as well as countertransference. Wachtel (1993) accounts for these discrepancies by suggesting that much of what clinicians do in treatment results from the practices employed in their didactic therapies and, therefore, are not necessarily held in conscious thought. Wachtel cites Wile (1985) who suggests that the endurance of the classical zeitgeist in these instances may be accounted for by a process wherein generations of clinicians treat their professional offspring. Wile dubbed this unconscious process "psychotherapy by precedent." Thus, metaphorically speaking, as the DNA of all humans is traced back, by generations, to that of Adam and Eve, clinicians' genetic practice, generationally, harkens back to that of Freud.

Similar discrepancies between conscious theory and unconscious practice may also appear concerning attitudes toward diagnostic labels, "regression," "resistance," "symptom," and "countertransference," to name but a few. When writing and

speaking of, talking to, and thinking about patients, the language used inevitably colors the therapeutic process, for good or ill. The language used both reflects and forms attitudes. As Wachtel (1993) suggests

the feelings evoked in us by the patient are a function not only of our personal history but of our set as we approach the patient and the therapeutic task. This set, in turn, depends on how we conceptualize the nature of psychological difficulties and the therapeutic process. (p. 12)

This section does not address whether any single position on a construct is right and others wrong, rather it addresses attitudes created by, and reflected in, the clinical language. Many views of each term may be theoretically useful in recognizing that each clinical phenomenon may have obstructive aspects as well as communicative ones in their effect on the depth, pace, and efficacy of treatment. This study posits that unconsciously held focus on either aspect of these constructs is a mind-set tantamount to countertransference.

Karasu (1980) posits additional drawbacks. First he offers three clear assumptions upon which long-term psychodynamic treatment of somatizing patients is predicated:

1. that unconscious impulses are manifesting themselves in pathology of the organs;
2. that affective experience is inhibited or repressed and/or somatically manifested; and
3. that developmental stages of the individual are arrested and have never reached their symbolic, verbal, expressive stage. (p. 262)

But he then acknowledges that such generalizations are of little use. Although he doesn't elaborate, it is suggested their lack of utility is due to the likelihood that interpretation

will not succeed since the patients have so little ability to symbolize. He goes on to warn that the generalizations may actually interfere with treatment because they provide

ready-made explanations. Such categorical approaches only help to comfort the therapist. (p. 262)

It is suggested that other clinical formulations also may interfere in similar ways: by foreclosing detailed investigations of the dynamics at work in particular patients and in particular treatments at particular times.

For example, clinicians focused on regressed patients' immaturity may lose sight of the courage required to permit therapeutically necessary regressions. Either view of regression will alter ensuing dyadic interaction in its own way. Although time and debate have wrought changes in the understanding of diagnostic labels and the terms "resistance," "symptom," and "countertransference," it is typically difficult to shed aspects of the classical influence, wherein many clinical phenomena are viewed as obstructive of the healing processes offered by dynamic psychotherapy.

For instance, ironically, Singer (1970) begins his chapter on resistance with a case finally determined to be highly revelatory and not at all resistive symptoms. He avers that although some of the

"new" symptoms superficially resemble avoidance behavior, upon careful investigation reveal some significant aspect or problem of the patient and therefore cannot be considered manifestations of resistance . . . (p. 224)

Upon first reading his chapter, it occurred to me that when clinicians label behaviors resistive, it is likely that they not only intellectually believe, but emotionally experience, the behaviors as thwarting treatment and perhaps preventing them from doing their best work. Thoughts and feelings attendant to the label "resistance," although guarded against and even consciously unenacted, nevertheless, inevitably must impact on the treatment, as do all reactions clinicians have (e.g., Crespi, 1986). Granted, Singer indicates he engaged in a "careful investigation" of the symptom before he determined it to be revealing. However, given a patient particularly sensitive to others' beliefs as well as to criticism, as are many of the patients this study addresses, the attitude, based on the belief that the behavior was resistive, could easily foreclose Singer's "careful investigations," distance the patient, and, in the worst case scenario, end treatment, leaving patient and practitioner alike to deal with a failed treatment alone. For this, and other reasons, the concept of resistance is a controversial one.

Singer's anecdote also prompted a slightly differing line of thought; one concerning the power of the label. The words applied to phenomena, before or after "careful investigation," have power, for good or not, to form subsequent attitudes toward those phenomena. While engaged in work, clinicians, consciously or not, apply terms to patients and their phenomena such as diagnostic labels or the terms "resistance," "symp-

tom," or their own "countertransference." While acknowledging the positive communicational value of these terms, particularly in professional discourse, it is suggested herein that they also have a possible countertransferential nature which, without consciousness, may negatively impact the treatment and the patient.

**Diagnostic Labels:** For example, in Chapter 1 (the discussion pertaining to depathologizing trauma), the Gunderson and Sabo (1991) study was cited. They demonstrated the power of diagnostic labels. In some instances, the diagnoses of Borderline Personality Disorder and PTSD equally may be applicable to the same patient, but they evoke widely disparate expectations and responses from clinicians. The label "borderline" suggests patient pathology and flawed ego functioning, while "PTSD" connotes externally-caused etiology. As clinicians' unconscious thoughts about, for example, prognoses or etiology, arise they are colored by these diagnostic differences which will inevitably impact on future therapeutic dyadic interactions. Gunderson and Sabo (1991) report pronounced differences in practitioners' expectations of and responses to patients based solely on the connotative valences carried by the diagnostic label of "Borderline" as contrasted with that of "PTSD."

**Symptoms:** The formation of symptoms is generally thought to result from the conflict between instinctual drive forces (that become strengthened, as in puberty) and defenses (that

become weakened, as in physical illness), when guilt or anxiety threaten to break through into consciousness as affects stronger than useful as signals (Moore & Fine, 1990). Symptoms are thought to represent, symbolically, the struggle between wish and defense and as such are typically associated with the oedipal phase of psychosexual development (Campbell, 1989). Thus, the origin of symptoms as a psychoanalytic construct is marked by a belief in their symbolic, and hence, communicative nature.

However, sometimes their symbolic value is lost as clinicians' foci center on their repetitive, obstructive, and intractable nature. Bettelheim (1967), discussing autistic children's symptoms, recognizes that frequently residential treatments focus on attempts to limit the behavioral symptoms most distressing to staff (self-destructive behaviors or those considered particularly repulsive). Cautioning clinicians as to the message that sends, Bettelheim avers that if

we do not respect [his symptom] . . . the child's greatest effort, if we encourage him . . . to drop it, then we cannot convey our respect for the child himself either. We simply [convey] . . . that his spontaneous efforts to gain relief and even some mastery of his tensions are disparaged by us. Worse, it gives him the feeling that we ignore his communication--and all symptomatic behavior contains a communication--and wish him to communicate on our terms since we are unwilling to do so on his. (p. 169)

In the case of the symptom of somatization, usually associated with pre-oedipal development and therefore often not viewed as symbolic, it is doubly easy to lose sight of its

communicative value. When patients' somatic productions and discussion is ignored or banished in treatment, the message is that their only communicative system is either unimportant or unacceptable! It is suggested herein that although somatization is probably not symbolic, it still has communicative value (see Symbol or Signal discussion in Chapter 4).

Clinicians regarding symptoms as communicative are, nonetheless, confronted with concerns they and their patients may have about relinquishing them. For example, as expressions of the best patients could do with what was available at the time the symptom was formed (e.g., Fromme-Reichmann, 1946; Sullivan, 1953; Singer, 1970) which, as examples of their best and most creative efforts, are understandably difficult to relinquish. Or they may have been life-saving maneuvers and thus it may be frightening to give them up without assurance of adequate replacement protection (McDougall, 1989). Or, as communication of deficiency or trauma, wherein both patients and practitioners may face difficulties determining whether the symptoms' messages have been sufficiently received and acknowledged (Winnicott, 1953) to warrant discontinuance.

In a specifically communicative vein and about somatic symptoms in particular, Wepman (1988) avers that

in many patients there is a consistency between the symptom and what does not get said overtly. . . . [T]he unconscious is often expressed through the adoption of symptoms that reveal the person--if we are attentive to their messages. (p. 190)

Winnicott (1953) suggests that somatic symptoms are best seen as distress signals and cautions therapists to treat not the symptom (or signal) but the cause, thus "relieving . . . the need to send out the SOS" (p. 102). He asks therapists to see in the symptom of somatization

an organization of extreme complexity . . . produced and maintained because of its value. (p. 102)

Also positing a positive function of somatization but recognizing limits of its present communicative power, McDougall (1978) suggests that it is logically almost impossible to posit that a phenomenon as ubiquitous as somatization be understood only in terms of a lack of the ability to symbolically represent emotion, but that it must serve a proactive purpose, as well. Regarding the symptom of somatization, the only lack of which she is certain is practitioners' current understanding of what that purpose may be. Somatization, although typically viewed as a defensive or resistant endeavor, may also be seen as a way for somatizers to express themselves about that same material even while unable to experience, symbolize, or verbalize it. Thus, paradoxically, somatic disturbances may be seen as hiding, resisting, framing, expressing, approaching, and understanding problematic psychic material.

**Resistance:** Obviously "designed," albeit unconsciously, to ward off anything that may attempt to uncover certain painful aspects of psychic life, resistance can thwart therapists, can parry repeated attempts at discovery, and can prolong patient suffering and treatments. However, even resistance has

communicative value: its strength clearly, although most often without words, recounts the degree of fear patients unconsciously experience at the prospect of revelation (Fromm-Reichmann, 1946); and the psychic material protected may be partially, albeit silently, revealed by the choice and timing of resistive behaviors (Racker, 1968). Winnicott (1943) suggests that it is part of the clinician's task to

respect resistances, and see in them the unconscious struggle of the person to find himself. (p. 546)

In the same vein of a communicative view of resistance, Racker (1968) recognizes that

behind the resistances lies simply thwarted love, [and this knowledge] helps the analyst to respond with love to this possibility of loving, to this nucleus in the patient however deeply it be buried beneath hate and fear. (p. 159)

**Countertransference:** The remainder of this chapter addresses countertransference and its potential and utility and value when it is well-received, well-experienced, and well-analyzed.

### Utilizing Countertransference

Many clinicians believe countertransference to be a ubiquitous phenomenon that cannot be prevented (see Chapter 2). Some hold sentiments similar to those expressed by A. Reich (1951) who suggests that countertransference

is a necessary pre-requisite of analysis. If it does not exist, the necessary talent and interest

is lacking, but it has to remain shadowy and in the background. (Cited in Sandler, et. al., 1973, p. 67)

Considered omnipresent and expectable, in this framework, nevertheless, the focus remains, like the classical position, on countertransference as a disturbance. Epstein and Feiner (1988) aver that Reich

sharply rejects the notion that countertransference can in any way be used as a therapeutic tool, either as data for understanding the patient or as communication. (p. 290)

Admittedly, unanalyzed countertransference poses potentially serious threats to any treatment. However, if the focus remains entirely, or even primarily, on countertransference as obstructive disturbance, its potential use will be lost.

Heimann (1950), offering the first explicit statement of the positive value of countertransference, notes that

. . . the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'countertransference.' (Cited in Sandler, et al., 1973, p. 65)

In a later article, Heimann (1960) avers the analytic situation is a relationship between two persons and

what distinguishes this relationship from others is not the presence of feelings in one partner, the patient, and the absence in the other, the analyst, but the degree of feeling the analyst experiences and the use he makes of his feeling, these factors being interdependent. (p. 152)

Heimann believes countertransference alerts clinicians to the probability that they have missed something the patient is communicating and suggests they use countertransference to in-

form them when to search for hidden allusions in the patient's communications. Shane and Shane (1992), discussing Greenson's work, suggest that his view is similar to Heimann's--rigorous analyses of countertransference make conscious clinicians' unconscious awareness of processes occurring in their patients. Tauber and Green (1959) suggest that countertransference

be considered, not as an unwarranted and proscribed intrusion into the patient's field, but as a legitimate and valuable form of contact between therapist and patient through the prelogical mode of communication. (p. 148, cited in Singer, 1970, p. 299)

Racker (1968) offers these views on countertransference:

1. Countertransference reactions of great intensity, even pathological ones, should . . . serve as tools.
2. Countertransference is the expression of the analyst's identification with the internal objects of the analysand, as well as with his [the patient's] id and ego, and may be used as such.
3. Countertransference reactions have specific characteristics (specific contents, anxieties, and mechanisms) from which we may draw conclusions about the specific character of the psychological happenings in the patient. (p. 129)

Each model of countertransference engenders its own potential problems. The position posited herein is countertransference is expectable, ubiquitous, not indicative of clinicians' pathology, and useful. The potential problem within this definition is that therapists may be tempted to not work the material as assiduously as they might if it were considered indicative of their own pathology. In casual collegial discussion comments can be heard indicating elements of this problem are afoot: e.g., "The best one can do with countertransference is to recognize it and prevent its interference in treat-

ment," or "Usually recognizing its presence is sufficient to resolve countertransference." It may be that these statements are not indicative of the clinician's conscious or complete view of countertransference; are not necessarily reflective of clinicians' practice; and, in some instances, the stance proffered may be optimum for the particular case discussed.

Alternatively, the above state of affairs may be indicative of what Bollas (1987) discusses as resistance in the practitioner. He indicates an endemic lack of a "self-analytic element" and avers

I think we have failed to allow ourselves the full development of a psychoanalytic sensibility, which means the inclusion of ourselves as animated objects within the field of the analysable. We have lost pleasure in being bewildering to ourselves. . . . If our lives with our patients are lived in necessary seclusion . . . by virtue of the necessity of confidentiality, we can still explore mental phenomena and the puzzlement of being human by using ourselves as objects of examination. . . (p. 238)

Bollas avers that the receptivity that he suggests is a requirement for the development of the practitioners self-analytic function and is similar to a state of tranquility Khan (1977) describes as "lying fallow." In this state, feelings, dreams, and associations arrive, unsought. He expresses concern that few clinicians permit this state to occur but avers that it is this state that is required not only for all analytic work, but is fundamental to the exploration of countertransference for its utility. He continues and suggests that there appears to be a somewhat general resistance to the full

experience of countertransferential affects since many clinicians believe they must maintain neutrality and an even mind. However, he suggests that evenly hovering attention, while

an important frame of mind . . . does not preclude the value of another area of our analytic mind becoming distressed or deformed by virtue of the analysand's object usage of us in the transference. (p. 249)

In any treatment, when the self-analytic element and the willingness to fully experience countertransference are lacking, the patient is unable to develop their own self-analytic capacity. However, consequences of this absence are broader for the somatizing patients discussed in this study.

It is sufficiently difficult to work with patients whose pathology stems from pre-symbolic times and whose ability to verbally communicate core affect is limited or absent. Clinicians cannot afford to overlook or under-utilize whatever is available to help understand the occurrences in the psychic lives of wordless somatizing patients. As McDougall (1978) observes in work with patients who experienced trauma before the acquisition of functional verbal communication,

we may only become aware of the traumatic dimension through the unconscious pressure it exerts on the analysand's way of being and speaking, and thus may eventually *only be accessible if captured through our countertransference reactions*. (p. 248)

Potentially, countertransference is a robust tool that, in the work with somatizing wordless patients, is only too readily at hand. Its full experience and its full analysis provides important communications deriving from practitioners' prelogic-

al, unconscious, and frequently astute insights into their patients, the dyad, and themselves. As Bollas (1987) explains:

Very often the location of freely associated ideas--of those thoughts that spontaneously register the content of psychic life--is in the psychoanalyst. This is so because the patient cannot express his conflict in words, so the full articulation of preverbal transference evolves in the analyst's countertransference. . . . The patient knows the object-setting through which he developed, and it is a part of him, but it has yet to be thought. (p. 230)

Countertransference resisted or remaining un- or less-than-well-analyzed in work with somatizing patients is not merely the same threat as it is to any treatment. Within this work, it additionally incurs a regrettable wastage of a resource already in meager supply--potentially useful therapeutic communication.

Bollas (1987) notes practitioners fully experiencing countertransference establish a therapeutic climate in which

the patient unconsciously perceives this belief and space [for the reception of communications from the patient]. The patient's recognition of our internal space for the analysis of transference, which speaks via object usage of our self, permits the patient to utilize this form of relating and knowing. At the very least, more non-verbal or 'primitive' states of being and experiencing will therefore find expression. (p. 248)

Freud, the original advocate of the abolition of countertransference, nevertheless recognized that it is through one's unconscious that the other's unconscious is understood. He suggested that the clinician

must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. (1912, p. 115)

And later, he averred that

everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people. (Freud, 1913, p. 230)

Although Freud never proposed these particular talents of the analyst's unconscious be applied to the employment of countertransference, it is, at least partially, within the countertransference that the clinicians' unconscious processes make themselves felt and known. It is within that same countertransference that the unconscious of patients is often to be found. Discussing preoedipal patients, Bollas (1987) avers

it is a feature of our present-day understanding of the transference that the other source of the analysand's free association is the psychoanalyst's countertransference, so much so that in order to find the patient we must look for him within ourselves. (p. 202)

Unlike Freud, but like others (e.g., Heimann, 1950, 1960; Racker, 1968; McDougall, 1978, 1984, 1989; Bollas, 1987), it is suggested that to try to banish, manage, or in other fashion, dispatch countertransference is to lose the contents of a potential treatment tool, which, in Singer's (1970) view, "may eventually turn out to be the core of the analytic process" (p. 301). An aim of this study is to heighten clinicians' awareness of the kinds of countertransferential responses that are expectable in work with somatizing and affectively disarticulate patients, to suggest that there are other components to consider as countertransference, and to hope this proves useful in efforts to maintain them as relatively unenac-

ted. However, beyond that, it is hoped that clinicians will foster a an ability to tolerate not knowing and a greater receptivity to fully experiencing their countertransference responses. Further, it is suggested that the full experience of countertransference facilitates its analysis and provides its utility.

As it is important to know a great deal more about patients' symptoms, such as somatization, than the fact that it exists, so too is it important to know more concerning countertransference than the fact it exists. Full experience and detailed investigation of it might first include focusing on the various resonances of the feeling states and raising them to consciousness. Clinicians may pose questions to themselves about those feelings: why and how they have come to pass; what part of the clinician is involved and why; to what in therapists' pasts do these harken back; why and how are they played out in the present therapy. Basically, the thrust herein is the overarching purpose in experiencing and analyzing countertransference is the data contained therein and the service those data can afford treatments. This is of particular import for treatments of patients lacking the capacity to experience and verbalize core affect, and thereby typically able to contribute little that is initially accessible to analysis. The extreme dearth of useable patient production engenders such considerable potential for countertransference, that it seems

useful to fully exploit for the treatment the countertransference which is so plentifully available from the therapist.

Strean (1993), acknowledging the common acceptance of the statement, says,

Every client recapitulates in treatment with the therapist the major interpersonal conflicts that he or she has experienced throughout life. (p. 210)

Bollas (1987) suggests that patients may do this in

such a determined and unconsciously accomplished way that the analyst is compelled to relive elements of this infantile history through his countertransference . . . (p. 200)

In addition to reliving patients' infantile history, therapists may relive some of their own, as well. It too is common knowledge that, although better analyzed and thus aware of the possibility and the process, therapists' unresolved issues may be brought into their work and that these and other countertransferential material have potential meaning and, most certainly, consequences.

Before proceeding further, it is important to note that this author does recognize the potentially profound discomfort engendered in practitioners sitting in the middle of a countertransferential melange. It is also recognized that this discomfort is augmented by not yet understanding what is transpiring. Understandable as it is that clinicians experience pressure to unravel and resolve countertransference quickly, Bollas (1987) notes that they are

almost too eager to translate . . . experience into analytic frames of reference. . . . [and] must acknowledge more frankly that in the midst of coun-

tertransference experiencing the analyst may for a very long time indeed exist in an unknowable region. (p. 200)

If treatments are to avoid the risks of premature closure of difficult issues facing both patient and practitioner, and the ensuing loss of valuable data, clearly it would be useful, albeit difficult, for both members of the therapeutic dyad to endeavor to foster the ability to tolerate and plumb--to fully experience--this unknowable region.

Gleaned from the works of several authors (Racker, 1968, Bollas, 1987; Giovacchini, 1989; Wrye & Welles, 1994; Konig, 1995), the following summary of concerns may usefully be applied when the countertransference melange has sufficiently marinated in the condition of unknowing--of experiencing. In general, attitudes and emotions engendered in therapists are best examined to distinguish:

1. Those in the way of the treatment and indicative of work therapists need to perform on their own psychic material;
2. Those required by the work of doing treatment--that inform therapists what to, and when to, interpret;
3. Those that put the therapist in the best position to offer the patient the best "object for the re-experience of childhood, thus affecting the process of cure" (Racker, 1968, p. 133); and
4. Those that are clues to the psychological mechanisms of the individual patient.

Moving from the general to the specific, affectively disarticulate and somatizing patients and their difficulty experiencing and expressing affect, test therapists' capacities to help their patients achieve these ends. Bollas (1987) avers that much of the work in the countertransference is the

struggle to put into imagery and language the experience of being the analysand's object. (p. 281).

With work, clinicians accomplish these tasks and make the products available to their patients as they ordinarily do in therapeutic interaction. Initially, somatizing patients are unlikely to be able to utilize them, however, in so doing clinicians have practiced those processes their somatizing patients typically cannot: experiencing, verbally mediating, and acquiring insight into emotions. Although possibly a remote hope with somatizers, Bollas (1987) suggests that careful engagement in these processes assists patients to do the same. However, even this remote possibility is lost when clinicians are moved to handle, manage, or abolish countertransference. When countertransference is thus prematurely dispatched, the very container for their patients' and their own emotions that are in need of both psychic experience and symbolic expression is also dispatched.

Substantially unable to represent their own and others' psychic states, many somatizers are likely to experience interpersonal difficulties. These, of course, also arise within their treatment (Fonagy, 1991). Further, as suggested in Chapter 2, patients wordless about core affective issues leave

clinicians with little more than the same path toward understanding that infants provide their caregivers: non-verbal communication. D. Stern (1985) sheds some light on a portion of this process. In discussing his concept of "affective attunement" with infants, he suggests that it differs from empathy because

it is not cognitively mediated, and it occurs out of awareness and almost automatically. (p. 144)

Further, he indicates that the phenomenon that comes closest to his meaning of affective attunement is Trevarthan's (1980) "intersubjectivity" in that it

concerns the mutual sharing of psychic states [but it differs because intersubjectivity] refers mainly to intentions and motives rather than to qualities of feeling or affects . . . (p. 144)

Lastly, remaining with the experience of affects, Stern notes that like empathy, affective attunement begins with emotional resonance but it

need not proceed towards empathic knowledge or response. Attunement is a distinct form of affective transaction in its own right. (p. 145)

Bollas (1987) suggests infants arouse "feeling-perception" in their mothers. This construct requires a cognitive component, beyond Stern's affective attunement. Bollas avers the baby evokes

a feeling-perception in the mother that either inspires some action in her on the baby's behalf or leads her to put the baby's object usage into language, engaging the infant in the journey towards verbal representation of internal psychic states. (p. 204)

Connecting the communication parallels between baby/patient and mother/therapist to countertransference, according to Stern, affective attunement will not necessarily lead to "empathic knowledge or response" and "is not cognitively mediated." It is suggested that this may usefully be compared to the pre-logical understanding that is often present in clinicians' countertransference prior to its analysis. Bollas' process of "feeling-perceptions," assumes an additional, more cognitive component, wherein the caregiver/therapist "thinks" about what an infant/patient may be signalling. The information so garnered, lays the basis for the development of empathic knowledge that is an addition to resonance and to affective attunement. In this state, among other activities, caregivers/therapists prepare the way for the symbolization and articulation of their infant's/patient's affects. This state may be likened to countertransference that is being, or has been, analyzed.

Not only are some aspects of the path toward understanding shared by the infant/mother dyad and the somatizer/therapist dyad, but so too are parts of the destination--that of eventual "verbal representation of internal psychic states" and verbal mediation of those affects. In light of Stern's and Bollas' contributions, it is suggested that both goals, may be begun through affective attunement and attention to the feeling-perceptions contained in the therapists' countertransfer-

ence. Bollas further suggests that the infant within the adult patient

cannot find a voice . . . unless the clinician allows the patient to affect him, and this inevitably means that the analyst must become disturbed by the patient. (p. 204)

Finally, clinicians' disturbances are reminiscent of the caregiver's response to her infant's distress, in that the signal is received and the process of determining its meaning begins. Somatizing patients may not be either consciously distressed or sending conscious signals but, Winnicott (1953) suggests, the somatic symptom is an SOS signal. (For the therapist, the process of decoding the signals and the use to which the products of countertransference experience and analysis may be put are explored in the Chapter 4.)

Many authors (e.g., McDougall, 1989; Fonagy, 1991; Ackman, 1996; Libbey, 1996) note the difficulties facing most affectively disarticulate somatizers relate to symbolizing difficulties. They suggest the process of symbolizing requires a space between "symbol and symbolized" and when this space is unavailable, as with somatizing patients, much of patients' psychic material can be located only in clinicians' countertransference (Bollas, 1987). If all proceeds as hoped, clinicians, inside their minds, have received and experienced their countertransference and have affectively attuned to and symbolized what they can of their patients' emotional states. However, somatizing patients, often unable to experience affective attunement or empathy, and to whom interpretations make

little sense (see Chapter 2), force clinicians to engage in these normally dyadic processes alone. However, it is suggested herein that within clinicians' own imaginations these processes may come to fruition, although patients may not be ready to directly partake of the fruits for a long time. If the frustration of playing this game for a long time, with only an imaginary playmate, moves clinicians to prematurely foreclose either the experience or the investigation of their countertransference, clinicians will lose patients' psychic material; the potential for a real playmate; and the potential for the necessary play space in which to create symbols (Winnicott, 1971, 1971a).

Basically, with symbolizingly impaired, emotionally disarticulate, somatizing patients there are two reasons countertransference receptivity, experience, and analysis are even more important than in other treatments. So little is available for analysis from patients that: (a) major countertransference difficulties arise and need to be addressed and (b) it is often only within the countertransference that patients are found, rather than in their own free associations. It is suggested that these modes of clinicians' relating to their countertransference--receptivity and experience--begin to lay the groundwork for the somatizing patient to eventually attain access to their own psychic states; to experience emotions for, perhaps, the first time; and to begin to develop symbols for

their own and others' affective states. (See Chapter 4, Treatment, for elaboration.)

**Commonground Underlying the Utilization of  
Countertransference and Symptoms**

In addition to finding patients and their psychic material in the countertransference as Bollas (1987) avers, it is posited that patients may also be found within their symptoms. This, perhaps, is more easily conceptualized in terms of symptoms registering as presences--e.g., somatization. According to McDougall (1978), the scientific observer, Konrad Lorenz, suggests the most difficult and often the most important observations are those that detect an object is missing or an action fails to occur. With this in mind, it is posited that patients can be found, as well, in symptoms that make themselves felt as an absence of an expectable phenomenon (e.g., the absence of affective words for core emotion in psychodynamic psychotherapy). The next chapter offers the construct of a somatic language as a method of finding affectively disarticulate somatizing patients within their symptoms.

Wrye and Welles (1994), discussing transference/countertransference difficulties involved in treating patients with preoedipal problems, indicate the expectability of "primitive preverbal body-based transferences and countertransferences" (p.62), often involving body fluids, i.e. urine, milk, feces,

mucus, vomit, and saliva. Since they are not discussing somatizing patients *per se* (although there are numerous episodes of somatization in their clinical vignettes), they do not refer to "body-based" transference/countertransference solely in the "concrete" sense generally used herein. They discuss a metaphorical level, as well. Their examples of preoedipal body-based transferences include: practitioners' offices and their contents representing the body of mother/therapist; a patient, normally garrulous, when her infantile longings became unbearable, would fall silent for several weeks, rhythmically stroking wallpaper next to the analytic couch; and a patient who brought in her "smelly" lobsters to fill the therapist's refrigerator with their aroma during her session. In addition to the enactments above, they aver patients' psychic material also is apt to arise in the primitive bodily states that have been discussed herein, and that the classical model of treatment is not well designed to deal with either form of patient expression. They suggest that enactments and physiological states, as well as the inchoate material confronting the therapeutic dyad, require resonance, indulgence, and play in fantasy (although, suggested herein, in the case of somatizing patients, clinicians usually play alone).

However, Wrye and Welles (1994) and Fonagy (1991) warn clinicians to be alert for strong pressures from patients for "realized" and "actualized" encounters since they have few tools for dealing with their psychic pressures symbolically

and require the "real" thing to satisfy needs that cannot be sublimated. They recommend, in work with problems believed similar to those of Balint's (1968) basic fault patients, that material deriving from the body of patient, as transference, or clinician, as countertransference, should not be ignored, but utilized. The assets in this material lie not only in noticing them but in their full experience and careful investigation. Although including these phenomena might potentially incur dangers in the therapeutic work, their exclusion denies much-needed data necessary for successful treatment.

In another vein, it is suggested that similar mind-sets are required of both patient and practitioner since primitive bodily states and inchoate material may occur belonging to either. Without these attitudes, fruitful experience, exploration, and utilization of these phenomena, whether symptom or countertransference, will be impossible. Herein, however, it is posited that before patients can learn these sets, clinicians must model both their development and employment. Various suggestions are proffered by clinicians to help develop a receptive state of mind conducive to the spontaneous arrival of unconscious derivatives. Bollas (1987) urges practitioners to stay in the realm of the unknown for as long as necessary to learn its contents rather than move too rapidly to translate their own or their patients' material into cognitive language. Bucci (1993) recommends that clinicians allow ample time for

patients to explore the non-verbal realm of experience before attempting to apply words to it and thereby catapult an event from the feeling state to the verbal system before the experience has yielded its unsymbolized contents. It is suggested that Bucci's proposal be followed for clinicians' material, as well. Winnicott (1971, 1971a) avers therapists able to remain silent **at appropriate times** are cultivating the "uninterpretive act" and thereby facilitating patients' ordinary regression to dependence which, in turn, permits early material to arrive in session. However, as Karasu (1980) suggests for somatizing patients, not so silent as to arouse anxiety. Lastly, Khan (1977) encourages clinicians to allow their minds to lie fallow and thereby become increasingly receptive to their own and their patient's material. Bollas (1987) avers that without this set of attitudes

the analyst may well preserve in the patient a quiet belief that psychoanalysis turns away from very significant areas of being, knowing, and truth. (p. 235)

On a somewhat differing tack, writing of skillful therapeutic communication, Wachtel (1993) observes a connection between practitioners' countertransference and patients' symptoms. He avers that therapists get angry and feel frustrated when they feel impotent to help but as soon as they see

a handle, the anger is likely to subside . . . The premium in our work . . . is so strongly on understanding (and the frustration and self-derogation that accompany our not understanding so substantial) that . . . we are often able to tolerate ac-

ceptingly many behaviors by our patients we would never tolerate in others--if we can have the consolation, indeed, the pleasure of understanding those behaviors (and thus of feeling effective). (p. 102)

Wachtel further suggests that a method of coping with countertransference is to better handle the patients' characteristics that evoke it: herein, wordlessness and somatization. He avers countertransference abates when

one feels competent in the presence of a patient, when one feels one knows . . . how to be therapeutically effective. . . .In general, the influence of unconscious conflicts and of residues from one's early history is most evident where ambiguity is greatest. Structure, in turn, helps to keep such influences in check and to create a relatively conflict-free zone. (pp. 12-13)

In the absence of structure and when one feels under-trained in a particular area of therapeutic functioning, Wachtel suggests that one's skills are then particularly

vulnerable to the stresses and pressures that are an inevitable part of therapeutic work and to the winds of countertransference. Moreover, for the same reason, this aspect of therapeutic functioning is more likely to be influenced without the therapist's even being clear that such influence has occurred. (p. 14)

Although Wachtel's (1993) discussions above are written about therapeutic communication, his words are richly applicable to any area wherein one feels one's training is insufficient to the task: herein they have been applied to the work with somatizing patients that is currently so lacking in training and is without firm theoretical support.

It is suggested that in addition to fully experiencing, carefully analyzing, and thoroughly utilizing practitioners'

countertransference, patients' symptoms also be addressed. The next chapter addresses patients' somatization and affective disarticulation with the hope of better understanding the patient's symptoms that evoke the countertransference. It is suggested that these combined processes--increased experiencing, analyzing, and utilizing countertransference and better understanding of somatization and emotional wordlessness--will set in motion an intertwined helix that lessens clinicians' countertransference and increases practitioners' understanding, patience, empathy, and efficacy.

### Chapter Summary

In this chapter, the scope of countertransference was enlarged beyond the expectable countertransference themes detailed in Chapter 2. It proposed including clinicians' somatic phenomena and clinical language as part of the countertransference reactions available for experience, analysis, and utilization.

It was posited that within an enlarged concept of countertransference symbolic and verbal communications of preoedipal and presymbolic patients eventually are to be located. Rather than attempt to manage or abolish countertransference, its full experience, its careful analysis, and its thorough utilization are explored. It is therein clinicians' unconscious minds can potentially understand those of their patients, supply some of the needed input to create the initial

steps for the development of potential space, and thereby eventually facilitate verbal expression of hitherto silent and somatic communication.

Lastly, it was suggested that a commonground exists upon which both the experience and analysis of clinicians' countertransference and patients' symptoms rests. This common basis comprises the combined facts that patients, particularly those who are less neurotic and more primitive, may be discovered within the countertransference and that effective ideas for better handling patients' symptoms allows for the creation of fewer countertransference responses.

### Chapter Three Notes

1. Gendlin, for his development of experiential psychology, was chosen by the Psychotherapy Division of the American Psychological Association to receive their first "Distinguished Professional Psychologist of the Year" Award in 1970.

## CHAPTER FOUR

### UTILIZING SYMPTOMS

#### Introduction

This chapter, proceeds from the commonground joining the experience and utilization of countertransference--to somatization and affective wordlessness--and utilizing the symptoms themselves. It opens with examples of psychodynamic treatment scenarios typically offered to somatizing patients. Following, somatization is examined as a symptom that may be put to use--in a therapeutic construct of a "somatic language" (e.g., McDougall, 1978, 1989)--employed by somatizing patients and containing somatic expressions of memory. These may be similar to "sensory motor memory" (Piaget, 1936, 1946), "sensori-motor affective level of experience" (Werner, 1948; Schachtel, 1959; Werner & Kaplan, 1963), and "somatopsychic memories" (Mahler, 1968).

Traditionally, grist for the analytic mill is expected to enter treatment via patient's words--slips of tongue, dreams, acting in and out of treatment, etc.-- all of which is, eventually, verbally encoded and communicated. Consciously or not,

practitioners often believe that only the material that can be, and is, verbalized has value for treatment. This may engender the sense that the patient's body is not quite physically present in the consulting room. However, affect is always somatically based (Darwin, 1872). Although not suggesting therapists are unaware of the soma, the literature indicates that they rarely feel secure in knowing what to do with somatic material and because the level of theory is not yet integrated, they might experience difficulty examining their usual treatment of somatic material (e.g., Karasu, 1980; McDougall, 1978, 1989). However, so doing may improve treatment outcomes with somatizing patients and increase the frequency, precision, and efficacy of already successful interventions with any patient.

### **Three Psychodynamic Treatment Modes**

The literature, collegial discussion, and supervised clinical work engendered the following overview of three currents in treatment typically made available to somatizing patients. This is not an exhaustive survey of the range of extant clinical models; that is well beyond the scope of this study. Rather, it is a short description of three prevalent modes of working with somatic symptoms in psychodynamic treatment.

In Chapter 2, the reader was introduced to the French autobiographer, Marie Cardinal, whose profoundly moving story,

The Words to Say It (1983), details her arduous search, first for medical, then for psychoanalytic treatment of her somatic symptom--ceaseless, life-threatening uterine bleeding<sup>1</sup>. Her analyst employs a treatment alternative diametrically opposed to the one suggested herein: after requesting an initial full accounting of their somatic symptoms, he prohibits patients to speak of them again--he considers somatic symptoms resistive. However, seeing them as such still permits the dyad to pose the question against what psychic issues are the somatic symptoms defending. This allows that somatic ailments have communicative value, nonetheless. Since somatizing patients frequently lack psychological mindedness, difficulty arises when practitioners attempt to interpret somatic symptoms--particularly, as resistive. Forbidding the topic relieves therapists of listening to material that is initially uninterpretable for lack of patient symbolic comprehension, and is often boring and repetitive. In this scenario, the hope is that patients are thus forced to find other ways to express the psychic content of their symptoms. Patients either succeed in developing alternative means of expression and the technique succeeds, or treatment fails. This technique bans the discussion of the symptom, and would probably prohibit the symptom itself, if it could. It is suggested that Cardinal's treatment was successful because she was a pre-symbolically traumatized somatizer who was quite symbolizingly adept, and was therefore more able to find alternative means of communication than the alexithym-

ic or 'ordinarily' somatizing patient would be. However, it is again suggested that in banning discussion of the symptom, material necessary to the treatment is lost, for any somatizer.

Alternatively, in line with McDougall's work (1978, 1984, 1989), this study encourages somatizing patients to delve into all the nuances, vagaries, associations, and vicissitudes of their somatic symptoms. This suggestion extends to those somatizers who do not naturally address their somatic complaints in treatment, as well. The recommendation is that practitioners join their patients: being very active; asking questions; listening intently for nuances of difference in form or content of the symptom from one session to the next; and pursuing those alterations. The view guiding this position is that somatic symptoms may be utilized positively--as communicative of the psychic difficulties that prompted the creation of the ailments in the first place. Since somatizing patients offer a dearth of the expected production--words about core psychic issues--it is suggested that instead, the plethora of their production of somatic symptoms be made a major focus of treatment and utilized. Inquiry into initial experience of the problem, when it seems to be worse, and what else is occurring in their lives at these times are examples (elaboration is offered in Treatment section, below). This process may offer therapists some of the needed, and comforting, structure that

is so lacking in the present level of theory of, and technique for, work with somatizing patients.

Making their symptoms a focus of treatment may begin as simply an invitation to share their somatic phenomenon. For instance, when suggesting to any patient that they say anything that comes to mind and that those marginal thoughts are valuable material, this "fundamental rule" might be augmented for somatizing patients. It may be suggested that they also include any somatic occurrence or development and that these, too, are important contributions--thus reframing the symptom from an obstruction to treatment to a contribution. This therapeutic alternative both intensifies and utilizes, rather than bans, the attention some somatizing patients dedicate to their somas and encourages them, and the more reticent others, to become investigative. Although protracted and repetitive, as all treatment is with affectively disarticulate somatizers, this technique appears to meet with somewhat more success than the others.

There is a third prevalent position among practitioners, wherein therapists, having repeatedly and unsuccessfully attempted interpreting, have ceased to consider somatic symptoms appropriate grist for the mill. Although allowing patients to discuss their symptoms, the difficulty in this position, is these practitioners do not join their patients in attending to the soma, or utilizing the communicative value of its symptoms. It is quite understandable that this occurs. At least

two factors contribute to the creation of this problem: North American English-speaking society is relatively divorced from the soma (Older, 1982; Montagu, 1971) and, as a result, we all suffer alienation from our bodies; didactic analyses and professional training institutions typically do not address the soma or our relationship to it. Both members of the therapeutic dyad are thus likely to bring to the consulting room unanalyzed material related to somatic issues.

However understandable it may be that many therapists do not fully understand utilization of their patients' somatic symptoms, the result is, nevertheless, unfortunate: patients are left alone in their psychic and somatic suffering; while therapists are left to wait for patients to move on to topics professionally deemed more useful--the interpretation of which somatizing patients may accept. In this scenario, since somatic symptoms are neither banned nor utilized, they are merely tolerated. These practitioners are in a bind: they are left with little interpretable material. The therapists taking this middle road suffer the drawbacks that result from the other techniques--the oft-times boring reiteration of symptoms and the inability to make interpretations apt to be received--especially, of resistance. Further, they cannot enjoy the benefits provided by either of the other techniques--interpretable material derived either from fully viewing somatic symptoms as communicative or from alternative means of expression patients may develop when discussion of their symptoms is prohibited.

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This practice, because it neither bans nor utilizes patients' somatic phenomena, is apt to create the leaden result of both the most frustration to therapists and the least clinical success for patients.

### **Utilizing Somatization: Somatic Language**

When the new-born is loved and accepted and its mother able to communicate its welcome by the touch, tone of voice, and facial expression with which she holds and ministers to her infant, all may proceed well. However, if not, and the baby is unappreciated, clearly, it cannot yet comfort itself with any understandings of its mother's overarching burdens, aversions to particular behaviors or tasks, or any other possible causes for the rejection. The baby's self, the baby's body, is then neither appreciated nor welcomed. McDougall (1978) suggests infants "know" their mothers' feelings and, further, "outside of what he represents for his mother, the baby has no psychic existence" (p. 252). Although it is suggested herein that her statement is broader than probable, McDougall does dramatically highlight the potential impact on the infant of such a rejection. Some clinicians (e.g., Bettelheim, 1967; Freyberger, 1977; Tustin, 1986) suggest babies thus rejected at such early times are less able to fully integrate their bodies and may view their bodies in a more autistic manner. Clinicians unsensitized to their patients' somas, may unwittingly retrauma-

tize those with this particular infancy by reenacting their early experience that so lacked somatic appreciation and welcome. Additionally, most patients are apt to experience the omission of the soma from treatment as one that ignores large parts of themselves: their physical selves. Obviously, good treatment enables patients to feel accepted. Increased clinical attunement to, and ideas about, the soma create an ambience in which any patient may feel more wholly, and more holistically, welcomed. While useful for most patients, it is suggested herein that this attitude is necessary for affectively wordless somatizers. Further, that welcoming and even spotlighting the soma may also ameliorate the many countertransference issues frequently engendered by the dearth of verbal communication, by repeated episodes of somatization, and by the lack of both theory and technique.

There are, of course, limits to the analogy of attention offered to patients and that typically available to infants. Most communication with infants is accompanied by kinesthetic and tactile stimulation. This is most emphatically not being recommended herein. This study, addressed to practitioners trained in psychotherapy, suggests strict adherence to the "thou shalt not touch" dictum. Clearly, the body is a sensitive expressive and receptive organ and is to be treated with the respect afforded any other aspect of the patient. It is suggested that the soma and its productions are afforded the attunement, interest, respect, resonance, play, and creativity

normally attendant to any and all patient productions. Wrye and Welles (1994), discussing "preverbal bodily based transferences and countertransferences," insist that

however urgent the patient's desire for actual bodily contact, the work remain exclusively in the domain of fantasy and words. . . . [If otherwise, it would foreclose] the creation of a narrative space for inchoate material, [which] permit[s] . . . the translation of preverbal bodily feelings into some kind of narrative coherence in order to foster therapeutic transformation. This applies equally to bodily experienced transference phenomena and to bodily based countertransference. (p. 62)

Weiner (1974) suggests that healing, whether psychological or physical, must contrive to "heal the mind-body split." Despite present knowledge of brain physiology that reveals far greater functional complexity than that to which he refers, Weiner's view is still generally applicable when he suggests that human brain structure reflects this split: that the left cortex basically subserves language and cognition while the right, the

emotionally empathic and intuitive prelanguage functions. In short, the abstract codification of experience begins to dominate and even replace primary experience. (p. 46)

Stern (1985), describing the complex interpersonal sensory-bodily matrix in which language develops, notes the positive achievement and power that language acquisition represents as well as the loss of the ineffable, unnameable mystery and magic of the world before words. He asks us to ponder the fate of the **experienced** patch of yellow sunlight dancing in the

crib, once it has been named. Ogden (1989), interpreting Lacan's (1953) work, notes that

In becoming . . . capable of using symbols to interpret our experience, rather than simply being trapped in our own lived sensory experience, we exchange one form of imprisonment for another. We acquire human subjectivity at the cost of becoming profoundly alienated from our immediate sensory experience . . . In this way, we unwittingly engage in a form of self-deception, creating for ourselves the illusion that we express our experience in language, while we are in fact, according to Lacan, misnaming and becoming alienated from our experience. (p. 198)

Shachtel (1959) ascribes to language two functions: one of articulating and the other of obscuring. He observes that

like the search for truth, which never reaches its goal yet never can be abandoned, the endeavor to articulate, express, and communicate an experience can never succeed completely. (p. 296)

Bucci's (1985) research on verbal and nonverbal cognitive systems details increasing degrees of separation from primary experience created by the symbolizing steps in linguistic codification, communication, decodification, association, and recommunication of experience that occur in the cycle of patient communications and practitioner interpretations transpiring in typical dynamic psychotherapy sessions. Cited in the Introduction to this study, Anzieu (1990), too, discusses alienation from primary experience. His viewpoint centers on the increasing separation from our bodies as a product of the progressive industrialization of society. He believes society is degenerating to the point wherein the body of today has replaced sex of Freud's day as the primary object of repression. These

views suggest that if there are cogent data available to lend support to the construct of a somatic language, it would be useful to do so. The construct of somatic language could not only prove useful in work with primary experiences of all patients, but because of their affective disarticulation, it appears a virtual requirement for work with wordless somatizing patients. When some somatizing patients do connect, finally, with affect and memories, it may be a raw, primitive, unprocessed experience (e.g., Giovacchini, 1993). These views suggest somatizers may unconsciously live closer to lived experience: without distortions, inherent in naming it; and/but also without words to express it, also inherent in the naming.

That the "soma" "speaks" has been noted by others: Conger (1988) suggests the "body that hides beneath clothes often blatantly expresses what we consciously deny" (p. 107); Darwin's (1872) research demonstrates bodies always involved in present emotion and even in recall; van der Kolk (1996) indicates that physiologies chart traumatic histories; Baum and Sterner (1988) note that a "person's history is locked in the muscles as surely as it is locked in the mind" (p. 124); and lastly, Weiner (1974) suggests that the body

sustains us even when we do not. When we refuse awareness of our experience our body takes over the task of knowing and remembering, feeling and reacting, defending, attacking, and fleeing. The body knows what the mind knows not. . . . Our science and art of therapy will open vast new vistas as we increasingly steep ourselves in the as yet strange language of the body. The conscious 'mind' or 'ego' may yet be rescued from its alienated futility as we restore the mind to its body. 'Where mind is,

there shall bodymind be,' should be our battle cry.  
(p. 48)

### **The "Soma" Enters Treatment**

Somatic communication comprises all the body's experiences and memories expressed on a continuum from the prosaic to the dramatic, from a yawn to a conversion reaction. Any patient's somatic realm enters the treatment room in the form of their real bodies; their somatic behaviors; their body images; and their beliefs and feelings about the above. Since we may all somatize, patients not considered somatizers nevertheless may bring in somatic disturbances and voiced complaints or ailments; unvoiced ailments or silent suffering; and non-ailments including gesture, facial expression, use of interpersonal space, tics, posture, movement, stiffness, atonicity, etc.

Somatizing patients bring in all the above and more. As mentioned in Chapter 1, somatizers add their

organ malfunctions and other conditions in the etiology of which psychological factors play a prominent role; the perpetuation of unhealthy habits and conditions; and unconsciously caused bodily injuries and malfunctions. (Robertson, 1988, p. 80)

The following compilation, detailed in Chapter 1 and abbreviated for repetition here, comprises Maley's (1988) and additional categories of the forms somatization may take:

1. physiological responses due to high states of arousal and autonomic imbalance--generalized "stress" responses;
2. physiological correlates of emotion;
3. "conversion reactions";

4. neuromuscular or visceral habitual patterns of responding to stress, e.g., Reich's body armor;
5. the symptoms of clinically recognized psychosomatic illnesses, such as some forms of asthma or arthritis;
6. body-image distortions or hallucinations from drug reactions or defensive splitting; and
7. indirect communications of psychic material including secondary gains from illness and pleas for help, comfort, attention, contact, control, or understanding.

These are the ways the somatizer's body enters the consultation room and it is these phenomena that warrant the attention of practitioners working with somatizing patients. The modes of thinking examined in the following sections may be usefully applied to these phenomena.

### Symbol or Signal

There is on-going debate about the possibility of psychic content in psychosomatic symptoms. It began with Freud's (1910) distinction between conversion symptoms that he averred have symbolic bases and, as such, are accessible to psychoanalysis and the other psychogenic somatic disturbances he believed to be inaccessible to psychoanalysis for want of symbolic meaning. Distinguishing between a neurotic, ergo oedipal, hysterical formulation, on one hand and disturbances stemming from a much earlier level of organization on the other, he suggests the latter's lack of symbolic content is predictable in that it stems from a preoedipal and presymbolic period of development. Glover (1949) agrees with the lack of symbolic content and, believing that psychosomatic disorders result from ac-

crued excitation finding release at a point of physiological vulnerability, states that although they are

influenced by psychic reactions at some point or another in their progress, have in themselves no psychic content, and consequently do not represent stereotyped patterns of conflict. Should they develop psychic meaning, it may be assumed that a psychoneurotic process has been superimposed on a psychosomatic foundation. (pp. 170-1, cited in Strean, 1996, p. 28)

Strean disagrees. He and others believe that personality dynamics, and so their psychic meanings, typically found in patients with somatic dysfunctions play a role in the development of somatic disorders (e.g., Dunbar, 1946; Fenichel, 1945; Alexander, 1950, 1952; Alexander, French & Pollock, 1968; McDougall, 1978, 1982a, 1989; Strean, 1996). Further, Alexander (1952) contends psychosomatic disorders have specific content and meaning; specific conflicts give rise to predetermined somatic disturbances--a sort of universal, consensual, and thus, truly symbolic relationship. To date, however, further research has failed to confirm this one-to-one correspondence between symptom and psychic meaning. Although this author believes Alexander's efforts were in the right direction--the communicative aspect of somatization--he overreached his data. He tried to take somatization past a signal, or a "tendency toward," or even an idiosyncratic symbol--a step too far--to a universal symbol.

Fonagy (1991) suggests that the genesis of psychosomatic disturbance may be directly related to an inability to "mentalize" or symbolize affective psychic states. Prior to sym-

bolic competence, this inability may have been caused by overwhelming trauma (Winnicott, 1963?); cumulative trauma (Khan, 1963); attachment difficulties (Ackman, 1996; Fonagy, 1991); privation, as opposed to deprivation, within the maternal matrix (Winnicott, 1963b; Giovacchini, 1993); or a combination of these. McDougall (1978) suggests similar genesis and, in agreement with both Glover (1949) and Freud (1910) above, believes there is a lack of organized symbolic meaning in psychosomatic disturbances, and notes that in discussing these phenomena

we are concerned . . . with the representation of the body and the capturing of affective accompaniments of instinctual presentations, it is highly probable that the phenomena associated with psychosomatic pathology have to do with psychobiological processes of a primitive and preverbal order, and that these have failed to be transformed into authentically symbolic processes capable of psychic representation. (p. 438)

However, she also suggests that the symptoms may be thought of as communicative, nonetheless.

Agreeing with McDougall, it is suggested herein that somatic phenomena are communicative but as signals rather than as symbols. For example, Hamilton (1996) notes important fundamental differences between statements such as the following:

1. The infant cries because it is distressed--mother hears it.
2. The infant cries to inform the mother of its distress and to call her to its aid.

In the second instance, questions arise concerning the baby's intent and the symbolic meaning of the cry. The cry becomes a symbol for the distress which is raised, on purpose, with

intent, to communicate with its caregiver. Although this may develop, it is not suggested as true for the neonate which is more like the first instance in which these questions are not issues. However in either event there is something to be perceived, whether or not it is symbolic or intended as communication. It is fair to assume that Hamilton, in speaking of intent, is addressing that of the infant and not a teleological sense of a creator or an evolutionary process that "designed" the species' infants to cry symbolically and its mothers to receive the message and respond correctly. In other words, there is meaning to the infant's cry but it is not necessarily symbolic or with intent. Further, infants can only be said to communicate if there is someone to receive, understand, and respond. This transpires without the necessity of postulating either symbol or intent. The cry, as signal, not as symbol, can be said to be communicative, whether intended or not, as long as there is someone attuned to receive its meaning. And so it is with somatizing patients. It is in this context that the construct of a "somatic language" is proposed as a means of attuning to the meaning of somatic disturbances, whether symbolic or signal.

Basically, McDougall (1978, 1984, 1989) suggests that the somatic symptoms of many patients do idiosyncratically represent, for them, clinically important psychic material. It is suggested herein that somatization thus usefully may be viewed as a non-universal, non-consensual, non-verbal, non-symbolic

foreign language whose grammar and syntax are idiosyncratic to the patient and are, as yet, an alien concept to many practitioners. In the context of considering somatic symptoms as signals, we may understand them to be unconscious unsymbolized affective psychic content that patients are unable to, or too frightened to, symbolically represent. Therefore, although a universal symbolic language of the soma has yet to be successfully propounded, the construct of an idiosyncratic or personal somatic language, fairly and usefully, may be postulated.

In another vein, although dreams are symbolic because their psychic content is represented, their "language" is generally not thought of as a universally symbolic language but rather as an idiosyncratically symbolic one. In other words, in a patient's dream a snake, for example, could be a phallic symbol. It would not be unusual. However, without this particular patient's associations to this particular dream occurrence of the snake, the meaning of the snake in this particular patient's particular dream remains unknown. However, the utility of their analysis has long been accepted as an important tool for understanding the unconscious (Freud, 1900, 1911). Much attention has been paid to dreams; techniques have been developed to decode and utilize the psychic messages encoded therein; they are considered the "royal road" to the unconscious. It is proposed that it is useful to apply similar reasoning and techniques to apprehending the somatic signals of unsymbolized psychic material and thereby open a much-needed-

ed road to the often non-dreaming, disarticulate, somatizer's unconscious.

Numerous parallels may be drawn between dreams and somatic phenomena. Like dreams, somatic communications can provide invaluable ore richly rewarding the dyad toiling in the therapeutic mine. Dreams typically, and somatization sometimes, may be understood as naturally occurring phenomena, not necessarily indicative of pathology but as communicative of un verbalized or un verbalizable material. Dreams and somatic phenomenon are patients' creations; the psychic contents of which are not immediately accessible and in need of the individual's associations to understand and interpret them. Like dreams, somatization may need the help of a therapist to translate and understand its meanings. Both dreams and somatic communications reappear in one form or another until the conscious mind receives and works through the psychic material within. Lastly, a patient's history and ensuing productions will validate or belie clinicians' interpretations of both.

Expectably, there are limitations to the parallels between dreams and somatization, as well. The content of dreams is symbolized but the material in psychosomatic symptoms is most probably not. While dreams are typically verbally communicated, somatization is notably non-verbal. Somatic disturbances are apt to arise in relatively immediate response to occurrences in session but there is usually greater temporal delay in the production of dreams. Also, impressions gleaned

from the literature and supervised experience, are that dreams are more typically remembered and reported by the more psychologically minded patient than by the more concrete somatizer; and that somatizers report somatic symptoms more usually as complaints than as phenomena to be explored and understood. In these last two instances the difference is not so much between somatic symptoms and dreams, *per se*, as it is between somatizer and dreamer. The last and important difference between the dream and the somatic symptom is that practitioners are typically well trained and experienced in the process of dream analysis and this is not yet so for the analysis of somatic symptoms.

Familiarity with the occurrences of a patient's day before the reported dream helps in understanding the material in the dream. Asking detailed questions of somatizers about what happened, internally and externally, just before the somatic symptom initially developed, or its more recent fluctuations, is useful in determining the stimuli at work in the somatizing process. Clearly, associations to their symptom and its stimuli elicited from wordless patients are apt to be less than bountiful, certainly less than those produced by the typical analytic dreamer, nevertheless, eliciting meager information is infinitely better than none for want of investigation.

Clinical response to a patient's offer of dreams is most welcoming. Dreams are cherished as access to the unconscious and assets to treatment. A similar reception, clearly, does

not typically await the patient's presentation of somatic disturbances. Generally, these are viewed as defensive or resistant--as obstacles to treatment. However, if clinicians come to appreciate, understand, and utilize somatization; to understand it as idiosyncratically significant, if not symbolic, a different therapeutic ambience ensues. It is one in which patients would feel somatically, as well as psychically, more wholly welcomed into treatment; one in which they may experience less shame over their inability to control their bodies. Not only is the patient more wholly welcomed but the clinician, in that welcome, has modeled that which Maley (1988) suggests is a requirement for the somatizing patient to learn--acceptance of the symptom, generally, and as a potential window, albeit "through a glass darkly," into psychic life, specifically. Herein, it is further suggested that without the clinician's belief in the same, the acceptance of the symptom cannot be modeled and the patient cannot learn it. The very somatization that previously created shame for patients, becomes transformed into an important contribution to their therapeutic progress in which patients can certainly take interest, and eventually even possibly, pride. An additional route is opened to the oft-silent elusive unconscious of the affectively disarticulate somatizer.

There is much that can presently be learned about an individual patient's somatized phenomena. Therapists need to

know more than the sole fact that a patient somatizes. As in psychodynamic work with dreams, the particulars about the somatic symptom are needed: where in their bodies; when in their lives; what occurred internally and externally just before the symptom arose initially and subsequently; what occurred internally and externally just before their symptom was exacerbated or abated ("just a little bit"); associations to all of the above; and lastly, what made it necessary for the patient to create the symptom, both generally and in its particular form. Although the capacity to somatize originates in infancy, for somatizers it is nonetheless the expressive medium of choice for issues both present-day and infantile.

As anecdotal material is about to be proffered, a few words about ways to think about these issues may be helpful. Although, at times, American-English idioms (Appendix A) and symptoms seem to make a tidy package, in no way does this study posit a one-to-one correspondence of symptom-to-meaning, or symptom-to-linguistic idiom. Rather, it is suggested that both symptoms and language bespeak a fundamental and intimate relationship between affects and soma. Patients may offer a fantasy or a dream or "devise" other somatic symptoms that equally well, or better, signal their distress. Further, it is suggested that insights gleaned from a symptom, dream, or association, are **a** truth, not **the** truth.

The following anecdotes illustrate small, undramatic idiosyncratic symptoms, that nevertheless, bespeak "bodily expressed" present-day issues.

A patient's core issues centered on betrayal, abuse, and abandonment. She began treatment with moderate difficulty symbolizing, seven years before this reported somatic incident. However, as a pre-symbolically traumatized patient, she was not as concrete as other somatizers and was able to learn to symbolize. Her work situation at the time of these sessions comprised a trusted boss upon whom her career majorly depended. She experienced several bouts of a slightly dislocated jaw. Upon repeated and painstaking examination in therapy, she realized each bout occurred just after a minor incident with her boss that she experienced as a betrayal and a threat of abandonment. She found it quite humorous when she finally realized the pain she experienced was upon efforts to close her mouth and represented her wish to confront her boss and tell her off. It was the product of a powerful desire to "not keep her mouth shut" to "open her mouth" in a situation where she could inflict substantial damage to her career if she acceded to her wish.

In this instance the physiological mechanism that produced the symptom is quite clear, her anger produced tension that she carried in her jaw, probably through clenched teeth, and created a minor dislocation. As she worked through her material about abandonment and betrayal, her musculature relaxed and her jaw was able to slip back into place.

A patient, compelled to complete a long and onerous task, after many months of work, developed severely blistering and itching feet that regularly disrupted sleep. He had been in treatment for two years and was an 'ordinary' somatizer displaying a wide variety of not serious somatization. In this instance, a dermatologist diagnosed his condition as stress-related. Subsequent investigation in treatment indicated he had been unable to admit to himself that he wanted to abandon his task, wander, and give into his "itching feet." It also became clear the condition was a "healthy" symptom choice since it was easily treated with medication and, at its worst, did not impair his ability to complete his task. Despite the systemic antihistamine that finally relieved the itch, the

blistering persisted unabated for six weeks until a few days after he was able to acknowledge his growing wanderlust.

The possible physiological connection here is less clear. It may be due to an increased sensitivity to allergens ubiquitously present but that produce symptoms when resistance is lowered by stress over which he feels little control.

The anecdotes above present relatively short-lived symptoms that, although connected to past issues, are rather directly related to current occurrences. The following anecdote more closely typifies the difficulties that most somatizers experience: past and present psychic concerns are more enmeshed; the symptoms are of longer duration; the patient's life is considerably disrupted by them; and resolution takes years of active probing and work.

The "broken-hearted" man entered therapy in his mid 40s with an eleven-year history of radiating pain emanating from under his left scapula, making it difficult and painful for him to use his left, and dominant, arm and hand. He had unsuccessfully sought medical treatment and physical therapy for several years. He was mildly alexithymic, these were his primary somatic symptoms, and he displayed a considerable level of concrete thinking. After several years of probing for his life's story and the vicissitudes of his physical symptoms, he revealed that the greatest loss incurred due to his pain was that he had been unable to lift and hold his daughter since she turned four years old. When he realized that his symptoms had coincided with her fourth birthday, he cried, a little. It was the first time in treatment. He gained a slight increase in range of motion and slight decrease in pain. It took another year to disclose that he had had a younger sister who died when she was four years old! His family never spoke of the event, his sister, or their feelings. After this, he began to sob frequently in session. It took more years for him to become consciously angry about the tragedy and the family's stony silences, and for him to recognize how frightened he was of the degree of his anger. He was able to regain almost complete use of his arm with relatively little pain. At present, under major stress, the symptom returns but never as severely or as enduringly as originally.

Some of the physiological mechanisms became clear, as well, as he associated to his symptom and its vicissitudes. As always, the symptom is multidetermined. As his daughter turned four, unconscious feelings for and about his dead sister arose. His physical symptoms represented grief and anger that he could neither feel nor remember. His fear of his anger had chronically tightened the muscles that would be used if he were to enact anger in a punch. Unconscious grief over his early loss was at odds with his familial taboo against experiencing or expressing emotion. It was as though his muscles had pulled in to keep the affect locked in. Finally, he concluded that his heart had been broken by his sister's death and the muscles in back of it had knotted to form a protective wall--to protect him from the feelings locked in his heart and to protect his heart from further hurt.

This next patient's difficulties are also of long duration, but her symptoms created little disruption in her life. As a matter of fact, she did not mention these particular ones in treatment until a present-day event triggered their discussion.

An elementary school teacher entered treatment in her 20s. The period described herein occurred in her twelfth year. Throughout treatment she had a variety of somatic phenomena. The ones presented herein were present when she began treatment and included a hair-trigger gag reflex and frequent repeated bouts of tonsillitis. Additionally, while brushing her teeth each day, she would gag, cough uncontrollably, and occasionally vomit. These data first came to light in a session as she was relating an upsetting visit to a throat specialist whom she consulted not only for her recurrent tonsillitis but for polyps she was developing on her vocal cords. She gagged and vomited both at the throat specialist's office and again in

session as she recounted the incident. She was mortified both times. As she prepared to enter the hospital for vocal cord surgery, she became increasingly terrified. Realizing that her terror had escalated beyond what the present-day situation seemed to warrant, she posited that something from her past was contributing to her growing terror. In the weeks left before surgery she decided to utilize self-hypnosis in her sessions to help control her steadily-mounting terror and to possibly help her recall her past. Very foggily, she recalled an image of being very young, pinned on her back with her nose held as she violently shook her head from side to side and attempted to keep her mouth closed. Eventually it coalesced into a memory of fellatio forced upon her by her adult uncle when she was about three years old and about which he had forbidden her to speak. She actually entered the hospital feeling calmer than she had in weeks! Much work was later done with her memories, and she has not had a bout of tonsillitis since her polyp surgery. Although while brushing her teeth she sometimes still gags and coughs, it is minimal, less frequent, and no longer escalates to vomiting.

The gagging and vomiting appear to need little explanation beyond that of physical reenactment of a response to an early event; a body memory. Vocal cord polyps are relatively common among school teachers but it is suggested that there was the additional stress of having been a secret-keeper within her family. As such, she may have developed an habitual contraction of her throat to prevent her words from coming out in full voice. However, it is more difficult to posit a plausible psychophysiological mechanism for tonsillitis that presented with fever, pustules, culturable matter, and was responsive to antibiotic treatment. It is, nonetheless, a way she found to scream her distress since her voice could not.

The point of these examples is that the clinical work is essentially the same regardless of the material patients bring in. It is the same for dreams, memories, slips of the tongue, physical enactments, and any and all somatic phenomena. The

goal is to assume it has meaning, even if not symbolic, and to explore and develop the personal meanings involved, whether symbolic or signal. Although the level of theory regarding the exact mechanisms and interrelationships of psyche and soma is, as yet unclear, this approach does appear to work on the heuristic level. However, no matter how neatly a somatic symptom and an English idiom may coincide, this study does not mean to imply that only one particular symptom will suffice to signal any patient's particular psychic difficulties.

### Contents of Somatic Symptoms

The precise nature of the psychic and physiological mechanisms that produce somatization, either in the somatizer as a regular occurrence and in the rest of the population as an occasional event, are as yet undetermined (e.g., Karasu, 1980; McDougall, 1978, 1989; Strean, 1996). Although, there are many avenues presently under investigation and the field is rife with possible answers, both physiological and psychological, none has yet integrated the available data. Therefore, this and following discussions suggest metaphors or constructs for thinking about the processes rather than the specific mechanisms leading to somatization. As there are many manifestations of somatization, there are also varied contents of somatic expression. The following list, indubitably incomplete, is drawn from collegial discussion, supervised clinical experience, and the literatures:

1. Patients may generally be unable to experience or represent emotion, both from the past and in the present, e.g. the alexithymic (Taylor, 1987; Nemiah, 1977; Sifneos, 1973). Fonagy (1991) and Ackman (1996) discuss how the capacity to experience emotion psychically, or the ability to represent it verbally, may not fully develop perhaps as a result of attachment difficulties with a mother unable to represent affect, either her own or her infant's. Wolf (1992), a developmental linguist, describes this as a lack of "narrative attunement." The adults developing from this early scenario, unable to psychically represent affect, frequently present somatic disruptions and ailments as a remaining route available for expressing emotion. Their affective disarticulateness is pervasive and steady.

2. Patients may utilize the soma as a means of physical identification with, or representation of, a significant object from early life. When this is primary, verbal emotional discourse may be minimally- or un-involved.

3. Patients may have suffered trauma prior to the establishment of symbolic competence. In the instance of developing egos overwhelmed by trauma, a developmental arrest or an internalized agency maintains the inability to achieve psychic representation (Davies & Frawley, 1994; Pearlman & Saakvitne, 1995; van der Kolk, 1996). Somatization is a common occurrence among pre-symbolically traumatized patients and their verbal expression of emotion may be attached solely to the

sequelae of trauma. In Chapter 2, Winnicott's (1963?) quote was offered as a way of conceptualizing its occurrence, it bears repeating here. He posits the original trauma is a

fact that is carried round hidden away in the unconscious. The unconscious here is not exactly the repressed unconscious of the psychoneurosis, nor is it the unconscious of Freud's formulation of the part of the psyche that is very close to neurophysiological functioning. Nor is it the unconscious of Jung's . . . world mythology. . . . In this special context the unconscious means that the ego integration is not able to encompass something. The ego is too immature [or the stimulus too overwhelming] to gather all the phenomena into the area of personal omnipotence. (pp. 90-91)

4. Patients having sustained overwhelming trauma after the establishment of both symbolic and linguistic competence, may still suffer sequelae similar to that of patients traumatized in earlier life (Schur, 1955; Krystal, 1978). These sequelae occur as a cluster including somatization as well as disturbances of memory, language, learning, relationships, and world view (Pearlman & Saakvitne, 1995). The severity of the syndrome varies with the duration of the trauma and the age of the individual at the inception of the trauma (van der Kolk, 1996).

5. Elaborating on the above and referring to later developmental levels, Schur (1955) and Krystal (1978) suggest that in the beginning of normal development, affects are primarily somatized. They believe if trauma interrupts development at that point, the individual will experience difficulty achieving the more advanced desomatized level of emotional development. Further, if trauma overwhelms more developed egos, the

achieved developmental advances may be vitiated and both emotional experience and expression may become resomatized. In either event, substantial emotional expression remains or becomes somatized.

6. In childhood, the expression of emotion, or a particular emotion, may have been forbidden. Although patients presently may be able to experience and represent emotion, they may remain under the sway of the childhood taboo and be too frightened to do so. In adulthood, the agent forbidding affective expression may still be another or may have become internalized. In either event, affective expression is thus likely to be somatized with disturbances of verbal expression connected almost solely to the forbidden emotional areas.

7. An otherwise emotionally articulate adult, under particular stressors triggering memories of a singular and traumatic event, may revert to the pre-linguistic, pre-symbolic state that existed at the time of that event and, thereby, produce an isolated event or period of somatization and probably profound affective wordlessness about the particular constellation of issues.

8. In general, expression of present emotion may be somatized because the methods of experiencing it psychically have not yet been learned or verbal representation is unavailable. More insight into this issue might be gained by investigating whether there is a greater tendency to somatize among linguistically challenged persons (e.g., aphasics; mutes untrained in

sign language; lone immigrants as yet unable to effectively communicate in the language of their new country; etc.).

9. The converse may also be true: the psychic understandings are available but the physical body is unable to demonstrate affective knowledge, as in the following example:

A female patient in her mid-thirties entered body therapy, a combination of hands-on Feldenkrais and Alexander techniques addressing only the soma. Although she had completed a long and successful psychoanalysis, she continued to experience the same somatic complaints with which she had entered analysis. These included various upper and lower back difficulties and a pronounced shortness of breath. After three sessions, her somatic symptoms resolved and her body's stance and posture sufficiently softened to allow her hard-won psychoanalytic insights to finally appear in her soma. In her fourth and final session she recounted that during the previous week, she had passed different friends on the street and at work who had not acknowledged her. As she stopped them, each expressed surprise that it was she--her new physical Gestalt was unfamiliar to them.

It is suggested that it may useful to think about this patient as though she had gained symbolic verbal and psychic knowledge of the affective contents of her somatic symptoms during the course of her analysis, but her body had not learned how to release habitual postures in order to physically incorporate that psychic understanding and express it somatically. Body therapy taught her body to release the old somatic habits and enabled it to better reflect her present level of psychic insight.

The contributing factors to somatization and affective disarticulateness are probably many and varied. Obviously, the above-suggested possibilities, and others, may occur in any combination. The key that may unlock the factor(s) con-

tributing to any patient's somatization is active, protracted, and detailed investigation. As the factors contributing to somatization are manifold and complex, so too are their possible meanings. One to one correspondences of symptoms to meanings--universal somatic symbols--have neither been established nor are they herein suggested. Rather, it seems somatic symptoms represent personal signals of verbally unsymbolized experience.

### Gender and Behavioral Considerations

In the course of researching this study, questions about the connection between gender and pathology arose. They evolved into a consideration of the expression of pathology as reflected in the uses to which each gender appears to typically put the soma. Since this interest is beyond the scope of a dissertation already wider than optimum, neither much research, time, nor thought has been spared for it. However, herein is the yield of the small foray into the area.

That which cannot be verbally expressed is often enacted.

Cited in Chapter 2 and employed again, Fonagy (1991) notes the

absence of mentalizing function . . . leads to a tendency to "act out" [enact]. . . because the ability to decouple mental representation from reality is vulnerable or absent. (p. 651)

Van der Kolk, Weisaeth, and van der Hart (1996) aver

People . . . traumatized as children have been shown to tend to act rather than to reflect. (p. 64)

This observation appears generally known within the context of violence and impulsivity. It arose as a question, too, whether hyperactivity, another form of motoric behavior, might similarly stand in lieu of reflection and/or affect. Although a single case, the first anecdote below (Body Memories)--a hyperactive little boy--suggests that, at least in his case, hyperactivity may also stem from the inability to symbolize. Most cogent herein however, this study is predicated on the observations that people unable to verbalize core affect also tend to somatize. These phenomena, enactment and somatization, have both been thought of by some as a form of release of pent up tension (e.g., Glover, 1949). Whether a product of tension, difficulty mentalizing, or tension pursuant to the inability to symbolize, it is posited herein that gender may be associated with the "selection" of symptom.

The following data are derived from the DSM-IV (1994) unless otherwise noted.

Hypochondriasis (4-9% of general medical practice) and Pain Disorders (10-15% of general population) tend to appear equally among men and women. However, the incidence of Somatization and Conversion Disorders is heavily skewed toward woman as high as 10:1. Early trauma is implicated in the etiology of Somatization Disorder (e.g., Toner, 1995). Between 10-20% of Somatization Disorders' female relatives also have Somatization Disorder and the male relatives of both Somatization and Conversion Disorders are "highly correlated" (DSM-IV, 1994) with Antisocial Personality Disorders (APD).

The etiologies of Dissociative Identity Disorders (DID) and Borderline Personality Disorders (BPD) are frequently associated with early trauma (e.g., DSM-IV, 1994; Seeman, 1995; Yonkers & Gurguis, 1995; Toner, 1995; Zanarini, 1997). DID is expected among females 3-9:1 (women average 15 or more personalities and men approximately 8). Among persons diagnosed with BPD, 75% are women and families of BPDs are likely to

contain persons with APD. It has been noted that BPD patients frequently have difficulty using language in consensual and conventional ways (e.g., Balint, 1968; Fonagy, 1991). Impulsivity and self-mutilative behaviors are likely in both groups (DSM-IV, 1994) and many are expected to somatize (DSM-IV, 1994; Kimble, Oepen, Weinberg, Williams, & Zanarini, 1997). The DSM-IV (1994) notes differential diagnostic controversies between DID and, among other mental disorders, Somatization. BPD and DID patients likely comprise a considerable portion of the pre-symbolically traumatized somatizer group discussed herein.

Antisocial Personality Disorders (APD--3:1 in general population), Attention Deficit/Hyperactivity Disorder (AD/HD--4:1 in general population, 9:1 in clinic population), and the rare Intermittent Explosive Disorders reflect a heavy preponderance of males. Conduct Disorders (3:1 in the general population) and Oppositional Defiant Disorders are also heavily skewed toward the male population when young, but become more evenly distributed after puberty. As the correlate of the discussion above, people diagnosed with APD are highly expected to have female relatives who have Somatization Disorders, Conversion Disorders, and BPD. The data on Learning Disorders (Reading Disorder are 6-8:1) and Communication Disorders (3:1) also demonstrate a distribution skew toward the male gender.

It is difficult to know the degree of assurance one can place in any of these statistics. For example, data for Learning Disorders and Attention Deficit Disorder are suspect due to the likelihood that referrals are based on the degree of disruption students cause at school: girls may have the same deficits but, lacking the disruptive feature, they may remain unREFERRED. Further, in the DSM, Learning Disabilities are not clearly reported by type and Communication Disorders receive little attention. Minimal Brain Dysfunction (MBD), is thought to include afflictions as varied as dyslexia, dyscalculia, learning disorders, hyperactivity, and attention disorders (e. g., Small, 1982). The research cited by Small suggests a skew toward the male gender for most of the subsyn-

dromes in MBD. However, although his study is a classic in the field of early childhood special education, the edition at hand is insufficiently current to be reliable.

There are additional data herein relating to the question of the body's use by persons unable to symbolize. The following observations of alexithymia were presented, examined, and provided with citations in Chapter 1 but are recollected here in order to glimpse at their possible connection to gender and behavior. As above, somatization is typically a female problem but alexithymia, although frequently associated with somatization, is more typically a complaint of males. However, there is a difference between the connections other somatizers have to their bodies and the one alexithymics demonstrate. The alexithymic patients "freeze" their somas--they are typically divorced from all somatic experience of emotion and are wooden and stiff. Perhaps this "alexisomia," as it has been dubbed, is a clue as to why they do not demonstrate the more typically male pattern of enacting affect via the sensorimotor apparatus, as opposed to somatization. It is posited herein that their pathology is being registered in the sensorimotor portion of the soma, nonetheless: instead of action it displays as the inhibition of that same action--a frozen sensorimotor apparatus.

More typically distaff somatization (e.g., Somatization Disorder, Conversion Disorder, the 'ordinary' somatizer, and the pre-verbally traumatized somatizer), however, is not ac-

accompanied by this type of bodily freeze. A differing sort of freezing does occur in hysterical paralysis, but it does not include the same divorce from the soma typically seen in alexithymics. The literature suggests that Conversion Disorder differs from most of somatization as discussed herein in that it is apt to be of later origin, more oedipal in nature, and therefore, patients more generally able to symbolize affect and generally more psychologically minded, although not about the issues most closely connected to the conversion symptom (e.g., Freud, 1910; Engel, 1968; Laplanche & Pontalis, 1973; McDougall, 1978; Moore & Fine, 1990).

Another element this foray yielded comprises a few data about dominance that it is believed do somehow connect to this discussion, although exactly how, is as yet unclear. An unusually high percentage of boys with MBD and its Learning Disorders and AD/HD are left-handed (e.g., Small, 1982). Additionally, there is data indicating greater incidence of left-handedness among alexithymics than can be accounted for by normal distribution (Parker, Taylor, & Bagby, 1989). Lastly and interestingly, the conversion symptoms reported by women display more often on the left side of their bodies (DSM-IV, 1994). In normal distributions left-handedness represents a substantially smaller percentage than right-handedness; this author's impression is that infant boys more frequently suffer birth trauma(ta) resulting in brain damage; that dominance switches may result as defaults in response to brain damage; and that

increases in left-dominance resulting from default are more likely because there is more right-dominance to begin with (W. King, 1997). The precise interconnection of these data is clearly unclear, but a sort of pre-logical knowing suggests further research along these lines will yield fruit.

The last small piece that relates to possible connections between somatization and enactment is the observation made by McDougall (1978) that pre-symbolically traumatized, symbolizingly challenged, concrete patients often use words as acts rather than as symbols with which to communicate affects or thoughts. At such times, unknown to practitioner and patient,

the latter is revealing the effect of a catastrophic failure in communication that has occurred at a time when he was unable to contain or to work through, psychically, what he was experiencing. The traces of these early failures are confined either to somatic expression, which may be considered as an archaic mode of thought, or may give a hint of their presence by the incoherences and blanks they produce in the patient's way of thinking and feeling [and talking]. . . . [Defending themselves from the nascent feeling they may use action to fill the void left by the ejected element,] an "action-symptom." In this way talking itself may be a symptomatic **act** . . . (pp. 253-4)

It is possible that that which McDougall refers to as an "action-symptom" is a thread that may tie these components together. Speech used as an act rather than to communicate may be related to the "enactments" of impulsivity, hyperactivity, aggression, and even to the bodily freezing of action by the alexithymic. Further, both McDougall (1978) and Fonagy (1991) mention that there is a greater tendency among these patients

to be involved in arguments and these may represent enactments that use words as acts rather than symbols.

Beyond this, exactly how these data combine and what conclusions may reasonably be drawn, this author has not yet explored. However, it is tentatively posited herein that gender is a factor in determining whether patients' unsymbolized emotional material is:

1. sensorimotorically enacted, as in hyperactivity, aggression, and impulsivity; or sensorimotorically frozen, as in alexithymia--the patterns more expected of men; or
2. it is somatized as in disruptions of physical processes and somatic disturbances, or in conversion reactions--the patterns more expected of women.

If, with further research and thought, these ideas are shown to have some validity and interrelationship, clearly, it remains to inquire as to possible sources of these patterns--the roles played by: brain dysfunction/damage; testosterone; socialization; the nature of trauma to which each sex is most vulnerable; etc.

In sum, trauma overwhelming developing egos frequently results in disturbances of the capacity to symbolize and verbalize affect (e.g., McDougall, 1978, 1989; Fonagy, 1991; van der Kolk, 1996). Schur (1955) and Krystal (1987) aver that affect represented in the body reflects emotions that either never achieved the normally-developing state of desomatization or became resomatized, both in response to trauma. Simply

stated, and perhaps even over-simplified, it is posited herein that symbolizingly impaired patients are frequently products of trauma and appear to employ some aspect of the body for expressing unsymbolized affect: men tending toward motoric enactment via, or freezing of, the sensorimotor apparatus and women toward somatic disruptions of physiological processes. The construct of "somatic language" may prove useful to therapeutic work with both patient populations: those motorically enacting, as well as those somatizing.

### Body Memories

Schachtel (1959) suggests that the "location" of what he refers to as "involuntary memory" is in a sphere

vaguely described as memory of the body or, rather, of the psychosomatic entity. The forgotten experience is revived by the recurrence of a sensation which has left a record . . . behind; or it is revived by the understanding and relieving of the bodily attitudes . . . which the forgotten experience produced. (p. 315)

Werner (1948), reporting on memory experiments notes that

bodily cues are of primary importance with young children; these cues become slowly subordinated to more stable perceptual relationships as a child grows older. . . .At the primary level, the . . . response appears mainly based on bodily (sensory-motor) cues . . . (p. 166b)

Rapaport (1953) describes "somatic affect equivalents without conscious affect experience" (p. 479). Shatan (1963), distinguishes between fixed habitual postures and attitudes along the Reichian model (1933) and transitory tensions arising from immediate emotional conflicts which may result in "slips of

the body." Schachtel, Werner, Rapaport, and Shatan, writing of normal affective states, normal development of memory, and of memory that does become available for recall, eventually: all connect these phenomena to the body.

A way of understanding the idea of emotions that are unexperienced and memories that are not remembered may be to consider the experience of anniversary reactions. These are not uncommon experiences, wherein people sense vague emotional reactions, perhaps a physical feeling of unease, but, at the moment, explanation does not come to mind. This is an example of a "memory," that for the moment, may be entirely experienced in bodily sensations and is unaccompanied by cognitive elaboration. Eventually, with work, anniversary reactions are accessible to cognitive elaboration, symbols for it coalesce from the fog, "memory" becomes memory, and it can be put into words. This often brings with it a sense of relief as explanations for the vague, nagging, and somewhat disruptive feelings, become clear. However, pre-symbolically traumatized somatizers may experience these inexplicable, vague and nagging sensations of unease or even foreboding for decades. For these patients, words do not come within short time frames, as they frequently do in the case of anniversary reactions. 'Ordinary' somatizers are apt to be, and alexithymics will definitely be, more removed from affective experience than pre-symbolically traumatized somatizers, but in their somatization

they may all be representing what is posited herein as unsymbolized affective "memory" or "body memories."

In the absence of symbolically encoded memories, when cognitive representation and verbalization is unavailable, the bodily cues of somatic disturbances and ailments may be the only possible way early experience may be cued for recall. Perhaps the body and its cues are the only access to pre-symbolic representation of early experience. Further, perhaps this is the proactive "purpose" of somatization that McDougall (1978) reminds us is lacking in the present level of theory of psychosomatics. As mentioned earlier, Bauer's (1996) research on infant memory indicates verbal recall of ordinary events in childhood is predicated on verbal competency at the time of their occurrence. For events occurring prior to both expressive and receptive verbal competence, and certainly for those occurring prior to symbolic competence, bodily cues may be the only available source of information. Bucci (1993) posits three coexisting cognitive systems in normal adults: the pre-verbal, the verbal, and the referential, and suggests that

Emotions are major organizing structures of the nonverbal system, composed of all the elements of that system--including sensory and motoric representations as well as visceral experience. (p. 5)

These data suggest that the body serves for the expression of unrepresented emotional experience.

Schacter (1996), reporting a wide range of recent empirical data, posits a memory system termed "implicit" memory, as opposed to episodic or explicit. Both he and Sacks (1995) re-

call the same famous incident to illustrate the workings of the implicit memory system:

[I]n 1911, . . . Edouard Claparede . . . when shaking hands with . . . [an amnesia] patient . . . stuck a pin in his hand. Although the patient had no explicit memory of this, he refused, thereafter to shake hands with him. (Sacks, 1995, fn., p. 53)

Both Sacks and Schacter note that the implicit memory system is most apt to retain incidents accompanied by the physical reactivity of emotional arousal. Schacter, discussing implicit memory, generally, among non-patient populations, describes it containing traces and impressions that are shadowy, hazy, illogical, dream-like fragments of experience, typically unattached to recognizable settings or stories. He further avers that these memories can be quite "penetrating in their emotional force" (p. 180), and cites research demonstrating the profound and pervasive influence that implicit memories have on judgements, preferences, and actions. Their impact and traces are best expressed in the visual media, as words do not facilitate their expression. Citing experimental and physiological data, Schacter avers brain structures supporting this memory system are relatively well established in utero, change relatively little after birth, and account for the memories of infants across the birth barrier. (E.g., Schacter reports a study, also cited in Stern, 1985, wherein mothers in their last six weeks of pregnancy repeatedly read aloud the same Dr. Seuss story. Their newborns demonstrated, through sucking, a preference for their mothers telling this story, rather than

one they had not heard before.) It also accounts for the ability of severe global amnesiacs, as in the quote above, to "remember" well enough to guide behavior appropriately, although not as explicit memory, and for anesthetized patients to recall occurrences during their surgeries. Schacter posits the implicit memory system serves unsymbolized psychic memory.

McDougall (1978), discussing adult patients' attempts to deal with traumatic events occurring before the acquisition of symbolic competence, observes that these events appear in analytic discourse not as thoughts or free associations but as "unshakeable facts." Experienced as facts, McDougall suggests they are not open for exploration and thereby stand in the way of the unfolding of the analytic process. It would seem that any "learning" predicated on memories acquired through the implicit memory system that Schacter (1996) proposes are unavailable for explicit recall. Therefore the learning based on them that unconsciously guides much of our behavior is likely to be particularly immutable. Attempts to mentally go back to check for goodness of fit between the implicitly remembered past experience and present understanding will be more than difficult. However, it is suggested that implicit memory contains elements of pre-logical, pre-symbolic knowledge which may be of great use to somatizing patients and their therapists. It is further suggested that if there is a way to connect to these sources, it is possibly through the body and its "stored experience."

These implicit memories are almost always unavailable for even cued recall (Schacter, 1996), may or may not be organized around specific affects, or appear as somatic emotional states or bodily states, that may or may not be organized as somatized ailments. Perhaps these memories are products of Winnicott's (1963?) "unexperienced experience"; examples of Bollas' (1987) "unthought known"; analogous to Werner's (1948; Werner & Kaplan, 1963; Schachtel, 1959) sensorimotor affective level of experience in infancy; examples of Mahler's (1968) "somatopsychic memory"; or instances of Piaget's (1936, 1946) "sensory motor memory."

Some patients with several personalities (DSM-IV [1994] --DID; DSM-III [1980] and DSM-III-R [1987]--Multiple Personality Disorder) have disparate somatic profiles correlating with their different personalities (visual acuity, pain tolerance, blood pressure, response of blood glucose to insulin, physiological ailments, pulse rates, sensitivity to allergens, symptoms of asthma and other somatized ailments) (DSM-IV, 1994, p. 485). A more relaxed personality may have a lowered blood pressure; one more emotionally willing to see may have better vision; and one less frightened may have a higher pain threshold. But how did these personalities of the same individual develop to differ in degree of relaxation, preparedness to see, or level of fear? Perhaps the differing physiological profiles are bodily products of events that formed their per-

sonalities and that each remembers, in part, as physical representations.

Some clinical anecdotes are offered as examples of what are considered herein to be body memories.

A 3-year-old boy came to an out patient children's psychiatric unit after being treated in the emergency room for a fall from a second story window. He was extremely hyperactive. He had been only somewhat hyperactive prior to 17 months of age, at which time he had been hospitalized for a medical condition and been placed in four-point restraints. Upon release from that first hospitalization, at 17 months, he became unmanageably hyperactive. He always ran, never walked, learned to open his front door and fled the apartment at every opportunity, and clambered out windows whenever no one was watching, etc. In psychotherapy, at age 3, after his third fall from windows, he was told about, and able to learn words for, what had happened to him in the original hospitalization during which he had been restrained, a year and a half previously. Within days of hearing of and discussing this event--attaining the capacity to verbalize his experience--his hyperactivity radically abated and he became mildly depressed. (Greene, 1995, personal communication)

This little boy felt compelled to overcome all restraint at any cost until circumstances could conspire to provide him with some combination of required elements. He finally acquired further development of his symbolizing function; specific data about his history and symbols for them; and an interpersonal connection to someone who could both listen and understand. Until then he had to reenact his reaction to his early restrained hospitalization. When provided with words for his earlier experience and someone to discuss it with him, it was as though he could experience and understand it, for the first time, in the Winnicottian (1963?) sense, and only then could he own the depressed emotional reaction to his now-experienced early trauma. It is suggested that his sensor-

imotor behavior stood in lieu of unrepresented traumatic events. His soma's sensorimotor apparatus behaved as "memory" of, and physical and emotional reactions to, the events of more than half his lifetime before. It is suggested that his story and the next two be considered examples of body memory, of a specific event and/or reaction to that event, that in his instance, is motorically expressed.

The next two anecdotes are illustrations of body memory as well, but in these it is somatic expression, as opposed to motoric.

A high functioning, prim woman in her forties entered treatment without evidence of somatization. However, in the second year, whenever the subject of her father arose, she evinced a somatic storm that variously included vomiting, diarrhea, constricted throat muscles, and spasms in her vaginal muscles causing intense pain and making it impossible for her to rise from the couch, where she writhed, until the spasm subsided. Her father had died in an automotive accident on a business trip when she was 26 months old. No further insight into her somatic reactions was gained in the next year and a half of treatment. Eventually, her mother was interviewed as a relatively reliable, albeit passive and naive, informant. The mother indicated that from the patient's age of three months until her father's death, she was aware that, when changing their daughter's diaper, the father would engage in digital vaginal and anal penetration, clitoral stimulation, and forced fellatio. The patient, over a two-year period, attained this knowledge from her mother. Although the patient never gained any direct memory of these events, she eventually became able to speak of her father without bodily disturbance.

Entertaining the possibility of connections between the particulars of this patient's somatic storms and specific events in her early life, offers greater treatment potential than viewing her somatic disturbances as physical upset connected to discussing her dead father. It permits patient and practitioner alike to consider the possibility that other material

raised may have associations to something with content, rather than just a release of tension.

The anecdote above and the one following are considered to be the clearest examples of body memory of these three in that complete resolution of the somatic symptom was almost immediate upon learning of an early traumatic incident. Little therapeutic working through of psychic material was necessary, or possible since, in both instances, no explicit memories were recovered. It appears that, in the last and the next cases, simply learning of their incidents was sufficient for the patients to terminate the persistent somatic message of the body memory. However, for the hyperactive three year old, above, some amount of discussion was necessary before his hyperactivity could abate.

A high functioning very verbal adult male entered analysis. Incidental to his presenting complaints was one somatic ailment, a stomachache that occurred under intense stress and that he considered unlike typical stomachaches. Over the years, his analysis proceeded well, many issues resolved, instances of stress decreased in intensity, frequency, and duration. Nevertheless, his somatic symptom persisted whenever stress occurred. The patient finally inquired of his mother whether she could think of anything from his early life that might account for his stomachaches. His mother recounted an incident, when at 18 months of age, the patient was laying in his crib next to his parents' bed in which his mother lay seriously hemorrhaging and being delivered of a stillborn infant. When the doctor had the dead baby in his hands, he hurriedly tossed it so he could return his attentions to the gravely ill mother. The dead infant landed on the patient's stomach as he lay in his crib! Upon learning of this event, the patient never had another of these stomachaches again. (Nechin, 1996 personal communication)

The traumatic events in both this last case and the three-year-old's occur around the developmental time Piaget (1936,

1946) posits the ability to demonstrate sensorimotoric reenactment as memory.

Taken together, these cases indicate the persistent and repetitive nature of somatization and sensorimotoric behaviors. It is suggested herein that both symptoms stem from the inability to represent affect or explicit memory cognitively. Each is an example of patients employing the soma itself or the sensorimotor apparatus of the soma for expression of body memories of specific early events.

Conceptualizing verbally unsymbolized emotional material as expressed in somatized symptoms is not new (e.g., McDougall, 1978, 1989). Conceptualizing sensorimotoric behaviors such as aggressive, impulsive acts, and hyperactivity, as outlets for that which cannot be verbalized is not new, either (e.g., Fonagy, 1991; Fonagy, Moran, & Target, 1993; Fonagy, Steele, Moran, Steele, Higgitt, 1993a). However, it is herein suggested that somatization and sensorimotoric aggression, impulsivity, and hyperactivity, etc., are behaviors related to each other; both stemming from a time before the ability to symbolize memory and/or affect ("the pre-reflective or physical self" Fonagy, et al., 1993a); and both employing the soma and/or the sensorimotor apparatus of the soma for expression of "body memories" and reaction to early events. Additionally, the alexithymic's propensity to "freeze" the sensorimotor apparatus into rigid and wooden bodies, also may be related. Understanding these various conditions or symptoms as products

of attempts to communicate verbally unsymbolized affect or memory, may help explain the persistent and repetitive nature of some somatization and sensorimotoric behaviors .

It is supposed possible to try to understand these examples in the classical tradition as repetition compulsions enacted until mastery is achieved. However, Stern (1985) avers that

many of the tenets of psychoanalysis appear to describe development far better after infancy is over and childhood has begun, that is when speech is available . . . [I]t is a suggestion that psychoanalytic theory has been misapplied to the earlier period of life, which it does not describe well.  
(p. 11)

It is suggested that Stern's sentiments are applicable to most of the cases described herein. The construct of body memories is a plausible alternative rationale to repetition compulsion: it explains the repetitive nature of somatization and the sensorimotoric behaviors of hyperactivity, impulsivity, aggression, etc. Within the body memory construct, the behaviors are viewed as continuous reenactments of either memory of, or reaction to, pre-symbolic traumatic events, which persist until the conscious mind can learn of, and process, the hitherto unsymbolized psychic and/or "real" events. In these cases, the soma provides the primary source of information that somatizing or enacting adult patients are offering about their pre-symbolic and non-symbolized lives. It is suggested that this view of somatic symptoms allows the dyad a useful perspective from which to work.

### Treatment

This section is written to offer some thoughts about applications of the ideas discussed herein to the treatment of somatizing patients. It is not meant as a complete statement of this author's thoughts about the treatment of somatizing patients but rather some thoughts deemed useful to consider.

The standard recommendations to therapists working with somatizing patients, adapted from Karasu (1980), are as follows:

1. Often their interpersonal relations are disturbed, they are apt to resist the development of transference. This lack of transference reflects their object relations in life. Therefore he warns against encouraging transference. If transference develops, it is likely to be negative. Since they have no ability to discuss it metaphorically it will be uninterpretable and therefore be immutable.
2. When they are silent, assure them that even what may seem trivial to them is important to the treatment. Do not interpret resistance, it is apt to alienate them.
3. They typically cannot tolerate clinicians' silence. They will not volunteer much, most everything will have to be solicited. Be prepared to be very active.
4. Solicit daily life data, tolerate and respect defenses, accept concrete thinking, but find ways to model or teach more psychological introspection, and resist premature interpreta-

tions. Since they typically are unused to or frightened of feeling, either emotionally or physically, do not ask how they feel.

5. As treatment evolves, early material will still not be volunteered but dependency on the therapist will develop. Any interpretation of it will be experienced as pointing out the weakness the patient has been warding off. Let positive feeling go on uninterpreted for a long time. Only after they've experienced positive feelings with relative somatic comfort should any experiencing or investigation of negative feelings be encouraged.

6. Be as consistent as possible in schedule, fees, demeanor, etc. They can tolerate little undependability, their somatic reactions are apt to be intense when and if it occurs.

7. After these steps have been followed for a long time and the patient is positively disposed toward both therapist and treatment; after patient has been relatively somatically stable; after patient has been able to tolerate affect; then and only then can the therapist expect any free association or reportage of dreams. Treatment as we know it begins, but most carefully: the dyad is essentially involved in a delicate balancing act.

Basically useful, Karasu's suggestions, nevertheless, offer no guidelines for handling somatic material, *per se*, or for coping with the abundance of countertransference the work is apt to incur. It is suggested that there is important unsymbol-

ized affective psychic meaning in both the countertransference and the symptoms. This material resides nowhere else, can be utilized and, unless made into a focus of the treatment, will be missed.

Robertson (1988) recommends that therapists of somatizing patients need to join their patients' concreteness, and that there is nothing patients bring into sessions more concrete than their soma and its complaints. A likely beginning, introduced earlier, is that the fundamental rule--request the patient to say everything that comes to mind--might be altered to also include a recommendation to say everything that comes to body, as well. What is suggested herein, is that practitioners help their patients get as specific as possible when they talk about their somatic symptoms. When practitioners inquire about patients' symptoms, their recitation will become less rote; their narcissism will be gratified; their loneliness may be slightly ameliorated; their most central feelings, expressed in the soma, will take the spotlight at the center of the treatment stage. And that is at it should be--somatic symptoms are the somatizers' core affect.

It is suggested that in work with any patient, a portion of the work always begins, and some is often maintained, entirely within clinicians' minds. Further, this fact is more true of, and will be true longer in, the work with affectively

disarticulate, symbolizingly impaired, somatizing patients. As suggested earlier (Chapter 3, Utilization of Countertransference), initial treatment plans for this work involve processes that are primarily, even entirely, initially internal to clinicians. Included may be:

1. special attention to their receptivity to countertransference (Bollas, 1987; Khan, 1977);
2. heightened tolerance of the experience of not understanding what is transpiring, perhaps for quite a while (Bollas, 1987);
3. special attention to "affective attunement" (Stern, 1985), and to their "feeling-perceptions" (Bollas, 1987), as well as full experience of their countertransference (Bollas, 1987);
4. efforts to actively, internally, imagine what is happening, and has happened, within their patients's psychic lives; and
5. a recognition that these processes and their products will likely need to be maintained within their imaginations, for a very long time, for future use with their patients.

These processes and their long term containment within imagination is difficult. These processes typically transpire dyadically, but it is generally impossible to engage in these processes with, or deliver their products to, somatizing patients. Typically the clinician's response is to abandon these processes. However, it is suggested herein that to do so is to unnecessarily abandon the patient.

Libbey (1996), in her work with her "non"-symbolizing patients employs a technique wherein the clinician imagines, as

vividly as possible, what patients were like as children. By evoking rich mental images she suggests clinicians may enable patients to approach genetic material more easily. She notes the effect of this process is to unconsciously inform the tone of voice she uses and thereby the nature of the ambience between the dyad. In turn, this appears to enable her symbolizingly impaired patients to become somewhat more connected to both their affect and their therapist and to become more verbally productive in sessions than before she adopted the technique.

It is suggested herein that as clinicians become more adept at utilizing these internal techniques of imagining, as well as noting and holding their countertransference experiences: (a) they will allow their patients' historical events, affective lives, and the meanings of their somatic communications to come to them; and (b) these internal imaginings and one-sided "dialogues" will positively inform clinical ambience and influence treatment. Further, clinicians may maintain the products of their imaginings and internal, one-sided attunement, affect-labelling, and greater empathic understanding for present use to further receive and analyze their countertransference. And lastly, clinicians may retain all of the above for future use, to be delivered to the patient as the patient becomes better able to be "touched" by it.

Wachtel (1993), discussing patients who are, in the instance he cites, treating their therapists badly, suggests that by using identificatory transference interpretations, patients' actions can be addressed directly, without blaming the patient, by reframing patients' behaviors into communications to the therapist of something not yet verbalizable. In this way the behavior may be seen

as a positive contribution to the task of therapy,  
as a way the patient is getting something important  
across to the therapist. (p. 100)

However, Wachtel cautions therapists not to try to do this if they do not believe in what they are saying since it can easily sound sarcastic. It is suggested herein that the impact on therapists of both wordlessness and somatization can be used similarly. When somatic symptoms are reframed into contributions to the treatment the results may be surprising and paradoxical. If patients' symptoms are primarily resistive or defensive, as opposed to communicative, the invitation to focus on, and utilize them in treatment, may cause a decrease in, or even the disappearance of, those somatic symptoms. While this may ameliorate patients' physical discomfort and permits the dyad to move on, it is not an end in itself since the symptom has not yielded insight beyond its use as defense. Additionally, this sort of reframing is a metaphorical intervention, and, as such, may fail, particularly with the more concrete somatizer. Nevertheless, the clinician maintaining the attitude that the symptom may be communicative may succeed in tak-

ing the treatment a long way in the necessary direction although patients may remain unable to make the symbolic connection.

On the other hand, if patients understand this reframing, and they are using their somas primarily communicatively, as mentioned earlier, they will feel less shame about their body being beyond their control, and perhaps even pride in their contribution to their own treatment. If the somatic symptom is primarily communicative it may decrease a little when it is made a focus of treatment but it will, as it were, persist in sending its somatic ailments until its signal is received. It may be thought of as doing its best to guide the dyad to its content. Hypothetically, it is conceivable, and consistent with this understanding of somatization, that symptoms may increase in severity when somatic "messages" are not received, are ignored, or are found and not worked through. In these instances, the "soma" will continue, as it were, to "send" or will "send" again: deeper, louder, and longer. Thus, an original symptom, for instance a muscular or skeletal problem, may become, for example, a visceral organ disease, a hormonal imbalance, or an immune system deficiency.

Rather than ask of patients if there "are times somatic symptoms are better?" it is usually more useful to ask "under what circumstances are they even worse?" As Wachtel (1993) recognizes, although the questions appear logically equivalent,

ent, the latter is more apt to elicit a useful and illuminating response. He observes that if the patient

is reassured that you [the therapist] are not trying to wipe out his experience, then he can begin to explore his experience in a more differentiated way . . . [B]eginning one's inquiry from an appreciation of the patient's frame of reference, and taking a step in the needed direction while keeping one foot planted where the patient still needs to be, can open up inquiry into questions that would be unaddressable if one were to attempt what would be in effect a frontal assault on the patient's defenses. (pp. 91-92)

Through this process patients learn to see variations in their symptoms without having to relinquish them if they have not "finished" with them; they learn that although an ailment is "a little better" under some circumstances, their therapists are still interested in them as well as in their symptom: they develop a more differentiated view of their symptoms and themselves which can lead to an increased understanding of their symptoms and the beginnings of psychically experiencing their primitive affects and pathology.

The following is a technique that may be useful to patients who have come to understand that their somatic phenomena are, at least in part, psychically caused. It can be used to keep rising somatic disturbances, resulting from rising unsymbolized anxiety, somewhat in check and consists of suggesting a dialogue patients may hold with their bodies, in session or out. 1. Patients pretend their body has a voice and they ask their body to answer questions like, "Why are you

hurting now? What has just happened to make it necessary for you to hurt?" etc. 2. Tell their body that they understand it is trying to tell them something. Attempt to make a bargain with their body: promise it that they'll do everything they can to learn to understand what it is trying to tell them and ask if it might ease up a little since part of the message has been received--the fact that there is a message. Tell their body that if they don't keep their promise to keep working on understanding the specifics of the message, that they will understand if their physical problems increase again.

### Utilizing Affective Disarticulateness

There are only a few aspects for clinicians to be aware of regarding attempts to utilize affective disarticulateness:

1. It may be more difficult to locate the patient in a symptom that is essentially an absence of an expectable occurrence in dynamic psychotherapy--in this instance, the dearth of affective language about core emotions. However, as noted by McDougall (1978), Konrad Lorenz observes that it is often in the absence of an expected action that the most important data is gleaned.
2. The countertransference therapists have to patients' emotional wordlessness, like their countertransference to somatization, will afford most of the clues that can be garnered about the unconscious processes of patients when they experi-

ence wordlessness. The countertransference to affective disarticulateness is handled in much the same way as that to somatization: increased receptivity to it; heightened tolerance of its presence and to not yet understanding its contents; expanded experience of it; and full analysis of it. The fruits of these processes, as with somatization, are likely to remain only within the mind and imagination of the practitioner, for a very long time before they can usefully be shared with the wordless somatizing patient.

3. Additional cues to patients' psychic lives may be afforded by whatever dyadic attention can be focused on the circumstances under which the emotional disarticulateness, and even concrete thinking, are least and most evident. Of course, this is done with a care to avoid making patients embarrassedly self-conscious.

### Chapter Summary

Somatization requires treatment in one of two manners. In one strategy, somatic symptoms are considered resistive and defensive. Since this interpretation of them is unlikely to be accepted by somatizing patients, this therapist prohibits the discussion of somatic symptoms in session. The hope, in this first style of treatment is that patients will be thus forced to find other means to express the psychological material that

necessitated the creation of their somatic problems, in the first place.

A different approach to the treatment of somatization is modeled by McDougall (1978, 1984, 1989), and was discussed herein. Somatic symptoms are treated as primarily communicative and become a major focus of therapeutic work. In this second strategy, symptoms are thoroughly examined in all their vagaries, vicissitudes, nuances, and associations. The hope, in this model, is that, eventually, clinicians and patients will learn to hear the somatic signals and patients will hear their therapists' interpretations of their somatic material: the dyad will decipher, accept, experience, and utilize the idiosyncratic somatic language.

A third, and prevalent position, runs into considerable problems. It neither banishes the discussion of somatic symptoms nor does it utilize them. Therefore, clinicians working in this position cannot avail themselves of alternative expression patients may develop when not permitted to speak of their symptoms; nor do they utilize the symptoms that are available. This appears to result in both the greatest countertransference difficulties and the least clinical success.

The construct of a somatic language was postulated as a tool enabling therapists to employ the second strategy described. An understanding of this proposed communication system allows therapists to join patients in their somatic symptoms thus facilitating a thorough exploration of patients'

ailments and their unsymbolized psychic content. Metaphorically, it can be said that the "soma" substitutes for the psyche and "stores and expresses" the message for which there is no symbolic memory. It "sends" those signals repeatedly in the form of physical communication. When the psyche finally "receives" the message, the "soma" stops "sending," much as when a caregiver hears her baby's signal cry, deciphers and attends to the cause of her infant's tears, her infant stops crying. However, if the message is not attended to, is pushed out of consciousness again, and is not worked through, it is again pushed into the soma and the "soma" will "resend," or develop another somatic communication in, as it were, continued efforts to get the message into the psyche. This may be thought of as similar to recurring dreams, recurring themes to different dreams, or the persistent and insistent cry of the infant before relinquishing hope (Spitz, 1941). However, unlike the infant who eventually gives up, the "soma," metaphorically, will increase its efforts to be understood. Thus, it is conceivable, and consistent with the approach to somatization espoused herein, that a rather simple muscle problem, if not attended to, may eventually develop into more complicated and serious somatic symptoms. Clinical anecdotes were offered to highlight elements of the constructs of somatic language and body memories.

Lastly, a short section was devoted to utilizing the symptom of affective disarticulateness as a contribution to the treatment.

**Chapter Four Notes**

1. A possible physiological mechanism producing Marie Cardinal's (1983) uterine bleeding could be that emotional perturbation triggered an hormonal imbalance of large proportion.

**CHAPTER FIVE**  
**NECESSARY HEAT**

**Introduction**

"Necessary heat" refers to the thought that heat is required for mutative therapeutic change to occur. More specifically, this study, addressing affectively disarticulate somatizing patients and the countertransference that work with them engenders, indicates these patients experience difficulty making both interpersonal and verbal connection with their therapists. Similarly, these patients are estranged from their own and others' psychic experience of emotion. The necessary heat refers to the heat of the forge in which links to span these gaps may be forged. When patients feel sufficiently safe from emotional inundation, they may permit themselves to experience their hitherto unconscious emotion. It is then they can begin to forge the symbolic verbal links to their unsymbolized, bodily-experienced and bodily-expressed, emotion.

**Patient Persistence**

Clearly, work with somatizing and affectively disarticulate patients is difficult, protracted, and frequently less than suc-

cessful. Fortunately, or unfortunately, many of them are truly therapeutically persistent, continuing in treatment and seeking new therapists despite repeated failures. Modell offers two views of this tenacity: his first (1976) poses that these patients view therapy as a transitional object as hard to relinquish as a toddler's "blankie"; later (1980), recognizing that transitional objects are bridges to relationships, he avers these patients continue therapy to avoid relationships. Neither of Modell's positions views this therapeutic tenacity in a positive light. Fonagy (1991) describes the interpersonal links made by enacting and symbolizing impaired patients:

If the patient uses the therapist to mentalize, the patient's dependence on the therapist for maintaining a relatively stable representation of himself will be absolute. Consequently there will be an adhesive quality to the attachment to the therapist.  
(p. 651)

Lesser (1981) observes alexithymic patients' relationships, in general, and also with their therapists, are either aloof or dependent. However, neither Fonagy nor Lesser appears to view their therapeutic endurance any more positively than does Modell. In work with emotionally wordless somatizing patients, therapists' tendency to be less than enthusiastic about their patients' sometimes characteristic perseverance is understandable. Their persistent presence may be experienced as boring repetition of complaints perennially disconnected from affect.

On the other hand, demonstrating a somewhat more positive view of therapeutic perseverance among primitive personalities, Robbins (1993) suggests that they live in a

chronic subtle state of [emotional] disorientation [and their sessions are] voyage[s] of emotional discovery [rather than searches for unconscious motivation]. . . . Part of the intense attachment the successfully treated primitive personality comes to develop toward the analyst [and treatment] is based on his experience that achievement of emotional orientation leads to more effective functioning and on the recognition that the analyst's attentions are essential in order that he attain and sustain this orientation. (pp. 248-9)

Many somatizing patients have life-long histories rife with unconscious emotion rarely experienced. Alexithymics are the prime examples of this, but it holds true, although less so, for the 'ordinary' somatizer, as well. These then are among the patients to whom Robbins refers, above, when suggesting that as treatment progresses they discover--frequently for the first time--the actual experience of emotion. Epstein (1996), offering neuropsychiatric studies, writes of patients reexperiencing traumatic memories, and suggests that

such a memory tends to produce, at higher levels [than non-traumatic memories], a wish for reexperience. The memory is endowed not only with painful feeling tone prompting avoidance but also with a pleasurable arousal [*italics added*] component prompting approach. (p. 32)

Schacter (1996) and van der Kolk (1996) cite neurochemical research studies of stress hormones that appear to account for the phenomenon Epstein notes. Whether one agrees with the argument that traumatic memory may produce a greater wish for reexperience than other memories, the general attraction of

somatic arousal is established (e.g., Stern, 1985; Robbins, 1993).

Since pre-symbolically traumatized somatizers generally experience emotion more easily than do the other somatizers discussed herein, it is not suggested that focus on somatic arousal is as necessary for them as it is for 'ordinary' somatizers and certainly for somatizing alexithymics. Thus, it is suggested that the therapeutic persistence of the more emotionally removed somatizing patients results from the somatic arousal that is part of the actual experience of emotion. As infants' caretakers stimulate and modulate the emotional experience of their charges, therapists--the trusted others--titrate this unfamiliar experience of emotion and protect their patients from emotional inundation. Although these data regarding somatic arousal pertain primarily to the treatments of the 'ordinarily' somatizing and the alexithymic patients, they may relate to pre-symbolically traumatized patients, as well. Winnicott (1963?) writes of those pre-symbolically traumatized patients who compulsively attempt to return to some unknown trauma in hopes of finally experiencing it, for the first time. It is suggested that this search is the search for the em"bodi"ment of an island of unsymbolized memory. Lastly, the somatic arousal data may also relate to Balint's (1968) basic fault patients whom he describes as having a conviction that something therapeutic is possible and evince "an unshakeable determination to get on" (p. 19).

It may be that those somatizing wordless patients demonstrating therapeutic tenacity are evincing hope that someone knows how to help, despite previous failures, and that they will eventually feel better. It is possible that the studies separately cited by Epstein, van der Kolk, and Schacter, in which the somatic arousal of emotion is experienced as pleasure, form the neurochemical profile of hope. In any event, it is suggested herein that many of these tenacious patients are hopeful and that since that very hope is such a fundamental component of any treatment, it is most fortunate that they have it; particularly since their therapists frequently are unable to hold it for them.

### Somatic Arousal

As clinicians listen to their patients and to their own countertransference, in the ways suggested in Chapters 3 and 4, they can share the newly understood somatic language and the fruits of it with their somatizing patients. However, no matter how much work is done by the dyad, concrete and affectively wordless patients may not become adept players with metaphor nor of the psychotherapeutic game. Nonetheless, several writers (e.g., Taylor, 1987; McDougall, 1989; Giovacchini, 1993) note that there are times when interpretations appear to "touch" somatizing patients. These interpretations seem to be those that are made at the moment of emotional occurrence, in

vivo, so to speak. They believe this is due to the lack of temporal distance between the event and the interpretation. It is suggested herein that an additional aspect of this lack of temporal distance may be that the body's reactivity at the moment of emotion enables interpretations to gain psychic access. An observation in Stern's (1985) work appears to confirm this:

affects not only make perceptions relevant by way of association; they also provide the ticket of admission for perceptions even to get into the mind. Without the experience of hedonic tone, no perceptions would be registered at all. (p. 65)

A primary aspect of hedonic tone is the body's physical reactivity (e.g., Darwin, 1872; Knapp, 1963). Several authors (Ikemi & Ikemi, 1986; Krystal, 1989) note that one of the necessary modifications to the treatment of alexithymic patients is consistent effort to stimulate an awareness of emotion and its somatic components. One may speak of emotion, but without bodily involvement, emotion is not experienced (Darwin, 1872; Knapp, 1963). Schacter's (1996) and van der Kolk's (1996) researches indicate a memory enhancing effect of somatic arousal produced by emotional arousal and they further note that recall is facilitated by being in the same mood as they were when the remembered event first occurred. Lastly, McDougall (1978) and Fonagy (1991) note that many symbolizingly challenged patients frequently arrange to get into arguments and their patients describe those experiences as the times they feel most truly alive.

In a different vein, although, in the general population, patients periodically demonstrate difficulty using and understanding words in a consensual manner, many of the more primitive and character disordered, the less neurotic, patients experience this as a relatively stable characteristic (McDougall, 1978; Balint, 1968; Fonagy, 1991). One result of this feature is that they often experience therapeutic interpretation as attack, demand, insinuation, rudeness, insult, injustice, or evidence of the therapist's lack of ability (Balint, 1968). Additionally, both Bollas (1987) and McDougall (1978) suggest these same patients frequently employ speech as action rather than attempts to communicate feelings, thoughts, or ideas. Their speech sounds "disembodied"--it is dissociated from the body and therefore from real feeling. Bollas (1987) quotes Sontag (1966) on the subject of "bad" speech which she explains is

speech not informed by the sensuous presence and concrete particularity of the speaker. . . Unmoored from the body, speech deteriorates. It becomes false, inane, ignoble, weightless, . . . inauthentic. (Sontag, 1966, p. 20, in Bollas, 1987, p. 234)

Bollas avers the therapist's task is to find "some way to give weight to language, to give it body" (p. 234).

A fundamental feature of catharsis is the combination of physical and emotional arousal involved in reexperience and is the same somatopsychic arousal that is involved in successful, mutative interpretation. Although catharsis is an insufficient component of change, it is considered by many to be a ne-

cessary one, particularly for more primitive state patients (e.g., Ikemi & Ikemi, 1986; Hedges, 1994). However, if working through is unaccompanied by the physical arousal of, the heat of, catharsis it can lead to the intellectualized "bad" speech that is unmoored from the body of the speaker--speech wherein the lyric may be right but the music lacks congruence or presence.

Hedges (1994), discussing work with primitive state patients, suggests that the in vivo nature of potentially successful interpretation involves the somatic reactivity of the clinician, as well. He notes that

by daring to feel the somatopsychic arousal of being fully connected to the deep emotional life of another human being when physiological drives, both sexual and aggressive, are mobilized and active in the interaction, the psychoanalyst provides the opportunity for a transformative experience to occur.  
(pp. 278-9)

Bollas (1987) avers that even "the most ordinary countertransference state is a not-knowing-yet-experiencing one" (p. 203) and that this loss of the therapist's assured sense of identity "within the clinical space is essential to the patient's discovery of himself" (p. 203). Hedges (1994) argues practitioners may experience a kind of "getting lost"--as in the throes of passion--stimulated by the "somatopsychic" arousal of an intense relatedness experience. He proposes that clinicians avoid mobilizing either defenses or boundaries but rather recommends sublimating that force, since any other action

closes off "potential channels for personal affective connection and communication" (Hedges, 1994, p. 284).

Herein, it is proposed that patients experiencing Hedges' (1994) "somatopsychic" arousal, or somatic reactivity, possess an ingredient necessary for interpretations to gain admittance to the psyche--with the more concrete patients, this usually occurs relatively late in treatment. Further, it is suggested that work with somatizing patients requires this same somatic arousal of their therapists, as well. Incapable of representing emotion or a memory of its physical reactivity, perhaps for somatizing patients, the in vivo experience of the physicality of affect, in a safe place, in the presence of a trusted guide, provides a key that permits, initially, psychic admission for only these interpretations. Experiencing affect permits development of the capacity to psychically represent and communicate personal meaning previously acknowledged solely by somatic symptoms. This may be the Winnicottian (1971a, 1971) potential space--the play and transitional space wherein creativity and learning occur--the space in which "we experience ourselves as alive and as the authors of our bodily sensations, thoughts, feelings, and perceptions" (Ogden, 1989, p. 200). In vivo, alive and vital, the material requiring symbolization and the trusted other to help bind anxiety are temporally, spatially, and emotionally available. It is suggested that this is part of the creative space and the necessary heat in which symbolic links to bodily-experienced emotion may be

forged. Further, this heat may be a component of the draw for somatizing patients who so tenaciously persist in treatment.

### The Transference/Countertransference Cycle

Metaphorically speaking, the heat referred to in this chapter depends on chemistry--the chemistry of somatic arousal and the chemistry upon which interpersonal relationships rest. Freud (1917a, cited in Racker) suggested "the boiling heat of the transference" is required for patients to melt "resistance," lower "defenses," to become amenable to psychic change. Racker (1968, referring to Freud's statement) notes that if patients are left "cold" by their therapist and the therapist's interpretations, if they manifest no transference, "they are inaccessible to our efforts and cannot be cured by us" (p. 30). Suggested herein, this is all the more true of somatizing affectively disarticulate patients in view of their difficulties forming interpersonal relationships and experiencing and symbolizing affect. Racker (1968) observes these

necessary patients' temperatures can only be achieved if the analyst also contributes sufficient heat--sufficient positive countertransference made real through his work--to the analytic situation.  
(p. 30)

He continues, saying,

The analytic transformation process depends . . . to a large extent, on the quantity and quality of Eros the analyst is able to put into action for his patient. It is a specific form of Eros, it is the Eros called understanding. It is, above all, the

understanding of what is rejected, of what is feared and hated in the human being . . . (p. 32)

Further, he says that

the therapeutic outcome depends to a large extent on the analyst's capacity to maintain his positive countertransference over and above his 'countertransference neurosis'; or else, to free it again and again from any harm it may have suffered, just like the Phoenix, which always rises again from its own ashes. (p. 32)

Racker recommends that therapists "not deny (or even inhibit) . . . interest and affection toward the patient" (p. 31). This permission, nay, exhortation, to display and make available to patients therapeutic interest and affection, helps create positive transference, which, in turn, creates more positive countertransference.

It has been suggested (e.g., McDougall, 1978, 1989; Fonagy, 1991; Ackman, 1996) that somatizing patients lack a Winnicottian (1971, 1971a) potential space between somatized reaction and unconscious emotion--between symbol (or signal) and symbolized (or "signalized"). Winnicott (1960b) suggests that in the absence of the capacity to generate potential space, patients rely on defensive substitutes for the experience of being alive--e.g., a false self. He views the analytic situation in terms of satisfaction, within the potential space of the dyad, of crucial developmental experiences missed in infancy, and the analytic process as one producing heat that results in "thawing" the "frozen" aborted self.

It suggested herein that the countertransference typically incurred in work with wordless somatizing patients prevents therapists from utilizing that same transitional space. It is hoped the attitudinal shifts derived from fully receiving, experiencing, and utilizing countertransference (including that arising from clinicians' bodies and from clinical language) and from full analyses of patients' symptoms (even if those analyses remain primarily or entirely in the minds of their therapists), may enable illumination to stand where once stood frustration. The frustrations typically experienced by somatizing patients and their practitioners may be replaced by increased empathy for the adult affectively wordless somatizers and the children they once were.

### Concluding Remarks

This study primarily suggests that clinicians do more of that which they are trained to do: analyze. It suggests that the foci of this analysis be the varied forms of clinicians' countertransference discussed herein and the nuances, derivatives, and vagaries of patients' somatic symptoms and affective disarticulateness. The following is a recapitulation of some of the major points made herein.

Chapter 1 offered expanded views of somatization from relatively normal occurrences through somatic storms and conversion reactions--as phenomena anybody may "devise." It also

explored, as separate entities, its accompanying conditions of emotional disarticulateness and concrete thinking.

Chapter 2 examined expectable countertransference to the expanded views of somatization and affective wordlessness. Chapter 3 proffered broadened the concept of countertransference to include clinicians' somatic phenomena and clinical language; thus providing fodder for analysis in treatments so lacking in interpretable material.

Chapters 3, 4, and 5 stressed the reasons to particularly attend to, and analyze, both symptoms and countertransference:

(a) Since somatizing patients usually lack both symbols and conscious affect, and their clinicians lack theory and technique adequate to the task, practitioners are left with little more than symptoms and countertransference. These may as well be used as fully as possible.

(b) Full use of the countertransference will help contain its obstructive incursion into the treatment.

(c) Countertransference is likely to be the only consistent source of symbolic material and it is also likely to be the primary source of the patient's psychic material.

Finally, the last three chapters, also examined components of these primarily internal analyses:

(a) A construct of an idiosyncratic somatic language was proffered and detailed in terms of signals rather than symbols and in terms of body memories.

(b) Suggestions were detailed to employ somatic language to understand somatic phenomena in whomever they arise.

(c) Reasons were offered, and suggestions for how, to increase practitioners' self-analytic mind set and receptivity to the experience of their own and their patient's material. These will also increase the patience each dyadic member has to better experience the unknowing state and the nonverbal state of knowing, before attempting to supply words.

(d) Clinicians' patience is also required to sustain the prolonged and almost totally internal nature of these normally dyadic processes. During the initial years of treatment, until somatizing patients learn symbols and can play with them in the dyadic potential space, these processes will occur only within clinicians' imaginations.

If . . . anyone wishes to search out the truth of things in serious earnest, he ought not to select one special science . . .

- R. Descartes

## CHAPTER SIX

### FUTURE RESEARCH

It is an interesting experience to quote Descartes as a person to unify the search for greater knowledge. His ideas, clearly brilliant and influential, created mind/body dualism--an amazingly enduring pervasive attitude antithetical to an holistic view of the human organism espoused herein. It is suggested herein that the holistic view is a requirement for the development of a theoretical understanding of somatization and improved treatment of the affectively disarticulate somatizing patient. The various strands woven into this present tapestry have been collected from consulting rooms and laboratories of many sorts. However, it is only in the last few decades that professionals therein are seeking and taking serious cognizance of each others' findings. Descartes' quote is particularly apt in this study--interactions of the mind and body--and in this section--future research. Questions surrounding somatization and its treatment raise varied issues and the possibility of answers depends on free exchange among theorists

toiling in many fields. This study alone touched upon clinical and the laboratory findings in the medical and psychological realms of infant and child development; symbol and language acquisition; researches concerning the brain, affect, memory, trauma, and dreams; and the fields of metapsychology, physiology, biology, neuropsychology, neurochemistry, linguistics, and philosophy.

The above-mentioned realms are all suggested avenues of future exploration. Some of the specific questions that have arisen during the course of this study include the following.

1. Is there correlation between the depth of clinicians' didactic analyses into their own psychotic cores and the degree of comfort they experience in treating somatizing patients?
2. How did it come to pass that so many of the major transformations in thinking about countertransference were products of contributions made by female analysts (e.g., A. Balint, Heilmann, P. King, Little, A. Reich, Sharpe, Thompson)? Also, what was the impact on these revolutionary women of their adherence to the convention of writing of the analyst with the male pronoun? Incidentally, except for the authors who have attempted the awkward "his and/or her" or "s/he" route, this convention is still followed, albeit with some exceptions (e.g., Wachtel, 1993, who writes of the male patient and the female analyst).

3. Investigation of the "primary" form of alexithymia comprising congenital brain anomalies has not yet included medical imaging techniques of the physiology of live brains, nor post-mortem investigations, of known alexithymics.

4. Despite the recognition of a possible 'primary' form of alexithymia due to congenital physiological anomalies, or an early 'secondary' form, as McDougall suggests, that is established 'at the breast,' there appears to be no literature pertaining to childhood manifestations of alexithymia, or the preludes of adult alexithymia. Although this may be due to the high level of social conformity usually evinced by adult alexithymics (McDougall 1978; 1989) which would preclude childhood referral, the following avenues of investigation may prove fruitful:

(a) children with autistic-like features (DSM-IV Pervasive Developmental Disorders) may be wearing the face of childhood alexithymia or the lack of relatedness that is a component of the autistic-like presentation may relate to the similar feature of adult alexithymia.

(b) children with the psychosomatic diseases prevalent in childhood (e.g. asthma or colitis) may provide some clues with which to recognize the visage of the child who becomes the adult somatizing alexithymic.

(c) a more thorough search for retrospective studies of what might possibly be alexithymia although presented under

other diagnostic rubrics. Or, looking for adult alexithymic cases whose childhood histories are detailed and well documented.

5. Still on the subject of alexithymia, further questions of their relationship to their bodies including response to various touch, i.e. soothing, tickling; a comparison between alexithymia and autism since there are some similarities of relationships, affect, and body connections that may prove useful.

6. Continued investigation of the parallels between the countertransference expectable in work with somatizing patients and those expectable in work with seriously ill, dying, and suicidal patients.

7. Further exploration regarding somatizing patients' reportage and use of dreams in treatment. The work in this study leads to an hypothesis that due to difficulties somatizers have with symbolization, they are likely to report fewer remembered dreams, have dreams with less symbolism, and most likely, report dreams with few associations and/or little curiosity. Surveying therapists regarding dreams of their somatizing patients, or sleep studies might determine whether symbolizingly challenged somatizers actually have fewer dreams. This last would answer questions concerning differences between having dreams, remembering dreams, and reporting dreams.

8. Further exploration of the relationship between female patients' somatization and male patients' use of the sensorimotor apparatus in acting out, impulsivity, aggression, or hyperactivity. Are these symptoms stemming from the same developmental difficulties and trauma that are expressed differently by the sexes? Are these gender biases in symptom formation a result of genetic differences, brain dysfunction and/or damage, differences in socialization, differences in the nature of the trauma(ta) that befall infants and toddlers of each sex?: investigation of the fact that among those persons who act out, men act on others, women on themselves: possibly related questions about laterality among learning disabled and alexithymic patients and the appearance of women's conversion symptoms on the left side of their bodies.

9. Investigation as to the role of and level of physical reactivity and the patient's ability to accept interpretation. Which patients appear to need what levels of physical reactivity in order to take in an interpretation?

10. Clinicians' experience of somatic reactions to their patients and their material: under what circumstances do practitioners respond with somatic responses? how do they handle their somatic responses? with what results?

11. Investigate senior practitioners' experiences of working with somatization and wordlessness: training in psychosomatics; theories of somatization; treatment progress and outcomes; ignored interpretations; concrete thinking.

12. Possibly allied to the DID or MPD patients whose personalities have different physiological profiles: studies of young identical twins who appear to show clearly discernable differences along the passive/dominance axis; young twins, to try to control for differences in later experience: investigate physiological profiles to see if personality and physiological profile are correlated. Hypothesis: The physiological profiles of the dominant twins will differ in some consistent ways from that of the passive twins (e.g., perhaps the dominant twin has lower blood pressure, less evidence of allergic sensitivities, less evidence of blood glucose problems, etc.). Perhaps dominant twins are better able to act upon the world to get needs met than passive ones and therefore are less likely to have somatic signals pointing toward potential physiological problems. This data may shed some light on the physiological differences found among some DID's personalities.

13. Investigate the literature regarding possible fluctuations in pregnant women's amniotic fluid of neuropeptides (suggested by the work of Bernstein, 1988; Pert, 1991, 1993) and hormones

(suggested by the work of Schacter, 1996; van der Kolk, 1996), etc. indicative of mothers' emotional fluctuations. Also, whether, and in what ways, fetuses are influenced by these fluctuations.

14. Investigate whether linguistically challenged people (e. g., mutes without sign language, aphasics, lone immigrants as yet unable to speak the language of their new country) demonstrate a greater tendency toward somatization or sensorimotoric enactment than the linguistically unchallenged.

## APPENDIX A

### AMERICAN-ENGLISH IDIOMS

#### EMPLOYING THE BODY TO REPRESENT EMOTION

The mother of a neonate understands her infant through attunement to, and interpretation of, her infant's body signals. American-English idiomatic language (our Mother Tongue) is examined for its use in clinical thought about somatization and affective disarticulateness. There is a most fundamental and intimate connection between our bodies and our experience of emotion. Verbal language, with universal symbols, reflects that intimate relationship between body and "feeling" (in all "senses" of the word). This lexicon may offer a springboard for ideas to work with the symbolizingly challenged patients who use their bodies, as we all do, as part of their repertoire of emotional response, but further, in lieu of psychic representation of their emotions.

**FACE**

to fall flat on one's face  
 to have a hang dog look  
 to be two faced  
 to be red faced  
 to be shame faced  
 to be ashen  
 to be crestfallen  
 to have egg on one's face  
 to lose face

**MIND**

to be of two minds  
 to have a heavy mind  
 to lose one's mind  
 to make up one's mind  
 to have a load on one's  
     mind

**EYES**

to be hit right between  
     the eyes  
 to have puppy dog eyes  
 to be icy, steely, beady,  
     eagle, teary, or  
     or red eyed  
 to be a sight for sore eyes  
 to be blindsided  
 to see red  
 to cry one's eyes out  
 to be short sighted

**CHIN**

to keep one's chin up  
 to take it on the chin  
 to lead with one's chin

**HEAD**

to be hot headed  
 to be light headed  
 to be head over heels in love  
 to be reeling  
 to be stunned  
 it makes one's head spin  
 to be touched in the head  
 it gives one a headache  
 to be dizzy (to be stunned or  
 to be an air head)  
 to be bull, mule, or hard headed  
 to have a swelled head  
 to lose one's head

**CHEEKS**

to be cheeky  
 to be rosy cheeked  
 to be apple cheeked

**NOSE**

to have one's nose out of joint  
 to be snivelling  
 to cut off one's nose to spite  
     one's face  
 to be nosy  
 to have no skin off one's nose  
 to be hard nosed  
 to keep one's nose to the  
     grindstone  
 to be unable to see beyond one's  
     nose  
 to put one's nose where it  
     doesn't belong

**NECK**

to stick one's neck out  
 to be a pain in the neck  
 to get hot under the collar  
 to take or get it in the neck  
 to be stiff necked

**MOUTH**

to keep a stiff upper lip  
 to cut one's eyeteeth  
 to be lying in or  
     through one's teeth  
 to escape by the skin of  
     one's teeth  
 it sets one's teeth on edge  
 to be long in the tooth  
 to say a mouthful  
 to have one's heart in  
     one's mouth  
 to be down at the mouth  
 butter would melt in one's  
     mouth  
 to be silver tongued  
 to bite one's tongue  
 to speak with a forked tongue  
 to be tongue tied  
 to be foul mouthed  
 to lick one's chops  
 to drool over something  
 to salivate  
 to be dry mouthed  
 to swallow one's pride  
 to eat crow or humble pie  
 to grit one's teeth

**HANDS**

to be heavy handed  
 to be two fisted  
 to be open handed  
 to have a fist of iron  
 to be high handed  
 to be left handed  
 to be underhanded  
 to give a backhanded, left  
     handed, or underhanded  
     compliment  
 to knuckle under  
 to be under the thumb of  
 to be in good hands  
 to have an itching palm  
 to be out of hand  
 to be off hand or handed  
 to hold on, off, up, down, out, or in  
 to have the situation well in hand  
 to have the situation out of hand

**THROAT**

to swallow one's pride  
 to eat humble pie or crow  
 to sing (tattle)  
 to have something stuck in one's  
     craw  
 to cough something up  
 to get choked up  
 to be unable to swallow  
     something

**TORSO**

to contemplate one's navel  
 to be a thorn in someone's side  
 to get a weight off one's chest

**BACK**

to be flat on one's back  
 to get one's back up  
 to do something behind someone's  
     back  
 to turn one's back on someone  
 to have one's back to the wall  
 to have one's back against the  
     wall  
 to bend over backwards

**SHOULDERS**

to have broad shoulders  
 to bear the weight of the  
     world on one's shoulders  
 to deal straight from the  
     shoulder

**ARM**

to get a shot in one's arm  
 to keep another at arm's  
     length  
 to be up in arms  
 to wear one's heart on one's  
     sleeve

**HEART**

to be hard hearted  
 to be faint hearted  
 to do something half heartedly  
 to feel heavy hearted  
 to be light hearted  
 to have an open heart  
 to feel sick at heart  
 to wear one's heart on one's sleeve  
 to have one's heart in something  
 to have one's heart in one's mouth  
 to have one's heart in one's toes, shoes, or boots

**GASTROINTESTINAL TRACT**

to be gutsy  
 to have guts  
 to be gutless  
 to know it in your guts  
 to have the stomach for it  
 to be unable to stomach it  
 to have a fire in one's belly  
 to be scared shitless  
 to lose it (control of sphincter)  
 to be off one's feed

**CIRCULATORY SYSTEM**

to be sanguine  
 to be hot blooded  
 to be cold blooded  
 to be bloodthirsty  
 to have bad blood between them

**ASS**

to be flat on one's ass  
 to be buggered  
 to be half assed  
 to give or get the shaft  
 to have a ramrod up one's ass  
 to be or have a pain in the ass

**SKIN**

to be thick skinned  
 to be thin skinned  
 to get under another's skin  
 to make one's skin crawl  
 to be touched by something  
 to have no skin off one's nose

**OTHER ORGANS**

to be phlegmatic  
 to be bilious  
 to be full of spleen  
 to be hysterical  
 to be lily livered

**MUSCULAR SYSTEM**

to be tense  
 to be rigid  
 to be flexible

**NERVOUS SYSTEM**

to feel nervous  
 to be nervy  
 to be nerveless  
 to have nerves of steel  
 to be paralyzed  
 to lose one's nerve  
 to not have a nerve in one's body  
 to get on one's nerves

**SKELETAL SYSTEM**

to be spineless  
 to feel like breaking every bone in someone else's body  
 to get down to bear bones

**GENITALIA**

to be fucked  
 to be ballsy  
 to have balls of steel  
 to be or get pissed off  
 to be a prick  
 to be a cunt  
 to gird one's loins

LEGS

to be weak in the knees  
 to be wobbly (in the knees)  
 to be with no leg to stand on  
 to feel cut off at the knees  
 to rest on familiar ground  
 to have cold feet  
 to be caught flat footed  
 to come out flat footed  
 to hit the ground running  
 to kick up one's heels  
 to kick oneself  
 to have itching or itchy feet  
 to be footloose  
 to have one's heart in one's  
     toes, boots, or shoes  
 to dig one's heels in  
 to be head over heels over  
     something  
 to have an Achilles' heel

TO BE FILED - ???

sore  
 tender

ANY YOU ARE ABLE TO ADD?

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