Pinocchio – a Psychosomatic Syndrome

A.		Sellschopp-Rüppell
M.		von Rad

Psychosomatische Universitätsklinik Heidelberg

Almuth **Sellschopp-Rüppell**, PhD, Psychosomatische Klinik der Universität Heidelberg, Vossstrasse 2, D-6900 Heidelberg (FRG)

In this address we should like to tell the story of Pinocchio, as it appears to us to have a number of elements in common with the case history of the psychosomatic patient. Thus – despite the risk that we shall have Pinocchio's donkey's head put on ourselves – we shall be referring to our earlier term, the 'Pinocchio syndrome', which we should like to explain and clarify here.

Pinocchio is a fairy-tale figure, who first appeared almost 100 years ago (1881) in a series by the Italian writer and journalist Carlo Lorenzini in the 'Giornale dei Bambini'. The story quickly spread all over the world (1).

Lorenzini, the son of a cook and a seamstress, lost his father while he was very young, and, as the oldest of nine children, he had to look early for a job. All his life he remained a fighter whose ideals were the improvement of education and the political struggle for independence. But at the time when Pinocchio was published he was already so debilitated by asthma that he could no longer do regular work. He was also looked on as an idler and vagabond and thus as a constant source of annoyance. Apparently it was difficult for him to make close emotional attachments. He did not have a family of his own – in honour of his mother he later named himself after her birthplace, Collodi (2).

It thus appears that the creation of Pinocchio in Collodi's old age is an expression of his desire to master his conflicts. The story of Pinocchio is full of wise humour and contrariety, in fact it is so unfeigned and true to life that it occasionally has something disconcerting about it and, in it, the same theme recurs again and again as if in counterpoint: in each wayward attempt to become a real person Pinocchio misjudges himself and his counterpart -each apparent step forward turns out to be a blunder; and it seems a real question as to whether the unhappy beginning of the story – freeing oneself

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with a kick and not looking back – is not, in fact, a better solution than the seemingly happy ending with its superficially successful adaptation.

In the following we should like to tell you the story of Pinocchio in short extracts. Then we shall pinpoint some essential characteristics of the psychosomatic patient as they are shown up in the story. Furthermore, we should like to indicate some particularities of the parent-child relationship in psychosomatic patients. Finally, we shall deal with some thoughts on these patients in the therapeutic situation.

The Story

Pinocchio's birth begins with a quarrel, followed by a verdict – he alone is guilty. Immediately afterwards he gets a 'warning' which is given him as a 'great truth' (p. 16) – 'Woe to those boys who turn against their parents and run away (p. 16) from home for no reason whatever; they will never come to any good in this world, and sooner or later they will repent bitterly.' The first time he tries to eat he fails absurdly: the saucepan is not real, it is only painted on the wall; instead of yolk and white the egg contains a chick, which mocks him.

Now he is to go to school. On the way he meets the marionettes who would like to play with him as their brother. He forgets school, but gets everything mixed up, himself into mortal danger, and calls in utter despair for his father for: 'I never knew my mother'. In real love for his father he intends to return home. But his incapacity to experience emotions and feelings and to differentiate between real and false friends – and to hold on to this differentiation and use it for his actions – is his downfall again. The fox and the fawning cat chum up to him, take advantage of him and finally hang him. Dying he murmurs 'Oh, papa! papa! if only you were here.' The story seems to have come to an end. But this is not to be, and a motherly fairy appears to save him, who – how could it be otherwise? – calls the most famous doctors of the region to her aid. They state that 'the wisest thing a prudent doctor can do, when he does not know what he is talking about, is to be silent' and that 'when a dead person weeps it is a sign that he is on the way to getting well' (p. 76). But Pinocchio does not turn out to be a good subject for their therapy. He refuses to take the medicine: 'We children are all like that! We are more afraid of the medicine than of the illness' (p. 80). He takes up the search for his father once again and ends up in prison. The paradoxes continue: in the same way as it is not the parents who may not leave him, but he who may not leave his parents, he gets into prison as the person who has

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been robbed and not as the thief. Thus everything he does gets confused and disharmony prevails: he runs away when he is expected to learn; he steals when it would be good to earn money. But there is also repentance and despairing efforts to make reparations for his own salvation and to please his parents: it is high time for him to become a real person like everyone else (p. 125). But despite the additional warning that his manner of living will put him in prison or in hospital he cannot keep to his resolutions.

At last he seems to have seen reason and gone to school. A large tea-party has already been arranged to celebrate his becoming a human being. But on the night before he makes a last attempt to escape into toyland, which ends cruelly. He is laughed at and mocked there, they try to drown him and sell his skin. He finally ends up inside the whale, where he meets his father who was shipwrecked looking for his son. The end is quickly told. During a fit of coughing of the asthmatic (!) whale he is thrown back into the sea with his father, whom he carries on his shoulders to the shore. At last he goes to school, works and earns money, with which he supports his parents. A happy ending?

If we look at the Pinocchio story in the light of some typical reactions which we find in psychosomatic patients, we notice the following: (1) He is made of wood; apart from his uncoordinated motor ability, it is obvious that he is totally unfamiliar with emotions. The only ones which occasionally break through are aggressive destructivity or abrupt despair. (2) An incapacity to relate inner experiences meaningfully to action is also conspicuous. The formation of experience takes place, rather, by performance training. (3) He exhausts himself in constant efforts to bring his desires into harmony with stubborn reality (toyland). (4) He has an overconcrete association with reality (painted saucepan) and the mechanical character of this

makes his inner retreat obvious. (5) Losses give rise to panic and are life-threatening. (6) Lack of introjects leads to the repeated attempt to establish contact with transitional objects, which must fail.

We now turn to the structure of the parent-child relationship, which seems to us to be similar to that of many psychosomatic patients. (1) An exaggerated demand for loyalty binds the patients to his family, and this leads to an insoluble conflict with other love objects. The parents cannot live without the child (one aspect of parentification); the patient is, however, left alone when he himself needs help. (2) We often find a pseudostrong father and an instable, unreliable mother. (3) An overstated and unyielding ideology of what is right and good, and a belief in their own selflessness, hardly allow any feelings of guilt to arise in the parents.

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Finally, we should like to point out that the therapeutic work with these patients must take the opposite direction; away from their compulsion to adapt to the norm – this implies an offer of a concrete, reliable, emotional attachment with strict observance of the countertransference as well as making available possibilities for representing conflicts scenically (group therapy, semiverbal methods) (3). We shall go into this in further detail elsewhere.

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Psychotherapeutic Problems with Psychosomatic Patients

Dr. Bräutigam: Quite apart from the concept of alexithymia, the question of special treatment techniques for psychosomatic patients is prompted by the general experience that psychosomatic patients have difficulties in the classic psychotherapeutic interview situation. The difficulties lie in the fact that the patient, with help from his therapist, be confronted with himself. He should not take his experience as given and his behavior for granted, but see it as open, as being susceptible to new alternatives. The situation, and course of his life as well as his own reactions should become matters of critical, clarifying reflections. Thus, it is hoped that the psychosomatic patient's verbalization will lead to his desomatization. The neurotic patient is characterized by highly ambivalent attitudes, fluctuating self-esteem and fixations as revealed in current memory bits, fantasies and other infantile material. Thus, he presents ideal conditions for a dialogue – particularly if he can reenact his infantile situation in his relationship with a doctor he experiences as a parent figure. The psychoanalyst needs only facilitate such dialogue by listening and responding sympathetically to the patient – perhaps by helping him along with interpretations when he falters in working through his past.

The psychosomatic patient does not usually share the neurotic patient's initial advantages: his symptoms and complaints are very much more bound up with current stresses and losses, etc., i.e. with external events. At the same time, his physical symptoms, whether based on destructive organic processes or not, are viewed as real physical conditions rather than as expressions of intrapsychic forces. Another impediment, if the concept of alexithymia is correct, consists in his 'concrete' thinking, lack of fantasy and incapacity to recognize alternatives.

Therefore, special therapeutic techniques must aim at helping the psychosomatic patient overcome his difficulties to enter into a dialogue with himself. He must learn to view from the outside the life which he now takes for granted; by disengaging a part of himself and an observer role vis-à-vis himself, he must become able to encounter himself and outgrow his limited and concretistic understanding of himself and of his world. For the neurotic patient, who can utilize fantasies, thoughts and spoken words, this appears a manageable task; for the psychosomatic patient this is extremely difficult, if not impossible.

How can one help the psychosomatic patient to enter into a dialogue with himself and to view himself from the outside? How can one widen his narrow and overconcrete perspective of himself and his world?

In their papers, members of my clinic staff have indicated the lines along which we are working. Group therapy seems to offer good start. Here one can enlist other patients in the group, who suffer from similar problems but are further on the road to progress to help the given patient in discovering something about himself. For example, these other patients may provide parallels from their own lives and thus help in the verbalization of one's experiences.

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The external dialogue with equal partners in the group can lead to a dialogue with oneself.

Initially, the group therapist and other members can represent the yet fragile new self in such a dialogue; they serve not only a reflective function, but they can also compensate in various other ways for the patient's own weakness in emotional awareness and in verbal fluency.

Another approach we found useful is 'sensual awareness therapy' (konzentrierte Bewegungstherapie). Generally, touching the patient is taboo in psychoanalysis and body awareness is usually not much fostered. Here, however, we foster such awareness deliberately and encourage the patient to perceive and express bodily feelings in a differentiated manner. We may either address him directly or utilize the resources of the group.

A third approach toward an inner dialogue is analytical ergotherapy (Gestaltungs-therapie). Here we encourage patients to deal with emotionally charged material by way of creative expression, i.e. by drawing pictures or modelling clay of other materials. Thus, anxieties, desires, memories but also the significant persons from the patient's life become accessible in an elementary fashion. These creations expose a part of the patient's own self. This part can then become to interpretation and clarification during the sessions with the analytical ergotherapist and other members of the group. Thus, a dialogue with a part of the self is facilitated. We have had our least experience with the modifications of standard psychotherapeutic techniques for psychosomatic patients. We refer to techniques by which the psychotherapist may alert his patient to new perspectives and alternative attitudes during critical and conflictual situations. By 'borrowing ego functions' from the analyst, the patient may then experiment with a new self-image and new behavior. Thus, he is released from the restrictive stranglehold of his concrete and own-dimensioned perceptions of reality. Here we should include what Fürstenau has called the 'vicarious exercise of ego functions by the analyst' a preparatory step toward a more classical analysis and dialogue with himself. We still know too little about the variable of the psychotherapeutic process as a whole to be able to say more exactly under which conditions of therapy the physical symptom itself enters into the healing process, i. e. the cathartic and comforting effects.

All these techniques are intended to counteract the psychosomatic patient's limited capacity for self-exposure and self-reflection – either by interpreting a part of his past life, or by developing for his current life, a new experimental matrix.

Dr. Shands: My first analyst, Hanns Sachs, had an aphorism that the analysis ends when the analysand realizes it will never end. This means to me that the analysand takes over the analyzing function in a self-reflective or reflective manner. The patient who cannot describe feelings cannot 'take a point of view' outside himself, one must first become an object to oneself by taking the point of view of the other. This is an ability the psychosomatic patient does not demonstrate; he does not develop the same kind of describable 'transference' reaction. In Piaget's language, this reflexive maneuver is an 'operation upon operations' or a second-order descriptive system. One most interesting aspect of this problem is that of accessibility to the 'private world' of emotional states. Cannon's classic work was based upon 'invading' the privacy of the body with electrocardiographs, electroencephalo-graphs, blood samples and the like. In a concrete metaphor, it is possible to suggest that a 'linguistic probe' is another form of instrument for invading the privacy of the inner world so as to render the otherwise invisible events there into an 'objective' or described form through verbalization.

Jakobson describes two polar ways of describing; that using metonymy with a basic

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relation of contiguity, and the other uses metaphor, with a basic relation of similarity. These two are as well the two modes of association in association psychology. Exploratory forms of psychotherapy use both modes, asking 'What was that like?' and 'Under what circumstances have you felt these feelings before?' using metaphor and metonymy alternatively. Lacai's famous analysis of Freud's 'Signorelli' dream analysis explores the dialectical relation of the two in great detail.

In my experience, the psychosomatic patient is unable to use the therapist as a symbol for other persons in his life in a conscious sense, that is, 'in the transference'. To the psychosomatic patient, 'doctor' is an idea he cannot play with, and the doctor who is there is a 'real' rather than an 'imaginary' relative. It sometimes happens that patients may learn or develop feelings after a long period of work; recently a patient I have seen sporadically for 17 years suddenly developed describable feelings for the first time in his mid-30s! To me, the implication is that there is a great deal of quite unconscious learning implicit in a relation with a preceptor that may continue long after the period we usually think of as that of learning.

Dr. Nemiah: I should like to make a couple of brief comments that perhaps go beyond the subject of psychotherapy, but which are, I think, needed to correct some misconceptions about alexithymia that appear to have arisen during this conference. I am concerned particularly at the view that has been expressed that the concept of alexithymia implies that those who manifest the characteristics are unresponsive, and that consequently nothing can be done to help them.

Nothing could be further from the facts. The essence of the psychosomatic concept is that patients with psychosomatic disorders are responding to environmental stresses and strains with a disturbance in psychophysiological processes. The questions to be answered are: How are they responding? What is the nature of the internal biological and psychological processes which are set in motion by environmental stimuli to result in a bodily illness? Do these processes differ from those found in neurotic patients and, if so, in what way? This is, after all, the basic theme of this conference, and it is to these questions that the concept of alexithymia is addressed.

It should also be pointed out that alexithymic patients with psychosomatic disorders are responsive to their environment in ways that are therapeutic. All of us know from experience that many such patients improve by merely being hospitalized – a procedure that removes them from a pathogenic stressful situation and provides them with a supportive and helpful human environment. This provides us with an important clue as to the kind of psychotherapeutic approach indicated for such patients – that is that a supportive relationship with their physician and other caretakers is central to their clinical management.

This leads me to a final comment. We have been tending to talk about psychotherapy today as if it were a single unified procedure involving the exploration of feelings and fantasies as a means through insight of resolving internal psychodynamic conflicts. Such insight psychotherapy, based on and derived from psychoanalysis, is, of course, a major form of psychotherapy highly effective for many patients. But it is not applicable to all of the clinical problems with which we have to deal, and the skilled psychotherapist employs, or should employ, a variety of procedures, his choice of technique being based on the needs and psychological characteristics of his patient. It is our contention, based on our experience thus far, that patients with alexithymic characteristics do not generally respond well to insight psychotherapy, and that other kinds of psychotherapeutic measures must be

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devised to help them. It is a value of the concept of alexithymia that it focuses attention on the psychological characteristics and needs of the individual who manifests them and challenges us to look for more effective psychotherapeutic techniques that will take these characteristics and needs into account.

Dr. Köhle: I am working at a department of psychosomatic medicine which is part of an internal medicine center. With this setting in mind, I would like to focus on the problem of establishing a working alliance with hospitalized psychosomatic patients. Apart from the problem of developing adequate modifications of the psychotherapeutic approaches suitable for this group of patients, we have to solve the task of winning the patients for psychosomatic treatment.

Whatever psychotherapeutic or behavioral approach we wish to apply, the prerequisite for building up a working alliance with these patients is the establishment of an environment that facilitates the recognition of psychic processes. In our country the psychosomatic patient is generally first confronted with a general practitioner or a medical doctor in a hospital who has not had any training in psychosomatic medicine. The approach towards his illness is therefore likely to be an illness-centered one. This implies a learning procedure for the patient who is successively taught to think and speak in illness-centered terms. At this point the theory of alexithymia comes in on which, in my opinion, there is not yet enough research material available in order to discuss the point of 'alexithymia' of the members in an institution or the alexithymogenic potency of institutions any further right now.

The psychosomatic consultant's task of building up a working-alliance with the psychosomatic patient is often so difficult because the individual patient's resistances are reinforced by the resistances inherent in the medical institution. Keeping this unpleasant fact in mind, it seems to be a necessary and meaningful policy to experiment with modifications of the setting in medical institutions. We have, therefore, concentrated our efforts in Ulm in this direction on a 15-bed ward of the University Department of Internal Medicine. It was our major aim to structure medical and nursing routine in such a way so as to allow a continuous development as well as a reflection of the relationship with the patient.

We reorganized the doctor's interview and developed an interview for nurses; we discuss these interviews every morning in a ward-conference and try to modify the daily ward rounds in a patient-centered way. In addition to this development in the organization of the regular ward events, we have established a 1-year training course in 'patient-centered nursing'. In our concept, medical and nursing care form the basis for the establishment of a relationship in which a patient, who experiences himself as primarily bodily ill, can feel secure enough to open up to a psychosomatic approach to his illness.

It is our experience that more patients can be reached in such a setting. The setting allows a continuous connection of bodily complaints and the patient's interactional experiences and emotional situation.

Dr. Wolff: I only want to make a few comments to illustrate my basic approach which I described on the first morning. When we are treating a patient in psychotherapy who has a psychosomatic symptom, be it functionally or structurally determined, the first thing we have to remember is that we are not treating a disease but rather that we are working with a person who is ill. How do we treat the person? Here I want to remind you of the notion which I quoted from Winnicott that for psychotherapy to be effective, both patient and therapist have got to learn to play together and find the right way of doing so. By this I

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mean that the patient and I have to play with fantasies, thoughts, feelings and experience, I entirely agree with Sifneos and Nemiah that in some psychosomatic patients the characteristics described as alexithymic are often a considerable obstacle to this kind of work as the patient may be out of touch with his fantasies and feelings. The question which I as a therapist then have to ask myself is not 'has he got no feelings', but rather 'where has he put his feelings?'

I will give you an example to illustrate this. A few months ago I was asked to see an asthmatic boy of 19 who had had asthma for many years, but who had recently also started to cut himself. The referring doctor had sent him to me with the comment that he doubted whether psychotherapy could help him as he seemed to be completely out of touch with his feelings. That seemed to be a correct description when he came to see me. The patient gave me a brief account of his asthma and of the fact that he cut himself, but when I asked him 'Why do you cut yourself?' he replied 'I don't know, I just do'. 'What do you feel when you cut yourself?' 'I don't know'. Some enquiry into his family and personal life also only elicited some factual information but without any relevant feelings. So I knew his feelings had got lost and I asked him simply 'Which arm of yours cuts which arm?' 'I always use my right arm and cut my left'. 'Right, I want you please to imagine yourself to be your right arm and later on to tell me what that feels like'.

Until then he had looked collapsed and bored and I had felt bored too, but when asked to describe what it felt like to be his right arm he got excited and said 'I could cut anything in the world, I'm feeling incredibly angry when I'm that – I don't like it, it's frightening, I prefer to be my left arm'. I said 'Alright, please be your left arm' and he said 'I feel very passive and completely at the mercy of anybody who would attack me. I don't like this at all'. Then he suddenly said 'I feel awful' and put his hand on his stomach. I said 'What is going on in your stomach?' 'I don't know'. Then I said 'Alright, shut your eyes and be your stomach and tell me what that feels like'. Then he said in a frightened voice 'very vulnerable, as if I'm going to go to pieces completely', at which moment both his legs began to shake and tremble. I commented 'Something else is happening to your legs, isn't it?' And he said 'Yes, yes, that's right'. He

looked at his legs and said 'It feels as if they couldn't support me'. 'So you want to collapse' I said, 'is there any part of your body where something is going on at the moment?' He replied, 'Well, I'm getting a headache'. I said 'Right, what's happening up there in your head?' to which his reply was 'I feel terribly confused'.

The lesson I learned from all this, and which I want to get across to you, is that when I work with an alexithymic patient, I use every means at my disposal to try and locate where his feelings have been projected into. To this young man, who by now seemed to have come alive, I was now able to say: 'We seem to have learned a lot about you. Your anger is in your right arm, your passivity and receptiveness in your left arm. Vulnerable and frightening feelings are in your stomach, the wish to give up completely is in your legs and, as a result of all that, you feel confused; but you don't feel that either but your confused feelings are put into your head. We will have to do a lot of work, in order to try and put all these bits and pieces together to make you into one whole human being.' He is now in psychotherapy where that process is slowly beginning.

I have given you this example to illustrate how playful and inventive one sometimes has to be when working with patients of this kind. Once one has helped them get in touch with their feelings and fantasies, one can in my experience continue working with them in

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analytically oriented therapy, often for a long period, provided one is prepared again to use similar methods if progress gets blocked by loss of contact with feelings and fantasies.

One last comment: during ongoing therapy it is essential to make continuous use of one's own countertransference because the patient instead of projecting his feelings into his body may project them into the therapist. Dr. Taylor has already described this to us; when the therapist feels bored or sad or angry he may be experiencing the patient's feelings and fantasies. This gives the therapist frequent opportunities of suggesting to the patient what he may be feeling or what fantasies he may be avoiding so that further work can be done in therapy.

Dr. Pierloot: After all the different contributions we have heard during this conference and this afternoon, it is hard to imagine that something new can still be said on the subject of psychotherapy and psychosomatic patients. So I would like to limit myself to a few remarks which I consider as a result of the opinions I have heard at this conference confronted with my own experience.

The first remark will be very complimentary to what Dr. Wolff has said. It concerns the term 'psychosomatic patient'. I wonder if, from the point of view of therapy, it is opportune to stress this term too much. Psychotherapy is after all always directed to the person and not to the complaint or disease. Moreover, every psychotherapy is a unique form of interaction between a given therapist and a given patient. What is important is the total personality of patient and therapist. And I am somewhat afraid that the labelling of a patient on the basis of one aspect of his functioning, the formation of psychosomatic symptoms, may create a negative bias towards this patient. The choice of a given form of psychotherapy should be based on the whole personality of the patient on the one side and the attitude of the therapist towards his patient on the other side. And I would like to complete this statement with the remark that sometimes it can be better to ignore or not to take into account the specific symptomatology. An example is the group psychotherapy for anorexia nervosa patients. In our experience, groups composed uniquely by anorexia patients are very hard to run. Since we simply ignore the anorexia label and treat these patients in groups consisting of different sorts of neurotic patients, the results are much better. A second remark regards the meaning of the presentation of the somatic symptom

in psychotherapy. Whatever the value of the symptom may be in the total economy of the psychological function of the patient, the presentation of the symptom to the psychotherapist has a meaning in itself. It may, for instance, be a form of seduction, but very often it appears as a barrier. It disturbs the communication between the patient and the therapist. The patient speaks another language than that the therapist would like him to speak, but it also disturbs the communication between the psychological experience and the somatic functioning in the patient. Heinz Wolff has spoken of a splitting of psyche and soma. In the same sense alexithymia can be considered as a splitting between emotional experience and verbalized feeling. The concept of splitting has been advanced by Melanie Klein and Fairbairn and has been elaborated by Otto Kernberg as the essential feature of the so-called borderline personality. It seems attractive to suppose a connection between different forms of splitting but I think we must be very careful not to make the term splitting to a new magical term that sounds good and explains almost nothing. Still it can be interesting to note that splitting, as described by the mentioned authors, is a mechanism that cannot be overcome by interpretation which is a classical tool in dynamic psychotherapy.

What is needed are procedures with rather integrative effects and in many contri-

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Contributions at this conference it has been proclaimed that the phenomena of alexithymia should be overcome by specific therapeutic procedures. I would only like to refer to our experience with the autogenic training of Schulz. Although I cannot confirm it in exact numbers, we have the impression that some alexithymic patients after completing the lower cycle of relaxation can proceed to the higher cycle described by Schulz and based on insight and interpretation. And that leads me to my last remark, more specifically with regard to the phenomena of alexithymia. From the point of view of therapy, the primary question seems to me in how far the phenomenon is irreversible. In the paper I presented yesterday I mentioned the puzzling finding that alexithymia correlates with drop-out in short-term dynamic psychotherapy, but not with less success in the completed therapies. That leaves open the supposition that in these completed therapies alexithymia had been overcome. What is lacking is a comparison of the rating of patients for alexithymia before and after certain therapeutic procedures. Therefore, we have to refine our measurement tools to plan new research designs and to provide data. I think that this conference has stimulated us in that direction and I am grateful to all the contributors who provided perhaps different but always interesting ideas.

Dr. Heiberg: I would like to share with you the experience that made me, so to speak, believe in the concept of alexithymia and in how to deal with it therapeutically:

Three years ago when I was giving a lecture in the Norwegian Psychiatric Association with our young residents, I had just come to learn about this new concept of alexithymia and I was very enthusiastic about it, ending up by saying triumphantly: 'Isn't it nice that this defect that others call lack of communication is no longer our fault, it's a deficiency in our patients! Would there be any questions or comments?' There were none.

Then we had a break of a quarter of an hour; one of my colleagues came up to me and very quietly said 'I didn't make any comments to what you presented to us because I recognize myself in that you spoke about. I think I am alexithymic the way you described it'. I went red and felt very embarrassed, keeping in mind what I had just said about deficiencies, but she took it very well and went on just telling me about it. She said that she used to be bothered by an ulcer that had really been incapacitating her for several years. She graduated from medical school and she

was always somewhat interested in psychiatry because she was curious about feelings and emotions. So she started to train to talk about feelings, to learn what feelings really are and she said that by this process, by sharing with her patients, she had herself gained new ideas, new awareness of what they were really talking about and she very nicely said 'You know, my ulcer has not been bothering me since I entered psychiatry'. She ended by saying 'but my family never talk about emotions and feelings at all and they all have hypertension or ulcerative colitis or ulcer or whatever you'd like to mention'.

To me that was a kind of turning point because for one thing it made me really believe in the concept and for another, she gave such a beautiful example of a spontaneous way of learning how to deal with it. I think that this learning concept is probably a very important part of the whole procedure of therapy with alexithymic patients.

Dr. Freyberger: My contribution concerns auxiliary therapist pools which consist of medical students who are able to deal with supportive psychotherapy in selected psychosomatic patients. In connection with the mentioning of supportive psychotherapeutic techniques in alexithymic patients, the question arises in which way the great discrepancy

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can be solved between the high number of patients who use supportive psychotherapy on the one hand, and the restricted number of available therapists on the other hand. In my opinion the best way at present to reduce this discrepancy is the foundation of students pools acting as auxiliary therapists and supervised by trained therapists within Balint groups. The application of supportive psychotherapy by an auxiliary therapist presupposes in the patient the following four psychodynamic processes which are the typical marks of the pregenital arrest and can be almost always found in alexithymic patients. The first psychodynamic process derives from a narcissistic conflict with the following oral-narcissistic acting out and the inability to transfer differentiated libidinous and aggressive wishes to the therapist; secondly, we observe marked oral-regressive fixations; thirdly, there arises -on the basis of an aggression conflict – an aggression defence and the resulting depressive traits, and fourthly, markedly insufficient insightful capacities. As a consequence of these four psychodynamic processes, which make a psychoanalytically oriented psychotherapy impossible, the following four supportive psychotherapeutic steps result which I described in this morning's session in my paper 'Supportive-psychotherapeutic techniques in primary and secondary alexithymia'. Up to now, we cooperated on the campus with a group of eight students for the duration of four semesters (Department of Psychosomatics, Eppendorf Hospital, University of Hamburg, Hamburg) and with a second group of eight students for the duration of two semesters (Department of Psychosomatics, Hannover Medical School, Hannover). For the purpose of supervision, the group met twice weekly for a period of 2 h each time. On the basis of this procedure we survey in 14 patients the supportive psycho-therapeutic treatments, performed by students, which lasted from 6 months up to 2 years. If the patient was in the inpatient clinic, two sessions weekly took place. In the outpatient clinic, the frequency of the patients' sessions depended on the intensity of the patient's oral-narcissistic needs. When the patient was not able to come in weekly or at 2 weekly intervals, then, in the meantime phone contacts were established. The supervisors and the students were all very impressed with the high supportive-psychotherapeutic effectiveness of these phone contacts. As to the outpatient clinic patients during the semester holidays, the sessions did not regularly take place. This was not a disadvantage when the patients were sure that the therapy would be continued later on, and a substitute therapist would be at their disposal

if suddenly an object-loss experience occurred. Originally we founded the auxiliary therapist's pools as a consequence of the urgent demand of the colleagues in the medical departments. These colleagues have had psychological difficulties with their patients during the somatotherapy. These difficulties particularly occurred in patients who were suffering from ulcerative colitis and morbus Crohn; furthermore, in dialysis and transplant patients as well as in patients who were suffering from cancer, and finally in those patients with functional somatic disorders who showed alexithymic features. Because of the work overloading of the doctors of our psychosomatic department, we saw no other supportive psychotherapeutic possibility than the organization of the students' group.

Dr. Sifneos: I would like to comment very briefly on three aspects which are mostly clarifications of some of the things which I have said here last Tuesday. The first one is on the alexithymic phenomenon, the second one is on psychotherapy, and the third one is on my own particular position as far as some of the criticisms which have been directed at me from various people are concerned. The first point is about the alexithymic phenomenon. The word was simply used to describe certain clinical observations that were made over

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very many years. I tried appropriately to use a Greek word or a pseudo-Greek word for descriptive purposes. Alexithymia is a nasty phenomenon. It is a nasty concept, but so is cancer. The fact is that they exist and that all the wishing in the world will not make them go away and it is up to us to fight against them. Now alexithymia presents such a challenge to our psychotherapeutic abilities, or to our own narcissism, that we want to deny it, or we want to rationalize it, or we want to relegate it to the lower classes, or we want to forget it. As Dr. Shands said the other day, for 30 or 40 years we have managed to forget it. We have succeeded unfortunately. It's up to us, up to you, ladies and gentlemen, to recognize it. The fact is, as I said on Tuesday, that alexithymia is here to stay whether we like it or not and it is going to be with us for the rest of our lives. It is up to us to be honest, to be scientific, to observe it, to study it and to do something about it.

The second responsibility I have is to the notion of therapy in general and particularly to psychotherapy. Dr. Wolff mentioned, on the day about psychodynamic psychotherapy, that my countertransference was involved. The only defence I can have to this criticism is that I like psychodynamic psychotherapy, I am a psychoanalyst and the major contribution of my professional life, small as it may be, has been on short-term psychodynamic psychotherapy. So I believe in psychotherapy very much but I also believe that it is a major mistake to offer certain kinds of psychotherapy when they are contraindicated, in the same way as it is to operate on the thyroid gland if the appendix has to be removed.

As pious as we may be about how much we like the patients, we do them a disservice when we make global generalizations about the patient. The fact is that we know that there are certain individuals who have low IQs and certain individuals who have IQs that are very high. This is a fact. Similarly, there are certain factors, certain genetic and developmental constellations which influence the psychodynamic makeup of our patients and which is our responsibility to evaluate. There are good psychotherapy candidates and bad psychotherapeutic risks.

Appropriate therapeutic techniques to fit specifically with the idiosyncratic needs of these particular individuals must be developed. A global offer of 'psychotherapy for all' is not the answer, popular as it may be judging on the applause. Finally, I want to clarify one misconception about my personal attitude which has been criticized. I have listed, and

fortunately it has been recorded on this tape recorder, four different etiological factors for the explanation of the alexithymic phenomenon. Furthermore, I mentioned that Dr. Frey-berger has contributed other factors as well. The alexithymic phenomenon in my opinion is challenging. In addition, there might be several kinds of alexithymia. The fact is, as I have mentioned, that it could be due to a variety of etiological factors: (1) a neuroanatomical deficit; (2) a neurophysiological deficit; (3) a developmental or sociocultural deficit, and (4) a psychodynamic paucity of defence mechanisms. I do not want to be put into a cubbyhole and I do not want my opinion to be distorted, namely, I favor only one, i. e. that alexithymia is a neurological deficit and that nothing can be done about it. This is only one of the four possibilities. I would very much like at present to have the audience participate in our discussion particularly since some of you have expressed the desire to have members of the panel discuss their ideas with each other as well as with the audience.

Dr. Pelsner: Referring to the introduction of Prof. Bräutigam, I would like to point out that we have long ago given up expecting psychosomatic symptoms to disappear by causing the patient to verbalize his emotions. But only because these symptoms are produced by repression of an emotional conflict rather than by an inability of the patient to

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express emotions, but also because the psychosomatic patient expects from his doctor in the first place that he will treat his somatic condition. The asthmatic patient may well have emotional problems, but he has also a deficient and faulty breathing, from which he wants to be cured. Only after he discovers that medication and breathing exercises are not sufficient to stop his asthmatic attacks, he will become motivated to discuss why this treatment is not sufficient to cure his asthma and then he will appear to be no longer alexithymic and discuss his emotional problems with his doctor. The same goes for the ulcer patient who, in spite of all medications and dietary prescriptions, is still suffering from his stomach and only then becomes inclined to discuss the emotional tensions of his work and family situation. In conclusion, I think that what we should aim at in therapy is not a verbalization of emotional conflicts, but rather to help the patient in changing his attitude in these conflicts. Unless we have achieved such a change in behavior, we have done nothing for our patient essentially.

Dr. von Rad: One often gets the impression here that there are such things as people who are alexithymic and that there are others who are not. I have not had this experience. The people I have seen have, if you want to give it such a name, always been more or less 'alexithymic'. I feel this makes a great difference as it is of such importance for the theoretical considerations and, for example, the etiological problem. There are individuals who are alexithymic in certain situations and not in others. Others are alexithymic in a certain part of their personality ('psychosomatic sector'), again others perhaps only in respect to a certain conflict area. This is one of the reasons why I want once more to urge Prof. Sifneos to standardize his questionnaire because we are obviously so often talking about completely different patients under the same heading 'alexithymic'. With the varied selection of patients we have, our experiences are consequently so varied and for this reason we do not know what we can call an alexithymic patient.

Dr. Kimball: My comments will follow those of the previous speaker. I think that there is no question that alexithymia exists as a phenomenon, as described. It is described, therefore it is. I think the question is whether it is a fixed behavior type related to a specific disease, or group of disease, or whether it is a defensive stance that occurs at a particular time in a particular situation with a significant other. I think this has great implication for research in these patients

manifesting psychosomatic illnesses. Do they act differently in different positions with authority, than they do in their families or with those that they are very close. Thus, we would need to see them in different situations. It would also apply that we would need to, in our researches, see these patients at different points of time. Now I think that this is particularly so when we try to relate this concept to the 'holy seven' psychosomatic diseases of Alexander, can we really say that these individuals have defensive patterns all of a kind? I would merely ask you to see an asthmatic patient in juxtaposition with a patient with an essential hypertension, and I would defy you to identify many similar characteristics in terms of defenses. Engel in his careful observations of patients with ulcerative colitis described different defensive patterns when the patient was in a state of remission or in a state of exacerbation. So I would ask those of us who would look at the concept or the phenomena of alexithymia that we look at what is common, if there is a common element, if there is a trait, or a behavior or a pattern than can be identified both during the stage of remission and the stage of exacerbation. I cannot pull this out of my clinical experience at this time. In my current thinking about alexithymia, I see it as a phenomenon that is seen quite frequently in psychosomatic patients in different stages

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in the development of the disease and at different times depending upon the course of that disease and as probably having something to do with stress correlations with significant others at a particular point of time.

Dr. von Kries: I want only to make a few remarks about the psychoanalytic treatment of the so-called psychosomatic patients. One of the main traits of alexithymia is the inability to express emotions. If there is an inability to develop and express emotional reactions, this must have to do with a very early disturbance of the mother-child relationship. This has been mentioned several times during this congress as well. We know that these early disturbances later in life bring about a definite lack in object relationships. The object cannot be perceived as a human being different from oneself. Indeed these persons are disturbed in a narcissistic way; in contrast to the era of Freud, we now assume that it is possible to help those patients and to bring about a change in their approach to others and of course towards themselves as well. I wonder whether the reduplication symptom of the French authors is not the same phenomenon we encounter in the treatment of narcissistic patients. The other person is merely used to fulfill one's own needs and, over a long period, we have to accept this. This narcissistic defect can be altered only if a person becomes capable of developing psychic pain and grief and anxiety. Qualities which in the mother-child relationship obviously could not be developed or had to be repressed immediately. But, and that is the crucial point, we have to have tremendous patience in those treatments. Balint speaks of the basic fault, a term which describes the above-mentioned symptoms, and he wrote that it is not important to make the patient speak, that it is much more important to create an atmosphere of tolerance and acceptance. I had patients who could not verbalize at all and I just said 'We both have to accept that and we must try to understand later why it is so'. And by starting to speak first, just making casual remarks about something, eventually the patient started to join in with what I was saying. Procedures like these of course take a tremendous time. I would like to quote MacDougall, who in her marvellous paper in 1974 described the psychic state of an alexithymic patient in the following way: she used lines of a modern folk song – it goes like this.

'I touch no-one and no-one touches me. I'm a rock. I'm an island and a rock feels no pain and an island never cries.' She concludes by saying '... the analytic process can produce overwhelming

change even though to do this it may lead the rock to feel great pain and the island to cry for many years to come’.

Dr. Philippopoulos: ‘...I would like to have Dr. Sifneos’ opinion on the role that cultural factors play in the development or in the genesis of some neurotic and/or psychosomatic manifestations including alexithymic phenomena. Personally, I feel that they do play a role not only among people of the same national structure but also among minorities of ethnic groups existing far away from their national trunk (immigrants etc.).

In a personal communication some years ago, Professor Paul Kielholz of Basel, Switzerland, to lay stress of the importance of socio-cultural milieu as a causative factor in the genesis of emotional, neurotic and psychosomatic disorders, told me the following story:

“Two Swissmen were having their evening beer in a Weinstube in Basel. They were sitting there for about an hour quite, silent and stiff. Then a third man comes in, approaches them, says ‘good evening’ and joins them to have his beer too. He remains speechless for an hour or so, pays for his beer, says ‘good night’ and goes away.

Then, one of the two men left behind said: ‘Well, this man talks too much!’ “

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It is, I think, apparent that the point I wanted to make is being supported by Prof. Kielholz’s story!’

Dr. Sifneos: In terms of the question regarding the cultural factor I think that it should be looked into just as much as any of the other factors. Under my ‘develop-mental hypothesis’ on the etiology of alexithymia, social, anthropological and cultural factors would be of course included.

Dr. Gaddini: A remark on the concept of somatization and desomatization as it has been used by Dr. Bräutigam in connection with learning and education. The point I am raising is that learning and education imply ego functions and ego functions imply a substrate on which to build themselves. This substrate is, for me, the self in the sense of Winnicott. The self is the result of the total experience of that which has gone on between mother and child in the early months. The concept of the *je* brings me back to the ‘safety concept’ that Dr. Bastiaans presented this morning. The elements which enter in the realization of safety as he describes it are the very elements which we find developmentally as basic to the process the infant in his first months undergoes in building his own self and subsequently in relating to his mother and to the outside world. Also, Dr. Bastiaans, idea that the ‘psychosomatic’ way of reacting to fear and stresses is a ‘deficient coping strategy’ which originally has established itself in the early interactions with mother is develop-mentally convincing. The moment this ‘deficient strategy of interactions’ between mother and child has established itself, it is, however, hard to go back. I agree with Dr. Nemiah that the exploration of feelings in adult psychosomatic patients is extremely difficult and not often useful; I do not know whether it may be harmful too. This is the problem of somatization as I see it: it comes to exist as a distorted form of communication early in life. This view implies that the only sort of intervention we may expect to be successful in the field of psychosomatic medicine is of a preventive order.

Another point which has interested me in the ‘Panel Discussion’ is that raised by Dr. Shands on the object and the subject. I am sorry he is no longer here. He said that in his view language is objective in respect to the subject’s private world: for him, ‘free association go between metonymy and metaphor’. In my view, if I look at the process of development, I can see the object which is there since birth but is not recognizable as such by the subject. From the point of view of psychology, the object starts to exist when the mental structure enables the subject to

experience it as such. Winnicott's concept of subjective object, which I find clinically enlightening, refers to the intermediary stage when the subject moves towards the object and withdraws from it.

Dr. Heiberg: I have been impressed with how many people in this congress have actual experience in the field of alexithymia. As you have been the first outstanding child therapist to speak here, I would like very much to know whether you know about any studies in these traits in children.

Dr. Gaddini: If you meant to ask me whether I worked with a special group of children called 'alexithymic', my answer is 'no'. I have not studied them as a group. I am not sure the characteristics we find in patients – adults and children – suffering from psychosomatic illnesses may enter one group. My own experience indicates that fantasy life is particularly poor in autistic children and, in a different way (mostly limited to its expressive capacities) with a few children suffering from psychosomatic disorders but not selected on the basis of this diagnosis. You may recall the project which I mentioned at a different part of this

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conference. It is on the basis of this longitudinal study that I have noticed a correlation between evocative capacities at 8, 10 and 12 months as expressed by the presence of a transitional object or phenomena and the capacity of playing at the age of four. This correlation points out to me an existing continuum of self-creativity (the transitional object is the creation of the subjective object) and the capacity of playing (and of sharing) later in life.

Inspired by these observations of mine, my allergological colleagues – with whom I work closely – have retrospectively noticed that in severe cases of asthma and/or atopic dermatitis transitional objects or phenomena are not usually found. In my study which was prospective, I have followed from birth to 8 years, children belonging to three different social groups (rural, urban and foreigners living in Rome) focusing on their going-to-sleep pattern at the end of the 1st year and on their capacity to play at the age of four. Nearly 40% in the urban group and over 70% of the foreign group had a transitional object (blanket, nylon, teddy, etc.) or phenomenon (a rhyme, a prayer, being rocked), while in the rural group where the child sleeps close to the mother the incidence of transitional objects is only 4%. The working hypothesis of this longitudinal study was that the transitional object is the first expression of evocative imaginatively (as contrasted to nonimaginative play, such as acting out and running around) comes next, as a derivation from it. The play of the severe cases of asthma observed by our allergologists, in whose past histories no transitional object had been found, had also been found to have more the character of motor discharge and/or testing out than that of a creative dramatization. Of course when we talk about asthmatic or atopic dermatitis children, we ought to clearly define the type and the severity of the illness. But this will be done more thoroughly on a different occasion.

Dr. König: The question is still under discussion as to whether you can get psychosomatic alexithymic patients into psychoanalytically oriented treatment. There were several speakers today who said they could do it. I may mention the names of Sellschopp, Wit tick and Stephanos; perhaps you can also remember Cremerius' presentation yesterday and I might join these people because I have had similar experiences. What these authors all have in common is that they all work, as I do, in a psychoanalytically oriented hospital. Further, they all practice analytically oriented group methods either doing group psychotherapy or running the ward and the team as a group or by group methods. And they all more or less employ auxiliary methods as mentioned by Dr. Bräutigam. What is it, however, that makes it work with some patients – not with all – but

with some? Is it group psychotherapy alone? We have listened to Dr. Ford's and Dr. Roberts' presentations which told us about very low attendance figures and a very boring and unproductive therapeutic process. As I said previously, the authors I mentioned getting psychosomatic, alexithymic into treatment all have in common that they work in a hospital and I think that in addition to the possibility of combining analytic group methods with auxiliary methods it may be the provision of a different set of social norms, counteracting previous social influences that makes hospital treatment effective. The fact that it is indeed effective has come to the notice of quite a few psychoanalytic practitioners who send us patients to initiate treatment which they later continue in their private practice. Therefore, if initiating treatment in a hospital setting is a feasible way of making these patients treatable, why don't you try it – and if you don't have the hospitals, put them up.

Dr. Freyberger: Dr. König's remarks were indeed very important. There are obviously psychosomatic patients who only show 'partial' traits of alexithymia. These patients
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should be suitable for psychoanalytically orientated group psychotherapy. According to my experience, however, there is also occurring a larger group of 'total' alexithymic patients who cannot be treated by psychoanalytically orientated group psychotherapy. Possibly a smaller group of these patients may be finally suitable for group psychotherapy after they have been processed by 1 or 2 years of individual supportive psychotherapy. I regard these therapeutic considerations as very relevant. Therefore, during every long-term supportive psychotherapy it will be advantageous to discuss closely the question of whether the patient can be expected to cope with merely a group psychotherapy or if other forms of interpretative psychotherapy are needed.

Dr. Taylor: I'll be brief. I would like to respond to the remarks made by Dr. Wolff and Dr. Sifneos because I agree that there do seem to be some misconceptions at this conference. First, I think that the phenomenon of alexithymia is not in dispute at all and I agree with Dr. Kimball on that point. Second, it is refreshing that Dr. Nemiah and Dr. Sifneos have emphasized the third and fourth possible explanations for alexithymia. I think that one of my own misconceptions came from reading their earlier papers in which a much greater emphasis was placed on the neurophysiological and neuroanatomical explanations but this conference has clarified that. Third, I think that what we mean by the term 'counter-transference' must be clearly defined because it is not employed in a perjorative way nor intended to offend. In fact 'counterresponse' may be a more acceptable term. The plea here is to consider the countertransference as an instrument of research which would help clarify the third and fourth possible explanations for alexithymia. The focus is on becoming more aware of the feelings, fantasies and dreams evoked in us by our patients and asking ourselves what further information these may provide about the inner worlds of the patients and how this information may be used in the treatment. Finally, in response to Dr. Frankel's comments, I would agree that many psychosomatic patients do become physically sicker when treated with analytical psychotherapy. However, many such patients also become sicker when they do not receive analytical psychotherapy.

Dr. Bräutigam: I would like to make some comments on Dr. Pelsner's remarks. The first point Dr. Pelsner made was that he stresses the importance of accepting the patient's physical complaint. I think it is most important with the psychosomatic patient to accept this kind of communication and to meet him on the level on which he understands his illness. Unfortunately, a psychoanalyst or psychotherapist treating psychosomatic patients as outpatients hardly has a chance of having physical contact with them. Therefore, I think it is better for some of these patients to start their

treatment by coming to the wards where they can have physical examinations, can experience a medical setting and can get into physical contact with their therapists. For the time being, at least, we have to accept the preverbal levels of that communication and understanding. A great number of patients have learnt to speak only about physical complaints and it takes a long time to shift their attention from physical complaints to feelings.

The second point that Dr. Pelsler mentioned concerns their learning experience. It is an important item for the psychoanalysts to know about. As a young analyst I was very puzzled when I saw a patient used the same words as I did, made the same kinds of movements -that he imitated me. I always thought that I was not a good analyst for having such patients that I had to be more distant and treat them in another way. I learned later that we have to accept such needs of patients to get in touch with us as real persons and, accordingly, to have an opportunity to imitate us. However, what may be necessary in the beginning of

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treatment may later become resistance on the road to autonomy and needs to be worked through. I would not follow Dr. Pelsler in giving up hope on the psychosomatic patient's ability to learn cognitively through the exploration of their conflicts and personal history. He may experience that new cognitive learning is also an emotional process and may lead to behavioral change. Therefore, I may say that I am as optimistic as Dr. Pelsler seems to be about the possibility of treating psychosomatic patients with psychotherapy on a verbal level. Evidently in this regard Dr. Sifneos and Dr. Nemiah are much more sceptical than we are. As to the treatment and research that Dr. von Rad mentioned, we possibly deal with a very selected sample of patients. It seems to me that you are dealing in Boston with patients whose physical complaints, education and abilities of verbalization differ from those of our patients. In order to overcome this problem Dr. Sifneos and Dr. Nemiah should come back to Heidelberg and study our patients with us – and we should go to Boston to observe their patients with them.

Dr. Nemiah: Let me just make a brief response to Dr. Wolff

whose remarks have been very stimulating for all of us. Dr. Wolff suggests that in treating psychosomatic patients it is essential to get at their feelings. I would agree with this as a general psycho-therapeutic principle

but in dealing with the group of patients under discussion here

there appears to be a basic problem. As we have tried to stress throughout the conference

such patients have a fundamental difficulty in experiencing affect and

in our therapeutic attempts at least

it has often been impossible to get at their affects by the usual therapeutic procedures. I should like to stress

however

that much more clinical experience is necessary before one can confidently state this as a valid generalization. Clinical investigation should be aimed in the future at systematically exploring the effectiveness of analysis and analytically oriented psychotherapy in a large number of patients with psychosomatic disorders. Only then will it be possible to determine whether one can uncover in them a capacity for experiencing both affects and fantasies.