Part I History, Assessment, and Cultural Shaping of Alexithymia

Chapter 1

History of Alexithymia: The Contributions of Psychoanalysis

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I begin this review of the history of alexithymia by taking us back more than half a century to the year 1964. Drs. John Nemiah and Peter Sifneos were working in Boston where Nemiah was Chief of the inpatient psychiatric unit at the Massachusetts General Hospital and Sifneos was Director of outpatient psychiatric services at the same hospital. They were trained in psychoanalysis as well as psychiatry, and had an interest in psychosomatic medicine. Franz Alexander's specificity theory of psychosomatic disease was still in vogue, in which specific intrapsychic conflicts were associated with the pathogenesis of certain diseases; there were several competing theories including a theory that psychosomatic disease involves a regression of ego functions to primitive levels and an accompanying regression in the physiological sphere (see Taylor, 1987). During the course of the year, Nemiah completed a research study on specificity in psychosomatic disease, which involved tape-recording interviews of patients with a current or past history of two of the following "classic" psychosomatic diseases: duodenal ulcer, rheumatoid arthritis, bronchial asthma, ulcerative colitis, and atopic dermatitis; the interviews were aimed at eliciting psychodynamic and situational factors related to the onset or exacerbation of each disease (see Nemiah & Sifneos, 1970a).[1] In the same year, Sifneos (1964) published a book titled *Ascent from Chaos*, in which he provided a detailed and moving account of his experience using "anaclitic therapy" to treat a rather hostile and demanding patient who had undergone a colectomy for ulcerative colitis. Anaclitic therapy was a controversial treatment developed by Sydney Margolin (1954) and based on the ego and physiological regression theory; patients were hospitalized and regressed to a state of marked dependency in which all of their wishes and needs were gratified. The aim was to bring about a physiological remission by resolving infantile conflicts and by changing the patient's mood. Sifneos's book conveys an immediate sense of the considerable emotional turmoil, including intense feelings of helplessness and despair, experienced by both patient and therapist when undertaking this type of therapy.

Perhaps disillusioned by that emotionally demanding experience, and probably influenced by Paul MacLean's (1949) observation that psychosomatic patients seem to have an intellectual inability to verbalize emotional feelings, Sifneos (1967) began to take a different approach in his clinical investigations of psychosomatic patients. Just 3 years after publication of *Ascent from Chaos*, he reported some preliminary observations on a randomly selected group of patients with "classic" psychosomatic diseases. The most striking characteristic that Sifneos observed was a difficulty many of the patients had in finding words to describe how they feel, almost as though they did not understand the word "feeling". Sifneos wondered if the patients had an "emotional agnosia" akin to the "visual agnosia" observed by Klüver and Bucy (1937) in monkeys.

The following year, Nemiah was appointed Psychiatrist-in-Chief at the Beth Israel Hospital in Boston, and Sifneos joined him as Associate Director of the department. Despite the heavy responsibilities of these positions, they continued to pursue their investigations of psychosomatic patients. Inspired by Sifneos's (1967) preliminary observations, and also by the phenomenon of *pensée opératoire* (operative thinking), which Pierre Marty and Michel de M'Uzan (1963) had observed among a wide variety of

[1] The so-called "classic" psychosomatic diseases are the seven diseases investigated by Franz Alexander – essential hypertension, bronchial asthma, hyperthyroidism, peptic ulcer, ulcerative colitis, rheumatoid arthritis, and neurodermatitis. The idea of a specific category of diseases as being psychosomatic was discarded several decades ago and replaced by a psychosomatic approach to all physical illnesses.

physically ill patients in France in the early 1960s, Nemiah and Sifneos (1970a) decided to re-examine available protocols of the interviews from Nemiah's earlier specificity study. Whereas Nemiah had previously reported that many of the patients in that study were characterized by the frequent use of suppression, repression, or denial of affects, re-examination of the interviews revealed that many of the patients had a marked difficulty identifying and describing their feelings, an absence or striking diminution of fantasy, and an externally oriented style of thinking. Sifneos (1973) coined the term *alexithymia* (from Greek stems *a* = lack, *lexis* = word, and *thymos* = mood or emotion) to denote this cluster of characteristics, and designed the *Beth Israel Hospital Psychosomatic Questionnaire* to investigate the prevalence of alexithymia in psychosomatic patients compared with patients with psychoneurotic or personality disorders. The results of the investigation supported the earlier findings with psychosomatic patients, but Sifneos observed that some patients with addictions or personality disorders also manifested alexithymic characteristics. A few years earlier, Henry Krystal (1968; Krystal & Raskin, 1970), a psychoanalyst in Michigan, had independently reported similar characteristics in many patients with substance use disorders and among survivors of the Holocaust living in the United States. However, Nemiah and Sifneos remained primarily interested in the association between alexithymia and classic psychosomatic diseases; their publications generated enough attention that alexithymia was selected as the main theme for the 11th European Conference on Psychosomatic Research (ECPR) held in Heidelberg, Germany in 1976. It was left to Krystal to begin to extend the concept of alexithymia beyond the field of psychosomatic medicine.

This background history of alexithymia is well known to most clinicians and researchers as it has been outlined in the literature on several occasions (e.g., Lesser, 1981; Luminet, Vermeulen, & Grynberg, 2013; Taylor & Bagby, 2013; Taylor, Bagby, & Parker, 1997). Less well known are the various ways by which the history of alexithymia has been influenced by psychoanalysis. For this chapter, I thought it would be informative and useful to trace this aspect of the history, pointing out allegiances to and departures from classical Freudian theory as well as the application of some concepts from contemporary psychoanalysis. This approach allows me to examine some convergences and divergences of thinking among the originators and leading proponents of *pensée opératoire* and the alexithymia construct.

I first compare the psychoanalytic approach to somatic disease in North America during the middle decades of the last century with the approach taken by Marty and de M'Uzan and other members of the Paris School of Psychosomatics.[2] This includes a discussion of drives and affects, and the role different theorists assign to them in the psychosomatic process. I then review the historical background to the concept of mentalization, and different theoretical models that associate alexithymia with deficits in the mental representation of emotions. I then outline the important role of trauma in alexithymia theory and describe changes in the emphasis that psychoanalysis has given to trauma over the decades. In the final section of the chapter I consider some therapeutic issues; in particular, I trace the emergence of a way of understanding and using countertransference experiences to facilitate the psychotherapy of alexithymic patients.

North American and French Psychoanalytic Approaches to Somatic Diseases

Derived partly from Freud's theory of the psychoneuroses, Alexander's specificity theory and other early psychosomatic theories of disease proposed by psychoanalysts in the United States assign an etiological role to intrapsychic conflict over wishes related to instinctual drives. The specificity theory includes a biological vulnerability (the X factor), but the emphasis is on a specific intrapsychic conflict for each of the seven diseases Alexander chose to study; the conflict was thought to be activated by situational factors such as the loss of a dependent relationship (Alexander, French, & Pollock, 1968). It is unclear how well Alexander's ideas were known in France, but according to Aisenstein and Smadja (2010a),

[2] Although Marty and de M'Uzan (1963) together described *pensée opératoire*, they subsequently had some theoretical differences and de M'Uzan did not remain with the Paris School of Psychosomatics (see interview with Dominique Cupa: www.cairn.info/revue-le-carnet-psy-2008-5-page-43.htm).

Marty and Alexander met in the late 1950s at the 20th Congress of the International Psychoanalytical Association in Paris and exchanged views on gastric ulcer disease; however, Marty developed his own model of disease, which was radically different from Alexander's psychosomatic theory and other existing theories. Rather than assigning a causal role to conflict, Marty's approach was to identify forms of mental functioning that might create conditions conducive to the emergence of somatic disease (Smadja, 2005). In particular, he described a disorganization of mental functioning marked by operative thinking, an absence of fantasy, and essential depression. Nemiah and Sifneos's proposal that alexithymia creates a vulnerability to somatic illness converges with Marty's focus on certain deficiencies in mental functioning. Indeed, the salient features of the alexithymia construct, as defined by Nemiah, Freyberger, and Sifneos (1976), include a paucity of fantasy and operative thinking as well as difficulties in identifying and describing feelings. Given the contrast with conflict-based theories of psychosomatic disease, and the generally poor outcomes of treatment based on these theories, Taylor, Bagby, and Parker (1991) proposed that the alexithymia construct was potentially a "new paradigm" for understanding the influence of emotions on physical illness and health. Twenty-five years later, Jacques Press, a Swiss psychoanalyst who trained in psychosomatics with Marty, similarly argued that Marty's proposal of an inverse relationship between the quality of mental functioning and the risk of somatization[3] produced a "new paradigm" for psychosomatic medicine (Press, 2016).

There is an important difference, however, between the theoretical formulations of Nemiah and Sifneos and those of Marty and his followers. Whereas emotions and feelings are central to Nemiah and Sifneos's formulations, Marty and the Paris School are focused on the traditional Freudian concepts of energy, excitation, and libidinal and destructive drives. This difference between the Boston and Paris psychoanalysts can be understood partly by considering the history of the psychoanalytic theory of affect, in particular the relation between affects and drives.

Drives and Affects

In his early writings, Freud postulated that excitation was generated by a "quota" or charge of affect that accompanies every psychical experience (Breuer & Freud, 1893–1895); however, he equated affect with energy and did not differentiate between drives and affects (see Karush, 1989; Sandler, 1972). Freud (1915a) defined drive or instinct (he used the German word *Triebe*) as "a concept arising on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating within the organism and reaching the mind" (pp. 121–122). Freud also proposed a "constancy principle", which assumes that a primary function of the mental apparatus is to keep the quantity of excitation in the nervous system at as low and as constant a level as possible; failure to rid the organism of excessive excitation was believed to have pathogenic consequences (Eagle, 2011). Thus, affective energy would lead to symptoms unless it was discharged, for example by linking the affect with ideas and talking about them. Although Freud initially attributed pent-up or "strangulated affects" to real traumatic experiences (Breuer & Freud, 1893–1895), he later – after concluding that patients were remembering early fantasies rather than real events – came to regard affects and ideas predominantly as derivatives of drives (Sandler, 1972). It was not until he formulated his structural theory of the mind in the 1920s that Freud gave emphasis to the experiencing of affects, namely that affects are inner perceptions which can function as signals that alert the ego to mobilize defenses against threatening impulses (Sandler, 1972; Stein, 1991). However, as noted by Sandler (1972), "[Freud] still made no formal theoretical distinction between the somatic aspects of emotion – which were still seen as drive-derivatives – and associated feeling-states" (p. 37).

During the 1960s and early 1970s when the Paris and Boston groups were formulating the concepts of *pensée opératoire* and alexithymia, the psychoanalytic theory of affect was still rather muddled; most psychoanalysts regarded instinctual drives as the primary motivators of human behavior and affects as drive derivatives (Sandler, 1972). Aisenstein and Smadja (2010a) describe Marty as profoundly Freudian and

[3] As outlined in Chapter 7 the concept of somatization is used in several different ways in the literature including descriptively to define a specific symptom or disorder, and as a process involved in the production of somatic symptoms. Marty (1968) uses the term to describe a process that can lead to a wide variety of somatic disturbances including organic disease.

primarily interested in transformations and disposition of instinctual drives. Even in the theoretical model that is used currently by the Paris School, instinctual drives are assumed to have their source in bodily excitation and have the role of dealing with the tension thus created. Moreover, the Paris psychosomaticists believe that "If the sum of the excitations continues to be excessive, the functional systems become disorganized and the mental apparatus overloaded, thus leaving the way open to somatization" (Aisenstein & Smadja, 2010b, p. 629). This conceptualization is consistent with Freud's constancy principle.[4] In recent years, several French psychoanalysts have acknowledged the importance of affect in psychosomatic theory and practice and now emphasize deficits in the psychic elaboration of emotions in alexithymia, but they retain the traditional view that affects are representations of the drives (Aisenstein, 2010; Pirlot & Corcos, 2012; Smadja, 2010). Indeed Aisenstein (2010) affirms that the approach of the Paris Psychosomatic School "is derived from the Freudian conception of the drive" (p. 51).

An alternative view of affect emerged in the early 1960s when the psychologist Silvan Tomkins (1962, 1963) proposed that affects constitute a primary innate biological motivating system. Tomkins identified eight innate affects each characterized by a specific facial expression, and argued that drives derive their power from affects. More than two decades later, Schwartz (1987), a psychoanalyst, similarly proposed that "affects are the prime movers of human motivation" (p. 467). Nemiah and Sifneos did not dismiss drive psychology, but they separated affects from drives and developed a psychosomatic theory involving a deficiency in linking emotions with words and fantasies rather than an overloading of the mental apparatus with excitations. They also made an important distinction between emotions and feelings, defining the former as the somatic and behavioral component of affects and the latter as the subjective experiential component (Nemiah et al., 1976; Sifneos, 1967). Contemporary neuroscientists, including Damasio (2003) and LeDoux (1996), make the same distinction; and recently LeDoux and Pine (2016) proposed that subjective feelings, in particular anxiety and fear, involve a different neural circuitry to the circuitry underlying the behavioral responses and accompanying physiological changes that occur in tandem with the subjective feelings. On the basis of findings from neuroimaging studies, Lane (2008) has similarly argued that "the neural substrates of implicit [unconscious] and explicit [conscious] emotional processes are distinct, and that the latter have a modulatory effect on the former" (p. 214).

During the 1970s, the traditional psychoanalytic theory of affect was challenged by Krystal (1974), who was critical of Freud's economic model and rejected the view that affects are merely physiological discharge phenomena that can become loosely attached to ideas. Adopting some ideas outlined by Max Schur (1955), Krystal (1974) proposed a theoretical model of affect development that was independent of instinctual drives. According to this model, the affects experienced by adults have evolved from two affect precursor states in the newborn infant – contentment and distress. The maturation of affects is conceptualized as a progressive process involving desomatization and differentiation of emotions; as the child acquires language and a capacity for symbolization, mental representations of emotions are constructed that thereafter can be communicated verbally as feelings. Krystal (1977) proposed that the capacity to tolerate affects and to reflect on one's affective experiences develops in parallel with the process of development in the nature of affect. He emphasized the importance of good parenting for this development, in particular the parent's attunement to and regulation of the infant and young child's affect states, and gradually teaching words and meanings for the child's somatic emotional expressions (Krystal, 1988a). Krystal (1988b) recognized that the quality of interactions between the parents and the child also influences the development of the child's imagination and creative capacities.

Mechanisms of Symptom Formation

Krystal initially observed alexithymic characteristics among patients with substance use disorders and patients with post-traumatic states; he later concluded that alexithymia could be a consequence of an arrest in affect development due to psychic trauma in early childhood, but could also emerge from a regression of affect, involving deverbalization, dedifferentiation, and resomatization of affects, which may occur as a response to major trauma in adolescence or

[4] If we substitute emotions for excitations, the constancy principle could be considered a forerunner of the concept of emotion regulation.

adulthood (Krystal, 1975, 1988a).[5] Like Sifneos and Nemiah, Krystal proposed that chronic activity of the somatic component of affects without connections to words could lead to "psychosomatic" disease in individuals who are biologically predisposed to the disease (Krystal, 1988a, 1997). He concluded that emotions are expressed behaviorally if they are neither verbalized nor expressed through somatic symptoms. Krystal observed, for example, that substance-dependent patients have an impaired capacity to tolerate and identify affects, which he suggested leads to their use of a drug to block or regulate affects (Krystal, 1975, 1988a).

The concept of regression is used also in the theoretical formulations of Marty (1968), but in contrast to Krystal, Marty postulated a regression of libido rather than regression of affect. Moreover, Marty (1991) and his followers describe two modalities of the somatizing process – somatization through regression, and somatization through unbinding of the drives (Aisenstein, 2008; Smadja, 2005).[6] The process of somatization through regression is presumed to occur in individuals with satisfactory or minimal impairment of mentalization; the mind becomes temporarily overloaded with excitation, which results in regression of libido from the psychic sphere to somatic sources, and leads to relatively benign and reversible medical disorders such as headaches and back pain (Aisenstein, 2008; Smadja, 2005). In contrast, somatization through unbinding of the drives occurs in individuals with marked impairments in mentalization, a concept I review in the next section. The unbinding is considered a self-destructive movement resulting from a depletion of libido and ascendance of the death instinct;[7] it first affects mental functions, resulting in a sense of emptiness (which Marty named "essential depression"), disappearance of fantasy and dream elaboration, and a mechanical style of thinking – *pensée opératoire* – that is factual and non-metaphoric and without connections to drives, fantasy activity, and symbolization (Aisenstein, 2008; de M'Uzan, 1974; Marty 1968; Smadja, 2005). The unbinding then progresses to involve somatic functions, thereby causing a "physiological anarchy" that allows for the possible emergence of a variety of medical illnesses. Marty (1968) referred to this process as "progressive disorganization" and suggested that its severity is likely affected by genetic factors. As these states become more or less chronic, a mechanical way of living sets in – *vie opératoire* (Marty & Debray, 1989).

According to Aisenstein (2008), somatization through the unbinding of drives usually ends in serious illnesses, such as autoimmune disease or cancer, which may lead to death. But there is some inconsistency among the French psychoanalysts; whereas de M'Uzan (1974) linked the classic psychosomatic diseases with operative mental functioning and "psychofunctional" disorders (which do not involve tissue changes) with libidinal regression, Aisenstein (2008) attributes symptoms of classic psychosomatic diseases, such as asthma attacks, and episodes of hypertension, peptic ulceration, and colitis, to libidinal regression. There seems to be agreement, however, that there is continuity between somatic regression and psychosomatic unbinding, such that the illness that might emerge depends on the quality of mentalization (Marty, 1968; Smadja, 2005).

A British Contribution

The British psychoanalyst, Wilfred Bion (1962, 1967, 1977), whose contributions are less well known in the field of psychosomatic medicine, shifted the focus from instinctual drives to emotions, and developed a model of mental functioning based on the early emotional communication between the infant and the mother, who he conceptualized as "the thinking apparatus of the infant". He introduced the term *beta elements* to refer to the raw emotions, primitive sensations, and meaningless perceptions that accumulate

[5] Krystal's conceptualization of affect regression could be considered a variation of the ego and physiological regression theory of disease.

[6] Marty and his followers apply the term "somatization" to somatic diseases as well as somatic symptom disorders, in contrast to most other authors who limit the term to bodily symptoms that are not sufficiently explained by somatic disease. There is agreement, however, that somatization symptoms differ from conversion symptoms in having no symbolic meaning (see Chapter 7).

[7] Freud (1938/1940) assumed that there are two basic instincts – Eros (a love or self-preservative instinct; the available energy is referred to as "libido") and Thanatos (a death or destructive instinct). Whereas the aim of Eros is to bind excitations with representations and link them together as ideas, memories, and feelings, the aim of the death instinct is to unbind and destroy such links thereby creating an excess of excitation seeking discharge.

and create tension in the infant and are communicated non-verbally to the primary caregiver, who is usually the mother. The mother receives these communications and, through her capacity to symbolize, she transforms them into images, feelings, and thoughts that render them meaningful and guide her responses to the infant. Bion referred to the modified elements as *alpha elements* and postulated a symbolizing or *alpha function* in the mother's mind that performs the necessary transformation. Through these ongoing emotional interchanges with the mother, the child gradually develops a symbolizing function of its own, which allows the child to transform emotions and sense impressions into images that can be used in dreaming and linked to word representations that in turn allow the child to communicate subjective feelings and learn to think about and give meaning to its emotional experiences. However, the development of a symbolizing capacity in the child may be seriously compromised by traumatic events or by persistent deficiencies in the alpha function of the mother; untransformed *beta elements* are then liable to be discharged through mindless actions or evacuated into the body, resulting in somatic symptoms or illnesses. Antonino Ferro (2011), an Italian psychoanalyst, points out that emotions that are not contained and transformed should never be confused with aggression. In contrast to the Freudian view adopted by Marty and the Paris School, Ferro suggests that what is generally thought of as a death instinct or destructive drive may be the result of the inability of the human mind to transform sensory and emotional input.

Bion's ideas about the processing of emotions by the mind were applied to alexithymia by Graham (1988). He suggested that the impaired imagination and symbolic thinking of alexithymic patients reflects a failure of the alpha (symbolizing) function so that emotions are experienced as sensual impressions, things in themselves that cannot be transformed into alpha elements that can be used in dreams, fantasies, thinking, and learning from experience. More recently, Magnenat (2016), a Swiss psychoanalyst, emphasized the importance of the infant and young child's experience of the primary caregiver's alpha function for the integration of mind–body experiences and for establishing psychosomatic unity. He proposed that a failure of transformation of raw emotional and sensory experiences through the alpha function of the primary caregiver results in the internalization of an "obstructive object", which represents the imperviousness of the parent to the child's emotional communications, and interferes with development of the child's symbolizing function and consequently with the capacity to mentally represent and contain and understand his or her own emotional states. Magnenat suggests that this early deficiency creates a fault line in psychosomatic organization to which the individual is likely to regress, at a later stage, and develop a physical illness.

Mentalization

Mentalization is commonly assumed to be a contemporary psychoanalytic concept introduced in the late 1990s by Fonagy and Target (1997; Fonagy et al., 2002), who defined it as the capacity to be aware of and to think about feelings and other mental states (e.g., beliefs, intentions, desires) in oneself and others. However, the concept of mentalization was actually introduced in the 1960s by Marty and other French psychoanalysts (Fain & Marty, 1964; Luquet, 1981; Marty, 1991) to denote the preconscious function of linking drive and other bodily excitations with mental representations (Aisenstein & Smadja, 2010b). It thus encompasses an individual's representational and fantasy activity (Aisenstein, 2008). Marty's concept was further elaborated in 1997 by two French-Canadian psychologists, Lecours and Bouchard (1997), who proposed a theoretical hierarchy of levels of psychic elaboration that could be used to understand different levels of mentalization observed in adults. To avoid the conceptual problems surrounding the psychoanalytic theory of drives and affects, Lecours and Bouchard used the expression "drive-affect" and conceptualized mentalization as "a general class of mental operations, including representation and symbolization, which specifically lead to a *transformation* of drive-affect experiences into increasingly organized mental phenomena and structures" (p. 858). Lecours and Bouchard (1997) recognized that their conceptual model shows some similarities with Krystal's theory of affect development, with Bion's conceptualization of emotion processing, and with a hierarchical cognitive-developmental model of emotional awareness proposed a decade earlier by Lane and Schwartz (1987). The concept of mentalization also converges with Nemiah's (1977) description of the "*psychic* elaboration" of emotions, a process by which emotions

are gradually differentiated and linked with images and words to be represented mentally and thereby experienced as conscious feelings.

Around the time when Lecours and Bouchard published their theoretical model of mentalization, Wilma Bucci (1997a), a psychoanalyst and cognitive psychologist in New York, proposed a multiple code theory of how emotions are processed and organized in the mind. According to her theory, emotion schemas are comprised of subsymbolic components (patterns of sensory, kinesthetic, and visceral sensations and motoric activity experienced during states of emotional arousal) and symbolic components – images and words. The three components are connected to varying degrees, by a *referential process*. As with Lane and Schwartz's (1987) theory of levels of emotional awareness, the linking does not transform one component into another, but allows for a transformation of the meanings represented in the non-verbal components and for translation into logically organized speech. The transformation of the meanings represented in the non-verbal components is necessary for self-reflection and for the verbal communication of subjective experience. The concept of referential activity is thus similar to the French conceptualization of mentalization as the linking of somatic affect and drive excitations with mental representations.[8] Bucci proposed that if the referential process is disrupted by conflict or trauma or fails to develop adequately, the symbolic and subsymbolic systems within the schemas are dissociated, thereby affecting the organization of the schemas, the regulation of emotional arousal, and the construction of emotional meanings. Applying her multiple code theory to alexithymia, she suggested that the dissociation within and between the verbal and non-verbal components when the connections are disrupted or fail to develop is "far more complex than being without *words* for *emotions*; in some emotional-somatic disorders, the patient is without *symbols* for *somatic* states" (Bucci, 1997b, p. 165).

The unifying aspect of the different theoretical models is that they each associate alexithymia with deficits in the mental representation of emotions, which are therefore experienced primarily as somatic sensations or impulses to action rather than as subjective feelings that can be identified and communicated to others. Without connection to images and words, states of emotional arousal are likely to be poorly regulated and may contribute to the pathogenesis of the various disorders with which alexithymia has been associated. In Bucci's (1997b) model, a range of somatic disorders of varying seriousness can potentially emerge depending on the degree of dissociation between somatic and motoric patterns of activation and symbolic representations, and also on the interaction with constitutional and other vulnerability factors (see Chapters 7 and 8).

Referential activity, the psychic elaboration of emotions, and mentalization (as defined by Marty) are clearly overlapping concepts that have proven useful in advancing alexithymia theory. Alexithymia also corresponds closely with a specific aspect of Fonagy's broader definition of mentalization, namely, *mentalized affectivity*, which includes identifying, processing, and communicating affects (Fonagy et al., 2002; Jurist, 2005). In recent years, Fonagy, Bateman, and Luyten (2012) conceptualized mentalization as a multifaceted construct and acknowledged its close relation to several other constructs, including alexithymia, emotional intelligence, psychological mindedness, empathy, and "theory of mind". As one would predict, there is evidence from measurement-based and experimental studies that alexithymia is associated negatively with these other constructs (see, for example, Bagby, Taylor, & Parker, 1994; Guttman & Laporte, 2002; Lumley et al., 2005; Moriguchi et al., 2006; Parker, Taylor, & Bagby, 2001; Schimmenti, 2017; Sonnby-Borgström, 2009). There is also preliminary evidence from a pilot study that individuals with a high degree of alexithymia score lower on measures of referential activity than those with a low degree of alexithymia (Taylor, 2003).

Consistent with clinical observations and the above theoretical considerations, Sifneos (1994) and Taylor et al. (1991, 1997) proposed that the features of alexithymia reflect a deficit in the cognitive

[8] Press (2016) considers the term "transformation" preferable to "mentalization" since the latter term implies a dualistic presumption, "to the effect that what has become mentalized has done so by losing its foundations in the body so that it becomes autonomous" (p. 100). As emphasized by Bucci (1999), however, sensory and somatic experiences do not need to be transformed, they are part of psychic life in their own terms. The linking of emotional states with images and words allows for *containment* of intense emotions and for transformation of the meanings represented in the subsymbolic component.

processing of emotions. There has been some debate, however, as to whether alexithymia should be conceptualized as a deficit or as a psychological defense. Knapp (1983), for example, considered alexithymia a defense against neurotic conflict. In his view, the working through of defensive operations, particularly denial, repression, displacement, and reaction formation, releases abundant fantasy and emotions, although he acknowledged that these are often terrifying in their primitivity. Hogan (1995) attributed alexithymia to massive denial, whereas Nemiah (1977) suggested that denial might be a suitable model only for understanding patients who develop alexithymia secondary to the onset of a severe physical illness, or whose alexithymic characteristics readily disappear with psychotherapy. Joyce McDougall (1982), a psychoanalyst in France (but not a member of the Paris School of Psychosomatics), conceptualized alexithymia as a form of *preneurotic* pathology resulting from disturbances in infancy and early childhood; she considered it a massive defense against primitive terrors and inexpressible pain. As mentioned earlier, Krystal attributed alexithymia to a regression of affect or to an arrest in affect development; he opined that alexithymia "is a defense in the teleological sense only" (Krystal, 1982–83, p. 375). McDougall (1982–83) conceded that the theories of defense and arrest are not mutually exclusive, noting that developmental arrest and regression are attempts to deal with psychic pain and the fear of being overwhelmed.

As Dorpat (1985) has argued, there is an interaction between deficits and defenses in all psychopathology. Acknowledging this interaction, Taylor et al. (1997) pointed out that alexithymic individuals are likely to employ immature defenses "in an attempt to organize the internal chaos that accompanies intense but poorly differentiated affective and drive arousal" (p. 91). Indeed, several empirical studies have found that alexithymia, assessed with the self-report *20-item Toronto Alexithymia Scale* (TAS-20; Bagby, Parker, & Taylor, 1994), is associated most strongly with the use of immature defense mechanisms, weakly with neurotic defenses, and negatively with mature defenses (e.g., Helmes et al., 2008; Parker, Taylor, & Bagby, 1998). A study in the Netherlands found that the associations between alexithymia and defense styles still hold after controlling for anxiety and depression (Kooiman, Raats, & Spinhoven, 2008).

Trauma

It is generally acknowledged that the concept of alexithymia was anticipated in the late 1940s by the American psychiatrist Jurgen Ruesch (1948), who described a disturbance in verbal and symbolic expression in many physically ill patients and patients with post-traumatic syndromes. He reported that verbal, gestural, and other symbols are not connected with affects and feelings, and proposed that emotions are channeled into either action or somatic expressions. Anticipating Krystal's (1988a) ideas, Ruesch attributed this disturbance to a developmental arrest as a result of traumatic childhood events. Although Nemiah and Sifneos (1970a) mentioned Ruesch's clinical observations of psychosomatic patients, surprisingly they overlooked the important association that he made with trauma. They referred to McDougall's suggestion that disturbances in the early mother–infant relationship contribute to the etiology of alexithymia, but they promoted mainly a neuroanatomical etiology involving a disturbance in the connections between the limbic system generating emotion and the cortical centers for the psychic elaboration of emotion (Nemiah, 1977; Nemiah et al., 1976).[9] Krystal, on the other hand, assigned an important role to emotional trauma in the development of alexithymia.

A concentration camp survivor himself, Krystal was very interested in the impact of trauma on psychological functioning. As noted earlier, he proposed that traumatic events in infancy or early childhood can arrest the normal development of affects and result in alexithymia, and that alexithymia might also be a consequence of catastrophic trauma in adolescence or adulthood that triggers affect regression. Krystal (1975, 1988a) observed that Holocaust survivors were prone to physical symptoms and had a high rate of "psychosomatic" illness; and that many substance-dependent patients have an impaired capacity to tolerate affects, which he suggested led to their use of alcohol or drugs to block painful affects.

[9] In response to criticism of this view at the 11th ECPR in Heidelberg, Sifneos (1977) declared that he considered a neuroanatomical deficit only one of four possible causes of alexithymia, the others being a neurophysiological deficit, a developmental or sociocultural deficit, and a psychodynamic paucity of defense mechanisms.

Members of the Paris School of Psychosomatics also attribute operative thinking and other deficits in mental functioning to early trauma (Aisenstein, 2006, 2008; Aisenstein & Smadja, 2010b; Smadja, 2010). And like Krystal, they suggest that the trauma may be experienced before the acquisition of language (Aisenstein & Smadja, 2010b). Marty (1968) referred to emotional trauma experienced in adult life that opens a narcissistic wound and sets in motion the process of progressive disorganization, which may lead to the onset of a somatic disease. McDougall (1982) discovered histories of traumatic types of relationship in infancy and childhood in some of her alexithymic and psychosomatic patients. As mentioned earlier, in Bucci's (2008) multiple code theory, traumatic events are assumed to disrupt the referential connections within emotion schemas such that symbolic and subsymbolic components within the schemas become dissociated, thereby contributing to unregulated states of emotional arousal in victims of trauma.

The emphasis that psychoanalysis has given to adverse childhood experiences in the etiology of psychopathology and somatic disorders has fluctuated over the decades. Although Freud abandoned his seduction theory in favor of the concept of psychical reality and the child's fantasy life in the production of trauma, he did not totally dismiss the role that external factors could have in increasing a child's anxieties. It was the Hungarian psychoanalyst Sándor Ferenczi who emphasized the importance of the external origin of trauma and its effects on the child's developing personality. In a trauma theory that he constructed during the 1930s, Ferenczi proposed that it is not only the traumatic situation itself that causes pathology, but also the lack of emotional support from the parents on whom the child depends (Peláez, 2009). The child reacts to the trauma with what Ferenczi called a "fleeting psychosis"; the stoppage of thought and perception paralyzes mental functioning, and results in a split in the personality such that the trauma is not experienced consciously or represented mentally and therefore cannot be remembered (Dupont, 1998). This defensive maneuver is similar to Janet's description of *dissociation* as well as Freud's concept of *primal repression*, and has nothing to do with repression proper.[10] Dupont (1998) writes that the split-off part of the personality exists as a "dead part, killed by the violence of the [trauma], enabling the rest to live a normal life, but with part of the personality missing and out of reach, like a sort of cyst inside the personality" (p. 235). Ferenczi later broadened the idea of trauma beyond sexual seduction of a child by a parent or authority figure to include emotional neglect, physical maltreatment, and empathic failure (Rachman, 2007). Because his theory of trauma diverged markedly from Freud's views, Ferenczi was regarded as a dissident and his ideas were set aside by most psychoanalysts. They were extended many years later by Michael Balint (1969), who argued that trauma can only be understood in the context of a relationship, in particular the child's relationship with the mother, who is the essential person in early childhood. Balint's formulation, which he integrated with the traditional emphasis on unconscious fantasy, was consistent with a shift that was beginning to take place in psychoanalysis from a one-person drive psychology toward a two-person relational psychology, and eventually to the perspective of most contemporary psychoanalysts that psychopathology develops within the family environment where actual parental behavior creates an emotional disturbance for the child (Rachman, 2007). The re-entering of trauma into mainstream psychoanalysis, and the increasing attention given to the reparative possibility of the therapeutic relationship itself, has had important implications for understanding and treating patients with a high degree of alexithymia.

The history of alexithymia and interest in trauma run parallel with the emergence and development of attachment theory, beginning with the contributions of John Bowlby in the late 1960s and early 1970s. In contrast to metapsychological concepts such as libidinal and destructive drives, attachment theory and trauma lend themselves to empirical research. Such research has yielded considerable support for Krystal's ideas and continues to advance understanding of the etiology of alexithymia. It is now well established, for example, that attachment experiences in early childhood influence

[10] Freud (1915b) described two phases in the operation of repression. The first phase, which he called *primal repression*, denies entrance of instinctual and affective representations into consciousness. In the second phase, referred to as *repression proper*, instinctual, emotional, and other experiences have been mentally represented and gain entry into the conscious mind, but are then excluded from it.

the development of emotion schemas, imagination, and other cognitive skills involved in the regulation of affective experiences (Cassidy, 1994; Fonagy & Target, 1997). Several studies have demonstrated an association between alexithymia and insecure attachments (e.g., Taylor et al., 2014; Troisi et al., 2001); and there is evidence that alexithymia or the difficulty identifying feelings facet are associated with retrospectively reported experiences of adverse experiences during childhood, especially emotional neglect (e.g., Goldsmith & Freyd, 2005; Paivio & McCulloch, 2004). Research studies exploring the relationships among trauma, attachment, and alexithymia are reviewed by Schimmenti and Caretti in Chapter 8.

Therapeutic Considerations

Long before the concept of alexithymia was introduced, several psychoanalysts and psychotherapists had acknowledged that some patients are deficient in certain psychological capacities and consequently do not respond well to psychoanalysis or interpretive forms of psychotherapy. In the early 1950s, Horney (1952) and Kelman (1952) found that some psychiatric patients came to an impasse in psychoanalytic psychotherapy because of limited emotional awareness, a paucity of inner experiences, minimal interest in dreams, concreteness of thinking, and an externalized style of living in which behavior was guided by rules, regulations, and the expectations of others rather than by their own feelings, wishes, and personal values. These patients were prone to developing somatic symptoms and often engaged in binge eating, alcohol abuse, or other compulsive behaviors, seemingly in an attempt to regulate distressing inner states. Although the patients were regular in their attendance at analytic sessions, they were not really engaged in the analytic process; unaware of an inner life, they tended to fill each analytic session with "a chronological recital of events [that] transpired since the last hour" (Kelman, 1952, p. 20). In describing patients with operative thinking, Marty and de M'Uzan (1963) reported that they speak only of actual events, any dreams they recall are closely connected with reality, and they expect nothing from the therapist except relief of their symptoms, without any affective involvement.

Ruesch (1948) discovered that somatically ill patients with a disturbance in verbal and symbolic expression of affect did not benefit from traditional insight-oriented psychotherapy. He advocated a modified psychotherapy usually lasting several years, which included educating the patients about their deficits, drawing attention to emotional cues such as vague bodily sensations, and teaching tolerance of feelings and a capacity for symbolic expression. Ruesch emphasized the importance of the therapeutic relationship and described the approach as similar to child psychotherapy; he advised therapists to be approachable, consistent, explicit, unconditionally accepting of the patient, and to express their own feelings.

Given the failure of alexithymic patients to interact emotionally with their psychotherapist, Sifneos (1974, 1975) concluded that psychodynamic psychotherapy was not a suitable treatment for many "psychosomatic" patients and might even be contraindicated. Nemiah et al. (1976) observed that pressuring alexithymic patients to discuss their feelings and fantasies sometimes aggravated their symptoms. They suggested that these patients might be better managed by supportive techniques; and like Ruesch, they emphasized that the therapist should be outgoing and verbally and affectively expressive.

Although Krystal (1982–83) concluded that alexithymia is the most important single factor diminishing the success of psychoanalysis and psychoanalytic psychotherapy, he was more optimistic about the use of psychotherapy than were Nemiah and Sifneos. Similar to Ruesch, Krystal (1979, 1982–83) recommended a modified form of psychotherapy involving various psychoeducational strategies for increasing affect awareness and affect tolerance, including focusing attention on the meaning of bodily sensations and other non-verbal manifestations of emotion, and teaching patients the signal function of affects and how to label and differentiate the various affects. As reviewed by Taylor and Bagby (2013) and by Ogrodniczuk et al. in Chapter 12, there is some empirical evidence and occasional case reports that psychotherapies that incorporate these and other strategies can reduce the degree of alexithymia. Although there is no evidence that reducing alexithymia cures a medical or psychiatric illness, members of the Paris School and advocates of the alexithymia construct believe that the working through of emotional trauma and improving the patient's mentalizing capacity may slow or halt the progression of illness. Over the years, psychoanalytic psychotherapists have come to realize that for these changes to occur, close attention must be given to the countertransference.