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**The Art Therapy Process
in the Context of the
Psychosomatic Syndrome
and Alexithymia**

Roselly Miller

**A Thesis
in
The Department
of
Art Education
and
Art Therapy**

**Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts in Art Therapy at
Concordia University
Montréal, Québec, Canada**

March 1989

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ABSTRACT

The Art Therapy Process in the Context of the Psychosomatic Syndrome and Alexithymia

Roselly Miller

This thesis attempts to define alexithymia, based on physiological (biological) and psychological (psychodynamic) theories, and its link with psychosomatic symptom formation and symbolic functioning.

Difficulties experienced in using traditional psychoanalytical and psychosomatic treatment methods with the alexithymic will be examined, necessitating consideration of alternate modes of therapy. This study is based on the fact that at times, verbal insight therapies are faced with limitations, and therefore considers the concepts of creatively oriented, nonverbal art therapy, and the use of visual art materials to assist in integration or reintegration of personality.

Expressive art therapies, with a developmental, object relations approach are explored as treatment alternatives for problems of symbolization and the expression of affect and to promote new levels of perceptual organization by expressing the past through its reenactment creatively, using art and image, and symbolic play for self expression.

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"Homo sapiens is the creature of symbols,
a creature who creates and manipulates symbols,
whose existence is defined by symbols,
and the unique creature who is also
simultaneously created by his own symbolic process."

H. Blum

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CHAPTER ONE

I. INTRODUCTION

1. Subject area.

This thesis will deal with symbolic function and the feasibility of the treatment of psychosomatic patients through art therapy.

Psychoanalytic theory postulates that when conflicts are not expressed verbally or via symbolic expression through dreams and fantasies they are expressed through somatic channels and may lead to the development of psychosomatic disorders (Taylor, 1984).

Difficulties in the ability to verbalize affect and to elaborate on fantasies, refer to a cognitive-affective psychic disturbance, the construct of alexithymia. All psychosomatic patients are not necessarily alexithymic, and there are varying degrees of alexithymia in different psychosomatic illnesses.

Man has been described as a creature of symbols, who creates and manipulates symbols, whose existence is defined by symbols, and who is also uniquely created by his own symbolic process (Blum, 1978).

The question this thesis will examine is if the alexithymic individual evinces an inherent inability to symbolize, to express emotions verbally, and a paucity in the use of fantasy and imagination. Consequently we shall explore whether the use of art therapy can provide an alternate method of self expression and communication through a visually-oriented, non-verbal, creative process that would lead to an enhanced ability to symbolize, and in turn lead to an alleviation of the patient's symptoms.

2. Discussion.

A brief definition of the triad of components in this thesis, psychosomatic disorders, the construct of alexithymia, and art therapy, will facilitate exploration of the topic for study.

Psychosomatics: The term psychosomatic originates from the greek words "psyche" which meant soul or mind in ancient times, and recently has come to mean behaviour, and "soma" which refers to the physical organism, the body. The psychosomatic syndrome therefore indicates a relationship between the psychological process of behaviour on one hand and the somatic structure of the body on the other (Eachman, 1977). In accordance with this Warnes and Harris (1986) state: "There are no disembodied minds."

Medical practitioners are developing a better understanding of the undeniable link between the two, and are considering that in order to prevent pathology an individual must be treated on all levels; physically, psychologically and spiritually, as well as in his relationship to his total environment.

The alexithymia concept. The concept of alexithymia originated in clinical studies with psychosomatic patients. The term, coined by Peter Sifneos in 1973 may be literally translated as "no word for moods" and describes patients with difficulties in ability to verbalize affect of emotions, with a limited ability to fantasize and imagine, a deficit in symbolic self expression, a pragmatic-operational style of thinking (pensée opératoire) (DeMusan, 1963) which is oriented towards details in the environment, a tendency to use action as a coping mechanism in stressful situations and a particular style of interpersonal relationships.

Lesser and Lesser (1983) note that the term alexithymia is increasingly being used in connection with situations far beyond its original definition, and

often used interchangeably with terms such as "psychosomatic illness" or "psychosomatic symptom formation." This is inaccurate, they assert, because some patients with psychosomatic illness display alexithymic characteristics, and others do not. Furthermore, research by Acklin and Alexander (1988) reveals that alexithymic characteristics are not uniform across psychosomatic disorders. There are also alexithymic characteristics in patients who are not physically ill, such as those who suffer from borderline and narcissistic personality disorders, posttraumatic stress, drug and substance abuse, and somatoform disorders, or even in patients with masked depression, character neuroses and with sexual perversions.

Wolfe (1977) cautions us not to consider alexithymia an all-or-none phenomenon. It is important to recognize that there are various degrees and varieties of alexithymic characteristics in different individuals which may vary in different degrees at various times in the same person's life. Freyberger (1977) has also made distinctions between primary chronic alexithymia and secondary situation dependent alexithymia.

In an attempt to describe the clinical concept of alexithymia we might question if it is a state or a trait, or if it is a defense or a structure. We may wonder if it is a deficit in behaviour or whether it is an achievement, or if alexithymia is a symptom in itself, an innate or an acquired behaviour, related to a specific group or unspecified people.

Testing methods include observer rated, self scoring and projective tests. The Beth Israel Hospital Psychosomatic Questionnaire (BIQ), the Schalling-Sifneos Personality Scale (SSPS), the Minnesota Multiphasic Personality Inventory (MMPI), the Toronto Alexithymia Scale (TAS) and others, have been devised and often used in conjunction with projective tests such as the Thematic Apper-

ception Test (TAT), the Scored Archetypal 9 (SAT9) and the Rorschach to measure the presence, degree of alexithymia and its effect on symbolic structure.

The etiology of alexithymia has been a complex phenomenon to validate. Attempts to explain it include theoretical and speculative research from various fields (such as psychodynamic psychology, genetic theory, neurophysiological and social learning factors).

Treatment considerations by Krystal (1982) considered alexithymia "as possibly the most single factor diminishing the success of psychoanalysis and psychodynamic therapy" (Taylor 1984).

Nemiah (1977) an advocate of the neurophysiological explanation of alexithymia noted that insight therapy did not reduce the use of ego defense mechanisms and lead to symptom reduction, because psychotherapy has not been known to affect the actual structure of the brain. In fact, Sifneos (1975) pointed out that psychotherapeutic intervention may result in anxiety-coping situations that might worsen the symptoms. Sifneos and Freyberger (1977) both recommended supportive and educative approaches.

Psychoanalytically oriented therapists do not conceive of alexithymia as a classical drive defense model but perceive its origin in severely disturbed developmental infant-mother relationships. This shifts the focus from neurotic states to consideration of more primitive mental states leading to an interest in object relation theories, self psychology and developmental issues. Taylor (1986) raised the possibility that alexithymic individuals may suffer primarily from psychic defects rather than intrapsychic conflicts and that their object relationships carry out certain psychological functions. These formulations are applicable to both physically and mentally ill patients.

Art therapy. Art therapy has implications as an alternate mode of therapy for the alexithymic. It involves a non verbal, creative form of expression and communication. It employs the use of visual art materials in an attempt to assist integration or reintegration of the personality.

As in verbal therapy there are many different theoretical considerations. Wilson (1986) describes Edith Kramer's emphasis on the "art" part as an approach veering towards a "sublimating, Apollian left hemispheric sense," while other American art therapists such as Margaret Naumberg, one of the 1940s pioneers in this field, espouses "art as a tool for verbal therapy in a spontaneous, insight, Dionysian, right hemispheric mode" (Ibid.).

Naumberg's psychodynamic approach to art therapy bases its methods on releasing the unconscious by means of spontaneous art expression: it has its roots in the transference relation between the patient and the therapist and on the encouragement of free association" (Ulman/Dachinger, 1975).

Naumberg's techniques are based on the assumption that every individual has a latent ability to express dreams, fantasies, and inner experiences as visual images, without the need for verbal translation. These visual images are a form of communication, a sort of "symbolic speech."

In the creative act, conflicts are re-experienced, resolved, and integrated, as they have through the ages by man, enabling him to reconcile internal conflict between instinctual urges and society's demands (Ibid.).

Art therapy, using a synthesis of verbal and nonverbal therapy may provide an alternate route to the unconscious and trigger associations, affects and memories.

Participation in body-felt sensory experiences, such as expressive and creative therapies may be of value in helping the alexithymic, whose problems

are pre-neurotic, to re-experience memories and later integrate and interpret them verbally through symbolization.

Expressive therapies which use painting, sculpture, sand play, movement and dance can help this relearning process through "enactive cognition" (Lewis, 1987). This can help individuals to re-experience early pre-symbolic stages which Winnicott (1971) describes as "pre-verbal, un verbalized and un verbalizable."

Expressive therapists are now beginning to study ways to develop a system for structuring personality that has a neurological basis. Many art therapists are using an object relations approach for patients who have developmental problems. Multidisciplinary approaches have implications for treatment of the alexithymic patient who has difficulty in verbal expression of emotions and limited ability to fantasize.

3. Methodology: Limitations.

This thesis has been divided into three major chapters in the following order; the psychosomatic syndrome, the concept of alexithymia and the art therapy process.

In order to consider how art therapy has possibilities as a vital tool in the treatment of alexithymia it is necessary to define the alexithymia concept and link its etiology to psychosomatic medicine.

Chapter One will begin the process of definition with a survey of the literature of psychosomatic medicine and the physiological and psychological processes of symptom formation. The neurophysiological processes of symptom formation in a normal population will be compared with Nemiah's neuroanatomic formulation of factors which influence the alexithymic's condition. Psychological

theories of psychosomatic symptom formation will be discussed, including the use of denial as a defense, the deficit model and developmental theories.

This data will be followed by a study of the components of the psychosomatic personality structure based on Joyce McDougall's research. It will illustrate some of the differences between the neurotics' and the psychosomatic/alexithymics' behaviours, fears, and manner of communication or non-communication of anxieties.

Chapter One will conclude with a discussion of treatment for psychosomatics based on modifications of traditional psychotherapy.

Chapter Two will be devoted to a clarification and definition of the alexithymia concept. It will describe its history, and etiology from various theoretical viewpoints such as psychological, neurophysiological, genetic and social learning. Testing and measurement of alexithymia will be reviewed briefly.

The characteristics of a hypothetical asthmatic alexithymic patient will be described, outlining the factors which predispose him to somatization and the onset of psychosomatic disorders, establishing the link between the two.

The description of the alexithymic as an individual with a cognitive-affective disorder and an inhibition in symbol formation will lead into an important segment on symbols, their formation, and the process of symbolism as a form of mental representation, which provides "a basis for more complex mental representations such as images, fantasies, thoughts, concepts, dreams" (Beres, 1965).

Treatment suggestions for the alexithymic will focus on developmental issues, pre-neurotic pathology and object relations and self psychology theories.

Winnicott's theories of the use of transitional objects and transitional space will ascertain creativity's role within the context of human development.

Chapter Three is devoted to the definition of art therapy and its potential as a creative, nonverbal treatment approach for the alexithymic. The art therapy process will be described, outlining the unique role of the art therapist, in the triadic relationship between therapist, image and patient. Therapeutic work is often effected in combination with other expressive therapies such as dance, movement and music, in an effort to aid the patient to reenact experiences from the past and restructure and integrate them into the personality (Lewis, 1987).

Various art therapy exercises will be suggested as they apply to various developmental phases of Mahler's object relations theory. The art therapy segment will culminate with a brief section on the use of art therapy to improve the process of symbolization for the alexithymic.

This thesis is limited to an overview of the alexithymic concept. Much of the research available is devoted to validating the construct. To my knowledge there is no data available on alexithymia and art therapy. However discovery of this concept is of importance because of the characteristics which are evident in patients with neurological deficits, organicity, sexual perversions, narcissistic and borderline personality, substance abuse, anorexia, and any "dissociative" disorders.

My personal interests lie in the field of the controversial borderline personality. Perhaps future research using art therapy treatment will open the doors to a better success rate with this population. It is my hope that this thesis will stimulate further interest in research.

II. PSYCHOSOMATICS

In order to understand the theoretical aspects of alexithymia, it is important to study its relationship to psychosomatic disorders and become aware of the physical, psychological or social factors involved in the process of psychosomatic symptom formation.

1. Psychosomatic disorders.

Historically, the mind-body problems goes as far back as ancient Greece when Plato cautioned, "It is the great error of the day . . . that physicians separate the soul from the body." In the mid seventeenth century French philosopher René Descartes designated the pineal gland, located in the mid brain as the contact point where the mind could connect the body. He "dualized" human beings in an attempt to retain his religious views that people were partly divine and yet an integral part of the animal world (Davison/Neale, 1982). The term "psychosomatic" connotes the principle feature of disorders wherein the psyche, or mind, is having an untoward effect on the soma or body, in which genuine physical symptoms are caused or worsened by emotional factors. They are real diseases, and do real damage.

Psychosomatic disorders must be distinguished from conversion hysteria which also has its origin in psychological processes, but whose symptoms only simulate the disease, are frequently symbolic and involve no physiological base (Butcher, 1971). Psychologically, conversion hysteria is credited with origins in libidinal and oedipal drives.

In 1939, psychoanalyst Franz Alexander contended that seven diseases which became known as the "holy seven", (the classical psychosomatic illnesses; bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension,

neurodermatitis, thyrotoxicosis and duodenal peptic ulcer) were aroused by specific emotions that were inexpressible (Grinker, 1973).

In 1942, after studying voodoo deaths whereby a curse could cause pain and death to the victim, Cannon proposed that certain vital body organs can be irreparably harmed if the autonomic nervous system is maintained in a highly aroused state through prolonged psychological stress, during which time there is no opportunity to take effective action. He showed how mind could triumph over matter and how death could actually be brought about by severe fright (Davison/Neale, 1982). This was the epitome of the effect of stress on the function of the body.

Today, psychosomatic diseases are referred to as psychophysiological diseases. Updated research in the field by C.D. Jenkins in 1985 proposed consideration of a breakdown of psychosomatic medicine into three categories of personal characteristics and processes; biological, psychological and behavioral.

Jenkins subdivided the biological into subheadings such as anatomy, biochemistry and physiology. He divided the psychological section into four general categories; perception, cognition, emotion and ego function.

The remaining personal processes were designated to the realm of overt behaviour, not because behavioral aspects were distinct from biological and psychological levels, but because they represented a different level of organization and expression of responses which could be measurable for the collection of scientific data.

Overt behaviour was subdivided into three categories: personal habit, interpersonal style and role functions, all taking place in an environment (Ibid.)

Jenkins' (1985) breakdown of psychosomatic medicine

BIOLOGICAL

anatomy
biochemistry
physiology

PSYCHOLOGICAL

perception
cognition
emotion
ego function

BEHAVIORAL

(overt behaviour)
personal habit
interpersonal style
role functions

Modern medical practitioners have taken the approach towards the prevention of pathology even further. The Psychosomatic Medicine Clinic in Berkeley, California adds another dimension, a fourth aspect to the all encompassing approach, by including man's spiritual make-up, for consideration.

2. Symptom formation.

Most attempts to describe the etiology of alexithymia focus on psychosomatic phenomena and symptom formation implying that they are the same. Lesser (1981) distinguishes between the two, claiming that they may be associated but are not identical.

However in order to grasp the alexithymia concept it is necessary to understand psychosomatic symptom formation in order to comprehend why a particular individual is susceptible, under what circumstances the disorders may occur, and why a particular organ and not another is affected.

A. Physiological reactions.

First, an individual may be predisposed to a particular psychophysiological disease because there may be a somatic weakness, inherited or acquired through illness or conditioning, in an organ or system that becomes vulnerable to stress (Davison/Neale, 1982).

Physiological stress reaction is an important factor in symptom formation. Chronic emotional arousal may lead to damaging effects in the specific weak organ system. The degree and duration of arousal will depend on the nature of the stress and the person's perception of it (Ibid.).

The physiological reaction results from an emotional state which is expressed through the operation of the autonomic nervous system which regulates the internal states of the organism (Butcher, 1971).

In a healthy body the actions of the two branches of this system, the sympathetic and the parasympathetic, which governs vegetative functions such as sleep and digestion, sometimes work in unison and sometimes against each other in a complex and delicate state of balance.

The aroused sympathetic branch prepares the organism for physical activity, either fight or flight, against an external danger, real or imagined, by discharging into various visceral organs of the body. This results in an increase in blood pressure and heart and breathing rate.

Normally, an individual finds a form of release for emotional tension. If he is incapable of doing so, the body cannot tolerate being in a chronic, emergency state of tension and it can develop physical symptoms.

Psychosomatic disorders may also be caused by precipitating life situations, psychosomatic self regulations, psychological patterns of defense and conflict formed in early life, and socio-cultural factors pertaining to the stresses that are characteristic in the individual's society.

Theoretical models utilized to explain psychosomatic symptom formation are either neuroanatomic or psychological. We shall survey them briefly, beginning with the neurophysiological theories which are concerned with the structure and the function of the adult's brain.

B. Neurophysiological models.

Structural defects or an absence in the neuronal centers which underlie affect, or in the pathways between them could affect the anatomical structures that underlie repression or the ego functions involved in psychic elaborations (Nemiah, 1977).

Ruesch discovered in 1948 that his psychosomatic patients in analysis lacked the ability to discharge their tensions verbally, through gestures, or symbolically, and seemed to be "stuck with their tension", with discharge through somatic channels as their only alternative (Lesser, 1981). He dubbed them "emotional illiterates" because of their inability to verbally describe their feelings.

MacLean's (1949) neurophysiological explanation for psychosomatic phenomena, built on the work of Ruesch and the Papez theory of emotions noted that patients with psychosomatic illness often appear to display primitive oral needs and respond to emotional situations with physical reactions. He speculated that their apparent intellectual inability to verbalize emotional feelings led to immediate expression of emotion through autonomic channels because of a faulty exchange between the phylogenetically more primitive rhinencephalon (visceral brain) and the neo-cortex (word brain). Emotional feelings originating in the hippocampal region would not be relayed to the neocortex for intellectual evaluation. Instead of developing a language of feelings and symbols, these patients would communicate through an "organ language" (Ibid.).

In 1977, Nemiah amplified this hypothesis, applying it more specifically to alexithymia.

C. Psychological theories of psychosomatic symptom formation.

Psychodynamic models:

Conversion theory. The psychosomatic symptom is viewed as a symbolic representation of repressed fantasies arising from unacceptable drives and affects.

In conversion hysteria however, the drives are libidinal and oedipal in origin, while in psychosomatic disorders the drives are usually pre-genital (oral and anal libido, and pre-oedipal aggression) (Nemiah, 1977).

Specific dynamic conflict. Nemiah discusses the contribution of Franz Alexander's (1950) specific dynamic conflict formation which is related to conversion, but different from it as it invokes the repression of special affects as the basic mechanism behind symptom formation.

Unlike conversion symptoms which have a symbolic representation in fantasies, in psychosomatic symptom formation there is a repression of affects which causes arousal of the autonomic system when the emotions are not discharged in verbal or overt expression.

In Alexander's view, unconscious emotional states specific to each psychophysiological disorder cause specific reactions. For example, the crucial pathogenesis factor in the creation of ulcers is the frustration of non-gratification of the dependent, help-seeking and love demanding desires, which leads to a chronic emotional stimulus which has special effects on the stomach (Davison/Neale, 1982). This repressed longing for parental love in childhood causes the overactivity of the autonomic system, and in the stomach organ, leading to formation of ulcers.

Lachman (1972) attributes the origin of colitis to excessive parental demands for bowel control exerted on the child during early toilet training. The

emotionality that results from the child's incapacity to fulfill these demands manifests itself in the child's inclination to punish the parent. Because the parent is so much stronger this punitive desire cannot be acted on, and the child directs these primitive tendencies against the self, at the offending part of the body. This may result in the eventual long term destruction of the bowel, and the onset of ulcerative colitis in adulthood.

Deutsch's psychoanalytic learning theory is similar to Alexander's theoretical model that when an early childhood illness affects an organ system, at the time of a psychological conflict involving any phase of growth and development, that they become linked in association in a stable and persisting complex.

In the adult, when external stimuli activate that conflict which is now unconscious, the function of the organ system associated with it is also affected, resulting in formation of psychosomatic symptoms (Nemiah, 1977). Deutsch also proposed that these physical symptoms were symbols representing emotional arousal that is not overtly expressed (Lachman, 1972).

When psychosomatic symptoms are the result of chronicity of arousal that leads to lesions in the organs supplied by the autonomic system, Nemiah (1977) considers them as secondary results of repression, not as the product of converted psychic representation.

Denial. The term "denial" has been used in reference to psychosomatic patients as a description of a defense mechanism against the expression of emotion and fantasy. Nemiah, (1977) stated in reference to Alexander's (1950) theoretical formulations, that although denial and repression were both defense mechanisms which have a special effect on specific individual emotions, that denial when related to psychosomatic disorders, was an even more extreme defense when applied globally to the totality of affective phenomena.

Nemiah and Sifneos (Taylor, 1984) argue that these neurotic defense mechanisms do not adequately explain the phenomena of absence of affect and fantasy. Sifneos (1974) observed, "what appears as denial of emotion, is in fact an absence of feelings."

McDougall (1982) also believes that feelings are not denied, but rather that they do not exist, and refers to developmental issues as the cause.

Specific-attitudes theories. Graham (1952) proposed that particular attitudes rather than chronic emotional states are associated with certain patterns of physiological changes that relate to specific psychophysiological disorders. For example: Raynaud's disease (cold hands) could mean that the individual wants to take hostile physical action and may not have any notion of what that action should be (Davison/Neale, 1982).

Classical and operant conditioning have also been suggested as having a role in psychosomatic symptom formation.

Deficit models. Marty and de M'Uzan (1963), a group of French psychoanalysts viewed psychosomatic symptoms, not as the product of dynamic psychic conflicts, but conceived of them as the results of specific ego deficits, in particular the absence in the capacity for fantasy formation and the experiencing of feelings (Nemiah, 1977). This concept is contrary to the theory of hysterical formation which results in repressed fantasy elaboration.

They reported on a characteristic way of mental functioning utilized by these patients, which they named "operational thinking", or "la pensée opératoire." While verbalizing, their patients referred exclusively to the present, describing actions and events in minute and endless detail in a detached, disassociated way, without conveying their emotional significance.

They also seemed "to have no appreciable relationship with unconscious fantasy" reported Marty and de M'Uzan, and one can imagine their consternation, as psychoanalysts, who rely on verbal communication, when they were confronted with these inarticulate psychosomatic analysands. They reported that the patient "appears to be a witness rather than an actor in his own existence" (Granich et al., 1984).

Developmental models of symptom formation

The preceding models dealt with have focussed on fully established mechanisms of the adult. The developmental models deal with an attempt to explain and understand the early life factors that have helped shape and form the adult.

The deficit ego models ascribed to by Marty and associates, and by McDougall attribute a defect of the ego to faulty fantasy formation and defective experiencing of affect. They trace its source to pathogenic mother-child relations. In his neuroanatomic model, Nemiah (1977) also credited inadequate maternal stimulation during infancy as a factor in the failure to develop adequate connection between limbic and cortical structures.

According to McDougall when an overgratifying or overprohibiting mother's behaviour towards the child affects the normal autoerotic gratification of her infant's instincts, the infant is prevented from developing a mental image of mother, as compensation, when she is absent. This earliest mental image of mother is what Nemiah (1977) refers to as "the prototype of fantasy and the failure to produce it irrevocably damages henceforth the capacity to form fantasy as a symbol and expression of instinctual drives."

Infantile psychic trauma, leading to an arrest in the development of affect, may contribute to alexithymia, according to Krystal (Taylor, 1984). This is consistent with Kleinian object relations theory, that pinpoints affective problems to the fixations or regressions at the paranoid-schizoid position when the ego is not yet able to form symbols, mentally.

Winnicott (1952) was one of the first psychoanalysts to attribute the pathology of psychosomatic disorders to pre-neurotic pathology deficiencies in early mother child relations. Evolving from his discoveries of the infant's use of transitional objects, and the importance of object relations to carry out psychological functions that are vital to normal development, recent research points to psychic defects rather than intrapsychic conflicts as a new way of conceptualizing the susceptibility of individuals to disease (Taylor, 1987).

Because Winnicott's theory shows connections between play and art in the development of selfhood it begins to be evident that art and play offer possibilities in the realm of treatment for the alexithymic.

Links between the psychological and the neurobiological in the formation of psychosomatic symptoms have been discovered and their interplay, along with psychosocial factors have all been important advances in the development of the concept of alexithymia as well as in consideration in the etiology of all disease (Taylor, 1986).

III. THE PSYCHOSOMATIC SYNDROME

As art therapists we must be able to understand how the previously described symptoms manifest themselves in the behaviour and personality of the persons whom we wish to treat. An examination of the personality structure of this particular population may aid us in ascertaining the appropriate approach.

The following composite of features that form the structure of the psychosomatic patient's personality are based primarily on research performed by psychoanalyst, Joyce McDougall and presented in 1982. This offers a psychoanalytic perspective to our understanding of psychosomatics and alexithymia, and compares their behaviour with the neurotic's.

1. The psychosomatic patient.

Joyce McDougall (1982) became intrigued by a particular group of sexually perverse "difficult patients" in her psychoanalytic practice, with whom she was experiencing therapeutic failure, or what she considered worse, interminable analysis.

Her initial interest was an attempt to understand the unconscious significance of their sexual deviance, which she eventually labelled after her research as "the most perverse alexithymic form of libidinal expression that exists" (McDougall, 1982).

She attributed their sexual inventions which seemed to offer them a psychic equilibrium, to a form of addiction and regarded them as a way to avoid affective flooding. She also discovered that many of these sexually perverted analysands suffered as well as with psychosomatic disorders.

These clinical observations led her to propose that two kinds of psychological disturbances, the psychosexual and the psychosomatic, stem from the

same archaic roots, the early mother-child relationship, an area where the psychoanalyst invariably seeks for an understanding of problems.

McDougall suggested that there were specific ways in which the mother might unconsciously relate to the growing child which could result in pre-neurotic pathology. For example, if she regarded the child as either a libidinal or narcissistic extension of herself, or if she attempted to control her child's bodily self and affective vitality, she could predispose the child to serious psychosexual and/or psychosomatic vulnerability.

McDougall also became interested in a second group of patients whom she referred to as "antianalysands in analysis." Superficially they seemed to have few psychological problems. However their outward behaviour, rigid posture and facial expressions, indicated a rather "robotlike" adaptation to external reality in which they seemed to have little identification with other people. In treatment they endlessly recounted external events, which seemed to be emotionally insignificant to them. They also seemed uninterested in their neurotic problems. McDougall referred to them as "normopaths."

When Apfel and Sineos (1979) studied the differences between neurotic and psychosomatic patients, they too noted that the latter gave elaborate descriptions of external events and endless descriptions of their physical symptoms. The neurotics, on the other hand, laid less emphasis on physical complaints and were able to use appropriate language to describe their feelings, symptoms and interpersonal problems. They were able to take appropriate coping actions, while the psychosomatics tended to cope with situations in impulsive actions.

Although the neurotics had conflicts, generally their interpersonal relationships were good. In contrast, the psychosomatics, as well as the alexithymics, had problems in interpersonal relationships, with a tendency for either marked

dependency or a preference for being alone and avoiding people. Apfel and Sifneos (Ibid.) described their personality make-up as narcissistic, withdrawn passive-aggressive or passive-dependent and psychopathic. They complained about tension, boredom, frustration, pain, void and nervousness.

While neurotics can describe anxiety through elaboration of fantasies, thoughts and interpretation of repressed material through dreams, the psychosomatics showed "a marked difficulty in verbally expressing their feelings and an absence or striking diminution of fantasy" (Nemiah and Sifneos, 1970).

McDougall was intrigued with this behaviour which she described as "psychic economy of affect." She realized that there were ways of dealing with affective experience other than the classical neurotic theoretical conception that "affect was separated from its representation, then displaced or converted to give rise to obsessional or hysterical symptoms."

She believed that the psychosomatic continuously tried to cut affective links attached "to instinctual promptings, emotionally loaded ideas, or relationships with other people" (McDougall, 1982). She suggested that this type of psychic dysfunction might be the result of an attack on perceptual consciousness itself. The patient may evade any fantasies or ideas that are emotionally significant by immediately evacuating them, and rapidly rejecting from the psyche both the affect and its representation, or by reacting with somatic outbursts rather than mental representations. She felt that this could account for the impoverished dreams and daydream life of the psychosomatic and the alexithymic. There was nothing available and stored, or repressed that could become the basis for dreaming. The symbolic dream material was therefore foreclosed from the psyche.

Levitan (1980) reveals in his studies on dream work that when the psychosomatic did interpret his rare dream, great attention was given to external events and to lengthy descriptions rather than to affect. Even during traumatic dreams which involved bodily injury or death to the dreamer the dream ego failed to protect the self by its usual use of a defense mechanism or by causing the dreamer to awake. Levitan speculated that the powerless dream ego is a carry over from waking life.

McDougall proposes that the psychosomatic attacks his psychological ability to utilize and capture affect, and drains external reality and people with whom he relates, of their meaning. In the service of psychic survival he may make a "pseudoadjustment" to external realities and relations with his feelingless states by becoming hyperactively involved in external events. This suggests behaviour of a defensive nature.

McDougall also noted the psychosomatic's confusion in labelling affect, which is the role performed by mother in the early stages of the child's development.

As well, during the presymbolic, non linguistic stage of development, in which symbolic communication takes place, McDougall credits mother's way of relating to her child's body as crucial. It is an important factor in helping to create a child's reality. This may affect a child's and adult's sense of body image. Many psychosomatics, she claims, talk about their bodies as though they were foreign objects, as though they were, in fact, unconsciously felt to be a possession of the mother. This lack of libidinal investment, McDougall explains, allows bodily pain as well as psychic pain to be ejected from the body. The psyche and soma, in effect have split. Psychic maintenance lays the subject open to psychosomatic disorganization, a state of psychosomatosis. In this split, the

mental functioning does not depend on repression and denial. Affective perceptions are largely eliminated and with them goes the destruction of meaning, so that the external reality and people in it are devitalized. "Feeling is not disavowed; it no longer exists" (McDougall, 1982).

Denial, discussed earlier under Alexander's (1950) specific dynamic theory, in a normal person is an ego-defense mechanism, learned in the main to deal with inner hurt, anxiety and self devaluation, and typically involves some measure of self deception and reality distortion. It is used to protect the individual from external threat, and guilt-arousing desire and action (Coleman, 1976).

A neurotic breakdown under stress usually occurs after the individual has attempted to cope with the situation and failed. In many traumatic situations the anxieties are transient and symptoms that develop will disappear when the threat diminishes. Denial is a defense mechanism used habitually and when necessary to protect an individual in a stressful situation.

Normal denial may be teamed with other physical and mental defense mechanisms such as rationalization or avoidance of the stress situation. The subject is aware of the danger and takes appropriate action.

Sifneos in 1974 also observed that what appears as denial of emotions in a psychosomatic/alexithymic is actually an absence of feelings. Although this defect may be credited to neurobiological dysfunctions, "of a biological defect in the brain", McDougall felt that her explanation, in psychodynamic terms might compliment the view that Sifneos proposed.

The "absence of affect", noted in the limited number of alexithymics who valiantly pursued their analysis, led McDougall to say that it was the result of a "constant attack upon both the psychic and the somatic pole of the awareness of

affective pain", and a struggle against experiencing emotional pleasure. She noted that Krystal, in his research in 1978-80, named this symptom "anhedonia."

McDougall proposes a similarity between the dynamic force of unconscious fantasies in the psychotics' and psychosomatics' mental functioning and also to the psychic mechanisms such as those, which are employed by the alexithymic to keep the archaic terror at bay. She compares a psychotic, who exhibits bizarre behaviour, with a superficially well adapted alexithymic-psychosomatic (and here she uses the combination form for the first time). "In psychoses *thought* functions in a delusional way; in psychosomatosis the *body* functions in a delusional way. Psychosomatic symptoms have neither biological sense nor symbolic significance" (McDougall, 1982).

The severe alexithymic has extruded a part of his own psychic reality rather than feel it. He is totally unaware that he has split off from consciousness an important series of fantasies and feelings.

When one questions why an individual is maintaining such a devitalized relationship with the world, and wonders what he is protecting himself against, the answer may lie in the difference between neurotic and psychotic anxieties.

McDougall suggests that the psychosomatic's unconscious fears are closer to psychotic. The neurotic is concerned with conflicts about adult rights to a love life, sexual pleasure, competitiveness and work situation, as well as narcissistic satisfaction. Psychotic anxiety revolves around the right to exist and be a separate individual, fear of loss of control and deep uncertainties about self identity.

The ego was seen as being overly cathected to objective reality and as having a purely utilitarian function devoid of symbolic value.

The interview situation favoured the neurotic over the psychosomatic patient according to Berens et al. (1977) and Cremerius (1977) in a report by Keltikangas-Jarvinen (1985) a researcher in Helsinki, Finland. The psychosomatic made an unfavorable impression on the interviewer and seemed disinclined to enter into therapy, nor understand or care about therapeutic intervention. The psychosomatic seemed able to communicate only through symptoms.

We see that a psychosomatic character pattern emerges that is distinctly different from the neurotic. There is the paucity of affect, an impoverished fantasy life, an inability to verbalize emotions, a difficulty in the recall of dreams and a utilitarian mode of thinking. Evidence of pre-neurotic disturbances, poor interpersonal relationships and issues of countertransference, will also affect the therapeutic situation.

When the psychosomatic's distinct form of mental functioning is an attempt to sever and stifle emotional links between himself and others, the strong emotions aroused in the therapist, who may experience the patient as dull, boring and frustrating, suggest the possibility that the psychosomatic may be alexithymic.

IV. TREATMENTS FOR PSYCHOSOMATICS

Psychosomatic disorders are now called psychophysiological. Although the symptoms are physical the cause of psychosomatic disorders is primarily psychological and is related to a person's capacity to cope with emotional stress, which on a long term basis can affect his mental efficiency as well.

In the earlier part of this chapter the basic causes of psychosomatic symptom formation were discussed in greater detail. Listed below is a brief summary (Wolman, 1976) to enhance the discussion on treatment considerations.

1. inherited or early acquired (through illness or conditioning) organ or system vulnerability.
2. chronic emotional arousal leading to damaging effects in a specific organ system.
3. psychological patterns of conflict and defense formed in early life (Alexander, 1940).
4. sustained emotional arousal in response to stress, the degree and duration of arousal depending both on the nature of the stress and the individual's perception of it. Cognitive processes are involved.
5. precipitating life situations, stressful events.
6. psychosomatic self-regulations, and coping mechanisms.
7. socio-cultural factors pertaining to the stresses characteristic of a given society.

Treatment considerations. The treatment approach to the psychosomatic must be interdisciplinary. It involves consideration of maladaptive changes in the system of body functions, the psychological characteristics of the individual, as well as the mechanisms that cope with stressful events that clearly play a part in the illness. Treatment also involves recognition of the fact that an individual is a psychological entity who interacts with his environment.

Although the attending physician's prime attention is focussed on the pathological and biochemical factors of the medical condition it is important for him to recognize psychopathology in the patient and refer him for treatment. Delay or postponement of psychiatric help may cause complications in the future which may be difficult to reverse.

Therefore, the therapist works in conjunction with the physician who is concerned with treatment of organ pathology, in an effort to reduce stress and prevent a total collapse of the patient. This allows the patient time to recoup his coping strategies. To this end, "anxiety suppressive" and supportive therapies are recommended (Sifneos, 1975).

The psychosomatic patient is difficult to treat because of his "pseudonormality" (McDougall, 1982). He appears to be normal.

A further complication is the usual reluctance of the psychosomatic patient to undergo a treatment which may still carry a stigma. Some patients would rather suffer the debilitating effects of a physical illness than admit that there may be something psychologically wrong. Wolfe (1977) says that sometimes playing the sick role will enable the psychosomatic to express his emotional problems via his symptoms which help him comply with expectations from society which he cannot fill.

Psychotherapy with a patient with a physical illness is also complicated by his weakened physical state which may require bed rest or a decrease in physical activity. That may create a passive-dependency and regression. The therapist may be in a bind about whether to be supportive and acknowledge the suffering of his patient, thus risking further regression and further incapacitation of the patient; or whether he may appear to be unsupportive and uncaring if he does not acknowledge the physical affliction. This is particularly relevant

in therapies like self psychology (Kohut, 1971) which emphasize the empathetic aspects of the patient-therapist relationship to help effect a cure.

1. Psychodynamic therapy.

Because some psychosomatics may not show evidence of psychopathology Taylor (1986) reports that Bastiaans and Groen (1952) claimed that they were usually "neurotics who pretend to be mentally healthy and well-adapted."

During the late 1950s it became apparent that psychoanalytic treatment based on the neurosis drive-defense model of the mind was inefficient in dealing with the psychosomatic patient. The psychoanalysts and psychosomatic medicine drifted apart, and the shift in treatment began to focus on more primitive mental states, an interest in early object relations and the self (Taylor, 1986).

Drop-out rates in psychodynamic treatment compared to systematic desensitization support the idea of the unsuitability of dynamic therapy. A study by Salminen et al (Sifneos, 1983) describes patients as having poor capacity for insight and difficulty relating psychological conflicts and life problems to their somatic symptoms. Sifneos (1983) believes that anxiety-provoking therapies where conflicts, feelings and defenses are systematically examined, is contraindicated and, (Sifneos, 1975), is more suitable for neurotics who have been evaluated and are able to tolerate the anxieties produced by the proings of the therapist. Martin (1986) finds the contraindication of insight-oriented psychotherapy as debatable, and credits its role in focusing on the importance of the disruption in the affect process for treatment. He states that the somatic symptom may be the only way for the individual to cope with the situation if the symptoms become severe enough to warrant the attention of the health practitioners.

2. Anxiety-reducing therapies.

Most therapists agree that reducing anxiety is the best way to alleviate the suffering from psycho-physiological disorders and regulate autonomic arousal (Davison/Neale).

Behavior therapists believe that since autonomic responses can be learned (Pavlov theory of conditioning) they can also be unlearned.

Behavior therapists employ usual anxiety-reducing procedures such as systematic desensitization, rational-emotive therapy and assertion training. If the person does not know how to act in a particular situation, behavior rehearsal and shaping may help him/her acquire necessary skills. Relaxation training is part of medical treatment.

Biofeedback. Lesser and Lesser (1984) advocate Rickle's (1981) use of biofeedback as an adjunct to psychotherapy with somatizing psychosomatic alexithymic patients. Rickles conceptualizes it as "a transitional object which facilitates the integration of physiologic-somatic events into the affect process. Biofeedback, suggest Davison/Neale (1982) improves somatic functioning and gives prompt, demonstrable exact information to the patient on heart rate, blood pressure, brain waves, skin temperature and other autonomic bodily functions.

3. Supportive and dynamic therapies.

Sifneos (1983) suggests that supportive therapies are most effectively used with individuals who by virtues of genetics, physiological and environmental constraints have failed to develop a mature character structure "and do not possess adequate strength of character structure to face the vicissitudes of every day realities." Such individuals, despite their precarious emotional equilibrium, do require the active support of their therapists in order to maintain a reason-

ably adequate functioning. The types of individual or group supportive interventions must be "anxiety suppressive" (Sifneos, 1983).

Groups. In reference to Group therapy which was recommended by Ford and Long, Apfel-Savitz (1977) used guided teaching, concrete visual feedback and medication. Group interaction was a helpful preparatory step to psychoanalytic therapy.

Alternatives to psychoanalysis, unless capacity to fantasize was improved, include group supportive therapies in conjunction with psychotropic medication, environmental manipulations, behavior modification and even relaxation, hypnosis and meditation techniques were the treatments of choice over dynamic psychotherapies.

Art group therapy with psychosomatics. In 1983 Phillippopoulos and Lucas utilized art group psychotherapy with a fluctuating group of nine psychosomatics in a non-psychiatric setting, referring to it as an "appealing" method of therapy employing art which is one of the oldest forms of human communication.

Among the criteria for selection in this art group was the existence of a psychosomatic complaint, a history of a meaningful relationship with another person during childhood, a capacity to express feelings freely, an above average intelligence and psychological mindness/sophistication, and motivation for personality change and not for symptom relief.

It is obvious that these criteria would immediately rule out the alexithymic.

Activities such as scribble drawing, sketching, painting, clay modelling woodwork or other media were combined with free association comments which were used to help release inhibitions and increase insights, which in turn

provided symptomatic relief from anxiety. Phillippopoulos and Lucas (the therapist) called this an "acting out" of the conflict through the media.

They felt that transference, abreaction, reality testing and sublimation were dynamics that were obvious with this group. Insight and ego strengthening appeared to be obvious as well, but not as apparent. The results yielded definite improvements in the members' actual life, emotional state and artistic productivity.

However, when dealing with the paucity of affect, the evidence of pre-neurotic disturbances in relationships, and countertransference issues we must distinguish the psychosomatic from the alexithymic who is rarely able to reduce anxiety by making repressed conflicts available for interpretation through dreams, or other mental images.

In the following chapter, the treatments recommended for the psychosomatic patients by researchers and clinicians will be reexamined for their relevance to the alexithymic patient. A completely different method of treatment will be discussed, which considers the unique characteristics of the alexithymic, and the potential of art therapy as a nonverbal, creative therapeutic approach.

CHAPTER TWO

I. THE CONCEPT OF ALEXITHYMIA

Thus far this study has dealt with psychosomatic medicine, psychosomatic symptom formation and the personality structure of the psychosomatic. Before we examine the potential of art therapy to deal with the problems which are unique to the alexithymic, we will describe the alexithymia concept, and clarify its link to psychosomatic medicine through a survey of the literature.

"Alexithymia" is a term coined by Peter Sifneos in 1972 whose literal meaning is "no word for moods" (derived from the Greek: a = lack, lexi = word, thymos = emotion).

"Alexithymia is a descriptive concept that telescopes a number of clinical features into an easily communicated term" (Lesser and Lesser, 1983). The most recent research refers to alexithymia as a multidimensional construct defined by cognitive-affective characteristics such as "difficulty in identifying and describing feelings and bodily sensations, impaired symbolization as evidenced by a paucity of fantasies, and a preoccupation with external events" (Taylor and Bagby, 1988).

The concept has been extended and applied to hypochondriacal patients, somatizers, aphasics and to patients with psychiatric problems such as borderline and narcissistic personality disorders. Alexithymia has even been linked with sexual perversions, substance abuse disorders and other type of acting out character pathology (Acklin and Alexander, 1988).

Primary and secondary alexithymia.

Freyberger in 1977 suggested that there are developmental and acquired forms of alexithymia. Primary: a chronic, lifelong trait and secondary, as a reaction to a stress, a defense mechanism, or as a defense against aging in geriatrics (Shipko, Alvarez, Noviello, 1983).

1. History of alexithymia.

Alexithymic characteristics were first observed in patients with classical psychosomatic disorders. Their prescribed treatment was psychoanalysis because of the psychodynamic theory that when conflicts are not expressed and dealt with verbally, they are expressed through somatic channels (Lesser, 1981).

2. Psychological origins.

Because of his lack of success with insight therapy with this population, Ruesch in 1949, studied them and noted "a disturbance of verbal and symbolic expression in psychosomatic patients, whom he labelled 'infantile personalities'" (Taylor, 1984) and which he considered was the core problem in psychosomatic medicine.

Further research by Joyce McDougall (1982) which was documented in great detail in the first chapter, expanded on Ruesch's theory from a psychoanalytical point of view. She believed that this inability to name, contain or work through affective states was a psychotic defense mechanism, more radical than the neurotic's denial.

She also attributed early mother-child relationships and pre-neurotic pathology to vulnerability and predisposition to later psychosomatic disorders. Her description of the psychosomatic personality structure does supply us with needed insight into the alexithymic's psychological problems.

3. Pensée opératoire.

An important contribution to the development of the alexithymia concept is a certain cognitive feature that was noted by a group of French psychoanalysts, Marty and de MUzan in 1963, in their clinical work with psychosomatic patients. Mentioned in the previous chapter as an ego deficit model for psychosomatic symptom formation, the concrete, reality based, cognitive style was described as "operational thinking" or "pensée opératoire". It was characterized by endlessly detailed verbal descriptions of present day situations related in an unemotional, detached way.

Marty and de MUzan (1963) reported these patients as functioning mentally by the process of "replication", relating to others as though they were stripped down versions of their own self-images, a trait later verified by McDougall (1982). Furthermore, the necessary transference seemed to be an experience that was either non-evolving transference reaction, or a "massive, undifferentiated transference, exclusively devoted to a resistance of the Id" (Ibid.).

4. Neurological origins.

At the same time, in 1963, quite independently, Nemiah and Sifneos discovered in a study that 16 out of 20 patients who had psychosomatic illnesses exhibited a communicative style with "a marked difficulty on verbally expressing or describing their feelings, and a marked absence or striking diminution of fantasy" (Taylor, 1984).

Later, Nemiah in 1973 distinguished the alexithymic from the obsessional or hysterical personality by stating that this absence of affect and fantasy in the

hysterical patient was limited to an area of psychological affect, and that the obsessional patient was able to fantasize richly.

Although Nemiah (1976) pinpointed early mother-child relationships as the origin of the alexithymic problems just as McDougall (1982) did, he speculated on a neuroanatomic developmental model, based on "a defective post-natal development of neuron structure resulting from a lack of environmental input." Inadequate maternal stimulation during infancy might be a factor in the failure to develop connection between limbic and cortical structure. He attributed alexithymia to a "functional discontinuity between the emotion laden nonverbal right hemisphere and the rational verbal left hemisphere, as a discontinuity between the functions of the limbic system and the neo-cortex."

Nemiah (1977) also describes the internal processes that occur in an affect-provoking event "as two sets of reactions put into motion; the perceptual-cognitive and the affective."

Nemiah detailed the various steps in normal neurobiological functioning.

Normal functioning.

1. A conscious perception of the external event.
2. The somatic components of affect (emotion) are aroused, which undergo a psychic elaboration which consists of:
 - a) a refinement and delineation of raw emotion into a variety of qualitative different nuances that have potential for conscious experience as feelings, e.g. anger, fear, joy, sadness.
 - b) a linking of the feelings with words that describe them.
 - c) the production of fantasies expressive of the feelings, which at the same time determine the imagery of the fantasies.
 - d) the arousal of a network of memories and associations related to the feelings.

In the normal course of events all, or most of these elements, will appear in conscious awareness and will be expressed in an appropriate manner". (Nemiah, 1977)

Abnormal functioning.

The disturbances in this affect-response to an external stimulus could occur at several points. One might be a blockage in the pathways from the process of psychic elaboration to conscious awareness, that was described above. An alternate possibility according to Nemiah (1977), may be an absence or defect in any or all of the elements of psychic elaboration, or he suggests, there could be a blockage in the pathways leading from the somatic, emotional component of affect to the area of its psychic elaboration.

He explains that this blockage would lead to a short-circuiting and deflecting of the transmissions of energies aroused by the external stimulus. Instead of being dissipated in normal affective expression they might result in an increase in activity of other elements in the system (the somatic emotional component for example) or in other abnormal discharges manifested as somatic symptoms.

These disruptions could have a psychological origin, resulting from deficits and defense, or from physical discontinuities in the neuronal structures and pathways.

Nemiah's neurophysiological research, based on MacLean's (1949) theory which explained the alexithymia concept as due to a "functional discontinuity between the emotional nonverbal right brain hemisphere and the rational verbal left hemisphere," gains theory support from clinical studies by Hoppe and Bogen (1977). Hoppe, studying patients who had surgical commissurotomies for intractable epilepsy (split brain patients) also noted that they exhibited a limited

capacity to dream, or symbolize. The similarity to Marty and de MUzan's "pensée opératoire" led Hoppe to introduce the concept of a "functional commissurotomy" in patients with severe psychosomatic disturbances. Hoppe theorized that "a lack of interhemispheric communication resulted in concern of the left hemisphere with the translation of thing-presentations into word-presentations, while the right hemisphere, unable to verbalize, hypercathected bodily sensations" (Ibid.).

Lesser (1981) says this proposal, not properly validated, would be supported only if alexithymia was construed as a language disorder. The language of the alexithymic is essentially normal. It is the two right hemisphere tasks of affect expression and ability to fantasize that are impaired (Lesser and Lesser, 1983).

Further neurobiological research, including the discovery of the different, specialized functions of the two cerebral hemispheres, and Hoppe and Bogen's (1977) observations that "split brain" patients display characteristics of alexithymia, are generating interest in the neurosciences. Alexithymia has also been attributed by TenHouten and associates to a "functional commissurotomy" supporting Hoppe's suggestions (Taylor, 1988).

5. Genetic.

Not much experimental evidence is available to support a hereditary component on alexithymia although tests on Norwegian twins by Heiberg in 1977 concluded that there was a strong hereditary predisposition in monozygotic twins who had a higher concordance for these characteristics than dizygotic pairs (Sifneos, 1983).

6. Social learning.

Improper socialization or arrested development, and consequently blocked maturation was proposed as a cause by Zepf in 1977, who analyzed the language content of adult alexithymic and found it to be deficient in symbolic expression. He attributed this to certain aspects of early mother-child relationships. The over-attentive mother could restrain the child's emotional development, and inhibit the initiation and utilization of symbolic expression (Martin, 1986).

Sifneos (1983), also claimed that developmental factors within a family system or sociocultural environment could precipitate alexithymic characteristics.

Martin (1986) proposes that if alexithymia is a label for a constellation of cognitive and behavioral characteristics then the developmental approach may represent a more realistic approach to the etiology of alexithymia.

7. Psychogenic factors.

J.J. Groen (1974) believes psychosomatic diseases are man made diseases caused in man by his fellow men--the key figures in his immediate environment, family, parents, bosses, co-workers.

This approach is psychosocial, and psychocultural and involves society's effects and how it influences the behaviour of people and vice versa. Psychosocial stress and frustrations can upset the homeostasis of the communications in the group, and the internal homeostasis of the individual and his health.

Groen also stated that inhibitions of self expression placed on our western society results in a bottling up of feelings, of feeling afraid to cry, ask for help, or express frustration and aggression verbally, or by acting out. He believes that "psychosomatic disorders are regarded as internalized forms of behaviour (like displacement behaviour in animals) which occur when acting-out in speech

or muscular skeletal action is too strongly inhibited and seeks an augmented outlet in autonomic, visceral or endocrine activity" (Groen, 1974).

Krystal and Radkin in 1970 discovered similar characteristics, such as an inability to express feelings and absence of fantasy, in concentration camp survivors having posttraumatic stress, suggesting that alexithymia can develop in response to massive psychic trauma (Krystal et al, 1986).

8. Affects, emotions, feelings.

Sifneos (1975) chose to clarify meanings of frequently used terms applied to alexithymia research.

He defined "affect" as a general, personal and private state with components that were both biological and psychological.

The biological side of affect called "emotion" is expressed behaviorally. It is mediated through the limbic system which controls the autonomic nervous system, as well as through the hypothalamus, which functions on the exchange between the inner and outer worlds, "appearing to integrate the instinctual and possibly other kinds of behaviour" (Sifneos, 1975).

The word "feeling" denotes subjective thoughts and fantasies, associated with emotions, thereby implying neocortical activity. Sifneos stated that "both emotions and feelings may or may not be expressed by means of action" and he quoted Hinde (1972), "If we choose to disregard subjective experience, our knowledge of emotions depend on behaviour."

Although both emotions and feelings coexist in man's affective life, it is possible that emotions may exist without feelings. (Sifneos, 1975)

A misconception shared by many is that members of other non-western societies have achieved the perfect outlet for discharge of emotions and frustra-

tions via music, dance, rituals, and other nonverbal outlets, while our society deteriorates with suppressed anxieties. Taylor (1987) repudiates this notion. Catharsis is not achieved through frenzied abandonment orchestrated to the accompaniment of beating tomtoms.

Taylor (Ibid.) wishes to impress upon us the fact that the problem for the alexithymic does not lie within the failure to discharge the emotions, but rather in his inability to tolerate affects, and to derive clues from them which are relevant to his coping mechanisms for stress.

Significant was Nemiah's (1978) observation that alexithymics may "sometimes display outbursts of rage or of sobbing but are unable to elaborate further on what they are feeling" (Ibid.).

Crosscultural testing of alexithymics in Sriam, India in 1986, using the Toronto Alexithymia Scale (TAS) translated into Kannada (an Indian dialect) concluded that although cultural factors do influence manifestations of alexithymia, the disturbance does exist cross culturally. Although the Japanese are noted for their emotional reserve (Taylor, 1987), tests in Japan by investigators Nakagawa et al in 1979 and Nakai and associates do make distinctions between the neurotic and the alexithymic.

Multiple factors play a role in the understanding of such a complex phenomenon. How to discern who is alexithymic is the concern of those who test and measure.

II. ALEXITHYMIA MEASUREMENT AND TESTING METHODS

There is a wide consensus among researchers and investigators that alexithymia, "a hypothetical personality construct thought to be associated with hypochondriasis, somatization disorder and a variety of other medical and psychiatric disorders" is a difficult concept to operationalize (Bagby, Taylor and Atkinson, 1988).

Criticism against the lack of objective, standardized valid assessment measures has prompted some to believe that there is little empirical support for the construct. Lesser and Lesser (1983) noted that many investigators interpreted their findings as though the construct's validity had already been established, and assumed that clinical features were conceptually related. There have been various attempts to develop measures to operationalize and quantify the alexithymia concept, which involves both developmental issues and neurobiological factors in its etiology (Taylor, 1984).

Controversy also rages about whether alexithymia is a situation dependent state or a stable personality trait (Taylor, Bagby, 1988). Attempts to identify and qualify it are based on two theoretical concepts.

One hypothesizes that "limited emotional awareness and cognitive processing of affect leads to a focussing on and amplification of the somatic component of emotional arousal" (Ibid.). This may explain the alexithymic's tendency to develop hypochondriasis and somatization disorders, and the use of physical action for the discharge of tension, in behavior that includes substance abuse, compulsive exercising and bingeing with food.

Martin and Pihl (1986) believe that the alexithymic's inability to cope with stress on the neocortical level, will result in intense and aggravating physiologi-

cal responses, which will produce conditions conducive to somatic disorders (Taylor, Bagby, 1988).

The exciting news is that lines of investigation, from the neurobiologic side, with comparative studies of the structure and function of the brain, are converging with psychological studies, and advancing and bridging the gap between brain and behaviour. This is resulting in a revision of many traditional theories of personality and psychopathology (Ibid.).

Research has focussed on the comparison of various categories of clinically diagnosed psychosomatic and non psychosomatic groups of patients in an attempt to provide validifying evidence of the construct of alexithymia as a predisposition to psychosomatic illness. The very latest research by Acklin and Alexander (1988) not only verified the hypothesis, but also questioned the practice of including mixed groups of psychosomatics with non-patients, because of the hidden assumption that there was a uniformity of alexithymic characteristics throughout the wide range of psychosomatic disorders.

Researchers have been criticized for not following standard psychometric guidelines in measuring alexithymia, or having met the general requirements for standardized personality measures (Ibid.).

To date, observer rated and self assessment questionnaires, projective tests and content analysis of speech samples have been used. Most recently a graphic-projective test has been devised to measure symbolic function directly. (Taylor, 1984)

An exhaustive account of testing and measurements is beyond the scope of this study. A concise account of the better known tests in the three categories of testing will follow.

TESTS

1. Observer-rated questionnaires.

Beth Israel Hospital Questionnaire (BIQ). The BETH ISRAEL Hospital Questionnaire (BIQ) devised by Sifneos is the most widely used test. It is a 17 item forced choice (yes/no) instrument rated by the interviewer concerning the presence of alexithymic characteristics, plus 6 questions concerning the interviewer's own reactions to the patient.

Other scientists question the bias of the interviewer's influence on the test results. Although Apfel and Sifneos (1979) reported good interrater reliability with the BIQ, others found that the scoring is highly dependent on the experience, bias and style of the interviewer.

2. Self report scales.

Schalling Sifneos Personality Scale (SSPS). Another method of testing is the Schalling-Sifneos Personality Scale which is a 20 item self rating report that relies on the individuals' perception of their thinking processes and thereby avoids the interviewer bias complication (Sifneos, 1979). Each item is scored on a four point scale from 20 to 80, where 20 indicates severe alexithymia.

Minnesota Multiphasic Personality Inventory (MMPI). The MMPI test, a 22 item alexithymia scale developed by Kleiger and Kinsman, standardizes the information collected from patients and is reported (Taylor, 1984) to have impressive stability over time and a 82% success rate when predicting alexithymia scores on the BIQ. It has been found to be lacking in both face and construct validity.

Toronto Alexithymia Scale (TAS). In 1985 Graeme J. Taylor, David Ryan, and Michael Bagby reported on the development of a new self-report scale. "The

Toronto Alexithymia Scale was derived with concern for theoretical congruence with the alexithymia concept, independence of social desirability, response bias and internal consistency" (Ibid.). A full report on the TAS and the validity of other testing methods may be found in Taylor/Ryan/Bagby's (1985) article.

Bagby, Taylor and Atkinson (1988) suggest using a multimethod approach incorporating the TAS along with clinical assessment and/or the BIQ to differentiate between those who are alexithymic or not.

3. Projective tests.

Ruesch (1957) was one of the first to use projective tests to evaluate alexithymic characteristics (Taylor, Bagby, 1988) employing the Rorschach and Thematic Apperception Tests (TAT). He discovered that patients with "infantile personalities" as he called them, could produce only very "primitive, unimaginative and stereotyped" fantasies in their response to these tests. Taylor and Bagby indicated that perhaps the interviewer may have influenced scoring and interpretation of these responses.

Rorschach Test. The TAT and the Rorschach were both used to quantify fantasy formation and verbal expression of feelings in a comparison between groups of psychosomatic patients and psychoneurotic patients or other control groups on the assumption that the psychosomatic groups were more alexithymic. Using the Rorschach tests Vogt and associates (1978) showed significant difference in fantasy formation between the two groups.

Acklin and Alexander (1988) believe that the Rorschach test is suitable for the measurement of alexithymia because its construct entails impaired capacity to fantasize, response to affect, and concrete, stereotypic perception as well as problems of cognition. They report on Bash's (1986) summarization of psycho-

somatic patients' characteristics by their limited number of responses, poorly formulated responses to colour, limited movements, and minimal amounts of resources in coping and adaptation. Psychosomatic patients were found to be readily discernible from the nonpatients on the seven Rorschach alexithymia variables (Ibid.).

On the subject of projective tests, Hammer (1980) brings up a valid argument. He agrees that the Rorschach test could provide richer personality pictures if the subject cooperates consciously and does not resist on a subconscious level. However since the subject's percepts must first be translated into and then communicated into verbal language, he suggested that other projective, nonverbal tests (which he did not name) might be applied. These could be used with persons who were evasive, poorly educated, mentally defective and/or with relatively underprivileged persons of low socio-cultural background who are frequently racked with feelings of inadequacy concerning capacity for verbal expressions, and those of concrete orientations. He believes that "drawings, like symbolic speech tap primitive layers. The child learns to draw before he can write" (Hammer, 1980).

Archetypal 9. Applied by Demers-Desrosiers (1982) to alexithymic patients the Archetypal 9 (AT9) test with nine elements was designed as a tracer of symbolic function and used along with Sifneos' BIQ Questionnaire. The scored Archetypal 9 (SAT9) was used on patients who revealed baffling somatic presentation or a discrepancy between the intensity of complaint and clinical and laboratory results.

The subject creates a drawing with nine symbols chosen to elicit anxiety and to suggest tools to resolve it, using Durand's (1967) theories of symbols.

The subject is then asked to write a story, and his ability to create a myth, and thus his ability to erect defense mechanisms against anxiety are demonstrated.

The nine stimuli are (1) a fall, (2) a devouring monster, (3) the sword, (4) the refuge, (5) something cyclical that turns or progresses, (6) a character, (7) water, (8) an animal and (9) fire.

Taylor and Bagby (1988) who regard the SAT9 as a promising measure of symbolic function contend that as the degree of alexithymia increases it is revealed, as the content and form of the drawings lose their subtlety, originality and cohesiveness. The most impaired in symbolic functioning draw disconnected symbols, lined up as numbered, or named symbols, or set up like a comic strip. They are unable to write a story, defend against anxiety or integrate the meaning of the story and the drawing of the symbol images.

Using the objectively scored SAT9, chronic pain patients were found to display various degrees of impaired symbolic function (Demers-Desrosiers, 1983).

Primary and secondary alexithymia. Freyberger (1977) divided alexithymia into primary and secondary form. Primary alexithymia is a chronic, life long factor that predisposes an individual to psychosomatic illness (Lesser, 1981). The latter, is described below as a reaction to stress, a defense mechanism. Primary alexithymia is of etiological significance in illness (Feiguine et al, 1982). Freyberger also included the possibility of alexithymia in geriatrics as a somatic defense reaction against the process of aging and the accompanying affective discomfort (Feiguine, 1982).

Secondary alexithymia. Work on post traumatic stress syndrome has been reported by Shipko, Alvarez and Novielo (1983) declaring the existence of alexithymic traits in non-psychosomatic patients such as in 22 combat Vietnam veterans who meet the DSM III criterion for posttraumatic stress. This is called

secondary alexithymia, which refers to the development of alexithymia in response to extreme life threatening illness or even concentration camp experience. In this case, it can be labelled as a highly adaptive defense mechanism, in which appropriate emotional response (fear, flight) would result in inappropriate handling of the situation, and an inability to cope with the stress. Many of the participants noted that the emotional numbing often resulted in a conscious effort and decision to depress the experience of emotion. However, the termination of this blunting was less under voluntary control and many reported absence of emotion later in such events as death of a parent or birth of a child.

Results from research done in 1983 by Smith reveal that higher alexithymic scores were associated with lower socioeconomic status, and in male patients, and those with less education.

4. Dreams.

The use of dream analysis as a means of assessing the ability to fantasize needs further exploration. Ira Lesser (1981) mentions uncontrolled studies of comparisons between the dreams of psychosomatic patients and psychoneurotic patients, that noted differences in reported content and symbolization. A higher number of psychosomatic patients could not recall their dreams.

H.L. Levitan (1980) in his studies on dreams reported that psychosomatic patients often displayed little awareness of feelings in response to anxiety provoking dream situations such as their own destruction. Ira Lesser (1981) states "it was hypothesized that in these patients, awareness of anxiety, and its usefulness as a signal function was not developed to the point of waking the dreamer. This inability to utilize anxiety as a signal of inner distress may be analogous to the waking state of the alexithymic."

To summarize, there is a consensus that more data is needed to study this phenomenon, and that one cannot categorically state that alexithymia is prevalent only in psychosomatic patients. It is evident in normal population, to varying degrees. It is not an all-or-none phenomenon, as Dr. Heiberg has pointed out in her genetic studies (Wolff, 1977). Alexithymia also varies in degrees among psychosomatic disorders (Acklin and Alexander, 1988).

With the availability of modern techniques of imaging such as the computerized tomography (CAT scan), magnetic resonance imaging (MRI), positron emission tomography (PET) and other high technology machines the study of the alexithymic's brain structure and function is now possible. Comparisons between alexithymic and non alexithymic individuals may help to accurately identify those with the disorder, along with standardized assessment instruments (Taylor, Bagby, 1988).

III. THE LINK BETWEEN ALEXITHYMIA AND PSYCHOSOMATICS

Since alexithymia owes its conceptual origin to research done with psychosomatic patients, we have already established a link between the two. It is necessary, however, to consider the extent of this relationship. A review of some researchers' comments and findings can enhance our understanding of the alexithymia concept.

Wolff (1977) discusses how some practitioners use the term "psychosomatic" in the sense of specific disorders with structural organic disorders, or to include functional physiological disturbances related to stress. Others include the term in an even wider sense to include behaviour disturbances and conversion hysteria.

He suggests that every physician should take the psychosomatic approach to every patient and concern himself with how physical, psychological and social factors contribute to bringing about a particular condition, symptom, or behavioral abnormality in this particular person at this time of his life and how those factors affect the course of this disorder.

Flannery (1977) says that "alexithymia is linked not to psychosomatic disease per se . . . but to a predisposition to a variety of puzzling disorders that are referable to altered body experience . . ." and that it should be possible to reduce morbidity of these disorders."

It means examining the state of discomfort which is related to the experience of the body, visceral tension and the functions of ingestion and excretion (oral, anal). That is why the umbrella of psychosomatic disorders include not only the classical "Holy Seven" but anorexia nervosa, colitis, uteral stones,

abdominal pains, enuresis, acute bladder retention, eczema, and many others, related to bodily functions (Ibid.).

Von Rad, and Lolas (1982) assume, often implicitly, that a relationship between alexithymia and psychosomatics exists. Yet not all of the so-called psychosomatics exhibit alexithymic features, a distribution of alexithymic characteristics exists in a normal population under specified conditions.

Von Rad and Lolas' second approach was to assess alexithymia simply as a cluster of features in different populations. From a predominantly descriptive standpoint it becomes closer to a precise organization of the construct (Von Rad/Lolas, 1982).

Shipko's studies in 1982 "demonstrated that alexithymia is more prevalent in somatizers than in subjects with classical psychosomatic disorders or in healthy control subjects" (Keltikangas-Jarvinen, 1985). The latest research by Acklin and Alexander (1988) states that "currently the construct of alexithymia has gained wide currency as a predisposing factor in psychosomatic illness." Recent proposals maintain that the inability to verbalize and express emotions, or "achieve the capacity for cognitive imagery (i.e., fantasy), as a means of effective coping and adaptation" (Ibid.) would predispose an individual to exhibit psychosomatic disorders. Sifneos proposed that originally in 1972.

In a Rorschach study composed of mixed psychosomatic and neurotic patients by Vogt et al (1977) the psychosomatic patients showed a marked restriction in the use of imagination and verbal expression of emotion (Ibid.).

Neurotic patients who can symbolize will represent their conflicts as conversion disorders through sensorimotor symptoms. "The somatic symptoms of the alexithymic patients have no symbolic meaning and should not be construed

as bodily metaphors for emotion" Taylor (1987) said, echoing this theory of McDougall's (1982).

In 1976 Zepf, starting off from a theory of socialization (based on Lorenzer) observed a lower sense of self esteem in alexithymics as compared to a normal population. He also believes that alexithymic subjectivity is characterized by the use of words more as signs than as symbols. Zepf interprets the alexithymic's shorter reaction times in verbal association tests as a lack of connotative dimensions in the reception and understanding of words (Zepf et al, 1981).

After examining the initial clinical observations on alexithymics, Ira and Bobbie Lesser (1983) noted alexithymic characteristics consistently among diverse groups of psychosomatic patients. They concluded that some patients with psychosomatic disorders display alexithymic characteristics, while others do not, and that some patients with alexithymic characteristics have physical illness and some do not. They also feel that the distinction between primary and secondary alexithymia, by Freyberger (1977) could be useful, as it explained the varying degrees of alexithymia.

In 1977 Wolff suggested that the degrees of alexithymia vary according to the psychosomatic disease. For example in a group of peptic ulcer patients only 15% displayed them. Using the Rorschach test, Acklin and Alexander (1988) confirmed this variability, testing psychosomatic patients and non patients. They noted that psychosomatic groups were more alexithymic than non patients, and that there were personality differences between the four psychosomatic groups tested: lower back pain, gastrointestinal, dermatology and migraine headache patients. Pain patients were significantly more alexithymic than the other groups, yet were indistinguishable from dermatology patients. All psycho-

somatic groups with the exception of GI who seemed to be more introversive, displayed difficulties in the management of affect.

After her AT9 testing Demers-Desrosiers' (1983) results showed that there was still an inference that alexithymic traits might represent an important disposition with regard to the manifestation of psychosomatic disorders.

Alexithymics also pose a problem for their medical doctors. Because of their difficulty in communicating their symptoms, their physical problems are difficult to treat. Eric Brown et al (1981) tested asthmatics with the Asthma Symptom Checklist (ASC) and reported on the unreliability of self reports as a gauge of their condition by those who were alexithymic. They believe that certain aspects of alexithymia lead to the "psychomaintenance" of the asthma. Flannery regarded alexithymia "as aberrant communication of physical symptoms" (Brown et al, 1981).

This vagueness about physical symptoms leads to overinvestigation, and excessive testing by the physician. Eventually the patient is referred to mental health practitioners.

Therapist interviews with patients who have psychosomatic disorders sometimes reveal no evidence of psychopathology. This seeming normality is a pseudo-normality; the "normative" facade that McDougall (1982) refers to. Negative counter-transference feelings by the therapist may tip the scales towards suspicion of alexithymia.

The ramifications of the usefulness of the alexithymia concept far exceeds its early discovery, in psychosomatic patients by Sifneos (1972) and other researchers. Alexithymic characteristics have been discovered among patients with severe drug dependence, substance abuse, posttraumatic stress, somatoform disorders, and described in patients with masked depressions, character

neuroses, and sexual perversion (Taylor, 1984). Although the term "alexithymia" was not used Taylor reports that Langs (1978) discovered that patients with narcissistic personality disorders had a similar nonsymbolic style of communication.

Alexithymia, and its research opens up challenges in the field of psychotherapy, especially with developmental theorists, "in an attempt to understand how early physiological experiences and bodily sensations acquire mental representations as feelings and thoughts that eventually result in a language for expressing the emotions" (Ibid.).

IV. THE ALEXITHYMIC PATIENT

1. Construct.

A composite, hypothetical image of the alexithymic patient will be presented as an object for consideration, in order to consolidate the data on alexithymia previously presented and to demonstrate how art therapy has implications for treatment.

Although women traditionally have a reputation for being more emotional, research indicates that middle aged men of a lower socioeconomic background are more likely to be alexithymic (Keltiganas-Jarvinen, 1985). Therefore we will assign this fictitious alexithymic patient masculine gender.

Certain cultures impose restrictions on the expression of internal distress, and encourage stoic behaviour. In our own western culture "real men don't cry" and it is more "manly" to complain of a physical illness than admit to psychological problems which may be construed as a weakness of character.

Studies also indicate clinical manifestations of alexithymia in other cultures such as Japan (1979) and in India (1986) where one would suppose that catharsis in the form of rituals, music and dance would preclude this disorder from these societies.

The alexithymic is described as an "emotional illiterate" (Taylor, 1984) who has difficulty in discriminating between emotional states and bodily sensations. He speaks not with feelings or words but via "organ language."

This limited emotional awareness and cognitive processing of affect focusses on and amplifies the somatic component of emotional arousal (Taylor, Bagby, 1988) which leads to hypochondriasis and somatization disorders. Unable to regulate and modulate distressing emotions the alexithymic's coping strategies

result in discharge of tension in direct physical action and behaviors such as compulsive exercising, binge-eating, abuse of substances and drugs and sexual perversions (Ibid.) These somatizers may be as incoherent about their body states as they are about their emotional states says Flannery (1977). They poorly articulate their diffuse feelings of distress, which may have both mental and physical qualities, or remarkably where it may be expected there seems to be an absence of distress.

The alexithymic may cover up his lack of awareness about his body state by behaviour that appears to be a lack of concern about his problems. "What seems to be a denial of emotions is in fact an absence of feelings" (Sifneos, 1974). Taylor's (1977) opinion is that feelings in the alexithymic patient are neither denied or absent but rather buried very deeply.

Because he is unable to communicate his symptoms verbally he frustrates his physician who has overinvestigated, overtreated and overtested him in an effort to detect the organic pathology and treat the medical symptoms of his disease.

He complains mainly about his somatic symptoms, in a communicative style that has little symbolic content, and which does not reveal much about his attitudes, emotions and wishes. His thought content is utilitarian, dry, devoted to literal external events ("pensée opératoire"), and he has difficulty in distinguishing one emotion from another.

He may react to stress with actions (Lolas, 1980), rather than discharge of emotions. He has few dreams or daydreams, and when he does dream it is more "realistic" than "the stuff that dreams are made of."

The alexithymic may show no evidence of psychopathology says Wolfe (1977) and this apparent false front may only be a sign of pseudonormality, a

trend which has been verified by Murray Jackson's research. However, researchers state that he causes distress to his wife and children in his relationships with them.

He functions "professionally" in the outside world but there may be a passive dependency in his relationship with his immediate family and passive-aggressiveness in his behaviour.

These psychological problems can be traced to early mother child relations (McDougall, 1982). The adult rages inwardly against his mother and he punishes himself unknowingly in the vulnerable body area for the control she exerted over him during his childhood. If his mother has confused him out acknowledging his feelings ("No, you do not really hate your sister") or stifled his expression of affect ("Be quiet! Wait till we get home, you'll get it!") then he has a good base for problems in adult life.

According to the literature the alexithymic man possibly might have a masked depression, be sexually perverted or have a character neurosis (Taylor, 1984). He could have a distorted body image, reacting as if he was disassociated from his body. McDougall (1982) describes his carriage as "robot-like" and his facial expressions are rigid, stony, without a radiation of inner liveliness. In fact he may appear to be so cool, so controlled, yet his outer facade may belie his inner anxieties.

His apparent lack of interest in his therapy evokes countertransference feelings of boredom and frustration in the therapist. Alexithymics differ from both psychoneurotics and psychosomatics when faced with therapeutic intervention. Taylor (1984) has documented the alexithymic's ability to arouse negative countertransference feelings of boredom and frustration in the therapist, along with his innate desire to create a space between himself and others in interper-

sonal relationships. Combined with his inability to convey analyzable material he is a difficult candidate for psychotherapy. He has been described as unmotivated in therapy. The drop out rate, as reported by Sifneos (1974) and McDougall (1982) is very high. Even worse, it may be as McDougall describes it, an "interminable" process.

Lesser and Lesser (1983) suggest that it may be the treatment and not the patient that is inappropriate.

This fictitious patient has a psychosomatic disorder. For the purpose of this paper we will ascribe asthma as his illness. Unfortunately the presence of alexithymia in asthmatics poses difficulties in the medical treatment of this disease, because patients' self-reports are unreliable. Its presence will also lead to psychomaintenance when the illness and trait exist (Brown et al, 1981).

Two subgroups of alexithymics may exist among alexithymic asthmatics. One group, described by Kleiger and Dirks (Ibid.) is overly tense and communicates affective distress by focussing on physical symptoms and events that are external and objective. The second subgroup denies affective distress and "behaves with counterdependent control." Both styles of behaviour contribute to increased hospitalization and medical problems regardless of the severity of the disease.

The MMPI Alexithymia Scale, and the Asthma Symptom Checklist (ASC) have been used to measure affective and somatic distress. The patient is diagnosed alexithymic. Let us consider how we may help him.

2. Therapeutic considerations.

Alexithymics--Psychoanalysis.

The prevalent opinion is that psychodynamically oriented psychotherapy and psychoanalysis have had little to offer the alexithymic patient, although the irony is that the concept had its roots in the initial research of psychoanalysts on their "difficult" psychosomatic patients.

In fact, Sifneos (1975) cautioned that insight therapy might make them worse and suggested, as others did including Freyberger (1977), that the psychodynamic approach should be modified for this special category of patients.

This is reasonable when one contrasts the non-communicative style of the alexithymic, with the neurotic who communicates symbolic material, thoughts, dreams, fantasies, feelings, and other analyzable material to the therapist.

Issues of countertransference.

Nemiah considers countertransference affects of the dull, boring, frustrating type as one of the diagnostic criteria of alexithymia.

Taylor (1977) suggested using the therapist's feelings of countertransference as a creative instrument to gain access to the patient's unconscious. He refers to Heimann's assumptions (1950-60) that the analyst's rapport with the patient is on an unconscious level, deeper than conscious reasoning, and leads to an understanding, reflected as a response in his countertransference.

When the therapist is faced with the patient's deeply buried feelings which are experienced as highly dangerous or ego destructive, he may respond with his own aggressive fantasies. He may find the patient deadly dull, or feel he is being bored to death by him. "What is happening in this relationship? Why do the patient's words have this effect on us?" queries McDougall (1982).

McDougall offers the psychoanalytic concept of splitting and projective identification as an explanatory hypothesis.

Projective identification is a psychological process between two people, as well as an intrapersonal phenomenon. In analysis this manner of relating to others reveals not only the way in which the person experiences other people, but also in the way in which his own fantasies, and problems can unconsciously be used to stir up strong affects and reactions in other.

Taylor (1977) reiterates "These countertransference feelings may be conceptualized in terms of introjective-projective relatedness and by fostering the development of a psychotic transference, intense feelings, fantasies and dreams are released."

The countertransference is the patient's creation, part of his personality and Hanna Segal suggests that violent projective identifications experienced by the child by his parents may be the cause. As the doctor-patient relationship parallels the mother-child relationship there is an unconscious recreation of early feelings and fantasies associated with introjective and projective manoeuvres. Taylor (1977) claims that "by sustaining and analyzing the countertransference the therapist can develop appropriate therapeutic strategies and interpretations which render the relationship with the alexithymic as anything but sterile" (Ibid.). During the art therapy section this theory will be amplified showing how it may be extended in a concrete fashion.

Through the alexithymic's unconscious need to withdraw from close intimacy, to create a space between himself and others, he manages to communicate this need and stir up considerable affect in others, and get them to join in this unspoken conspiracy to maintain a distance. This was equated "to a form of schizoid withdrawal from others and the maintenance of a devitalized inner state of which the individual is unaware. This is compensated by a "false-self"

adaptation to external reality, in which the patient is so to speak, dis-affected, while affect is mobilized in the other" (McDougall, 1982). Taylor (1977) states that "Projective identifications from the alexithymic patient may be reprojected as statements that he is a mechanical kind of being with a neurophysiological defect."

His psychic survival depends upon paralyzing his affective liveliness. Only by maintaining this inner deadness can he avoid the primitive dangers of implosion or abandonment and the risk of reexperiencing a traumatic state of hopelessness and helplessness, in which psychic existence, and perhaps life itself was felt to be threatened. "No baby is born alexithymic" states McDougall (1982).

Therefore the therapeutic focus is on the promotion of the maturation of the psychic structure in an effort to increase the alexithymic's ability to self regulate, and includes efforts to aid the patient to learn how to recognise, label, interpret, and organize feelings. Problem solving, coping and adaptive strategies are effected through stress management, behaviour and cognitive interventions.

Krystal (1979, 1982) has modified psychotherapy techniques so they may be more beneficial to the alexithymic patient. Taylor (1984) describes his techniques of shifting the focus of therapy from the content, to the form of the patient's communication, which suggests to me possibilities of art therapy as a modality.

In art therapy, in the creative act, the conflict is reexperienced, resolved and integrated. (Ulman, 1987)

Krystal (Taylor, 1984) also recommended that the therapist "first help the patient to observe the nature of his alexithymic disturbances"; to be helped to

develop tolerance of affect and learn "to recognize their emotions as signals to themselves which are self-limited in duration and intensity." The therapist assumes the parenting role and teaches the patient to accurately label and gradually verbalize his emotions.

Freyberger (1977) outlines "four components for treating primary alexithymics built up of stable object relationship; positive transference with the therapist; the therapist supplies words for emotions; the therapist uses well formulated interpretations, and an internist is always available."

Because secondary alexithymia is a transitory state, which serves as a protective factor, as a reaction to stress during highly difficult situations such as combat, it requires a slightly different approach and the therapist "must work on the verbalization of secondary hypochondrial self concerns, confirmation of infantile regressive traits, and strengthening of the denial work in the direction of realistically adapted behaviour in addition to the work outlined above. Therapy must include a 'supplementary psychological' handling of the medication and the apparatus used" (Granich et al, 1984).

Taylor (1986) conceptualized that highly disease-susceptible people have psychic deficits in addition to conflicts that are drive related, which explains their vulnerability to pre-neurotic problems, separation and object loss. He also cites the shift in modern day psychoanalysis from neurotic states of mind to more primitive mental states, an interest in early object relations and development of the self.

Acklin and Alexander (1988) attribute the development of psychosomatic disorders as indicators of "self pathology" within a person, to a "developmental failure in the internalization of endopsychotic self-regulatory systems. The failure to link mental representations with their accompanying affects, effected

primarily through caregivers, is thought to create a lifelong vulnerability in self-regulation impairment in relatedness to internal and external milieus, and susceptibility to psychosomatic illness."

Therefore my conclusion is that we must seek a therapeutic mode that bridges the inner and outer lives of the alexithymic, and aids him in the creation of mental images, and in the understanding of his affects.

We must also consider the concentration in psychosomatic medicine today is the concern with the "interplay of biological and psychosocial factors in the onset and course of all disease" (Taylor, 1986) and that for the treatment of the alexithymic, observations and findings point to the importance of both developmental experiences and neurophysiological factors (Taylor, 1987).

If we base the etiological explanation of alexithymia on Nemiah's (1977) theories that a neuroanatomical discontinuity between the neocortex and the limbic system is responsible for the failure to integrate fantasies and affective experiences, then Acklin and Alexander (1988) contend that we can automatically eliminate traditional psychotherapy, because it has never been known to change the neurophysiological structure or the functioning of the brain.

However, the neurophysiological process is important to various treatment approaches. In expressive verbal therapies there is an involvement between the verbal and the nonverbal parts of ourselves (Wilson et al, 1987). It is the combination of right and left brain therapies that will help the client to achieve body-mind integration.

For example, an aphasic who is able to cognitively understand language but who is impaired in his verbal ability to communicate might benefit by the development of right hemispheric modes of cognition that could stimulate the

workings of the left hemisphere. This is where right mode creative activities suggest possibilities.

Jean Piaget and Jerome S. Bruner (Feder and Feder, 1981) agree that an individual's intellectual development "proceeds through a hierarchical sequence of developmental stages from the sensorimotor through the operational to the symbolic (Piaget's term for image making)."

Taylor (1987) differentiates between the sensorimotor symptoms of patients with conversion disorders which can be interpreted in the psychoanalytic theory as a symbolic expression of unconscious drives and conflicts, and those somatic symptoms of the alexithymic patients. They are not symbolic in meaning, nor should they be misconstrued or misinterpreted as unconscious bodily metaphors for emotion.

Because our visual communication (Levinson, 1986) precedes our ability to communicate verbally, a non verbal modality may be a speedier mode of effecting a therapeutic alliance and interpretation of issues that are problematic and developmental.

Because there is a need for restructuring and relearning early vital functions, in addition to an inability to verbalize emotions, the alexithymic may require a nonverbal mode of therapy which may enable the therapist to delve even further back into the developmental phase of the patient.

Expressive therapists such as Brown and Avstreich (1986) advocate a synthesis of verbal and nonverbal therapies as an alternate route to analysis, to reach the unconscious, to trigger associations, affects and memories, "to aid in reflective mirroring and other restititional processes for cathartic release as well as neutralization of drives and for the formation of reconstruction in analysis."

This opens new therapeutic possibilities for intervention with the alexithymic patient based on his specialized needs.

V. SYMBOLS, SYMBOL FORMATION

The subject of symbols and symbol formation is one of the pertinent issues involved in the understanding of the alexithymic, who exhibits a deficiency in the ability to symbolize thereby experiencing difficulty during psychotherapy. It is also very relevant to our therapeutic consideration of the process of art therapy which permits the expression of symbols via nonverbal images.

We shall investigate transformation of experiences that are physiological, and which result in the capacity for symbolization, leading to the eventual development of language for the verbal expression of emotions (Taylor, 1984). We will also examine the relationship among bodily sensations, perception, cognition, imagination and verbal behaviour.

Symbolism is one of the crucial types of mental representation because it provides a basis "for more complex mental representations such as images, fantasies, thoughts, concepts, dreams, hallucinations, symptoms and language" (Beres and Joseph, 1970).

The World Book Encyclopedia (1965) quotes Beals and Hojer: "As far as we know, man is the only animal capable of symbolic behaviour" and Emerson (Ibid.) is quoted as saying "We are symbols and inhabit symbols."

Beres and Joseph (1970) distinguished the difference between man and animal's capacity for mental representation, which they defined as a "postulated unconscious psychic organization capable of evocation in consciousness as symbol, image, fantasy, thought, affect or action" which is "based on the memory traces of perceptual experiences."

Only in man is there a possibility for recall or evocation of a memory without an actual external stimulus. Lower animals require a new, immediate

stimulus that is identical or similar to the original stimulus. "Animals remember; man recollects" (Ibid.).

Dr. Sidney Levy and Dr. Richard Levy, developers of the Levy Animal-Drawing-Story, (LADS) projective technique, believe that symbols can range from the most "primitive forms of expression and communication, to the most exquisitely subtle and complicated forms found in art, literature, dream, folklore rites and religions" (Hammer, 1980).

While normal people are able to express a variety of fantasies, Demers-Desrosiers (1982) states that patients with a "psychosomatic structure" indicate a symbolic deficiency by their lack of ability to elaborate fantasies, or construct myths, and an inability to name or express affect. "A pathological imaginative structure is unable to represent. Sick imagination is a psychical function that loses its power of analogy and in which symbols lose their meaning" (Ibid.).

Our discussion on symbols will be elucidated with the World Book Encyclopedia's (1965) definition of the term.

1. Definitions.

"A symbol is something that stands for or represents an idea, quality or other abstraction." It can also be defined as an object, or activity representing or standing for a substitute or something else. In psychoanalytic theory a symbol is "an object, gesture, action, etc., representing a repressed emotion or impulse" (World Book Encyclopedia, 1965).

Beres (1965), a psychoanalyst who writes from the perspective of ego psychology, challenges the dictionary definition of symbolism "something that stands for and represents or denotes something else (not by exact resemblance but by vague suggestion or some accidental or conventional relations)".

Beres feels that this definition is too broad--it should be instead: A symbol is a "representation object that can be evoked in the absence of an immediate external stimulus."

Beres' rationale was that "something that substitutes for something else, is experienced as equal to the original . . . is not a symbol. It may serve as a sign or signal but a symbol must stand for and not stand in for the thing it represents" (Ibid.) Beres (1965) states that in normal psychic functioning "The substitute may serve in the place of the original object and the symbolic object may permit the illusion that the original object has not been lost."

He cites the example, that the infant who responds to a nurturing adult other than its mother, is responding to an equally good substitute object, not a symbolic object. At about 16 to 18 months, the infant can evoke a representation of his mother in her absence, and has the "capacity to know that the symbol is not the original object" (Ibid.).

Beres repeatedly emphasized that symbolism, as understood by psychologists and philosophers, includes more than a response to a signal . . .

Symbolism is the systematic employment of symbols to represent repressed material so that real meaning may not be recognized by normal consciousness. It evades censorship, as in dreams. "We call the dream element itself a symbol of the unconscious dream, thought" states Sigmund Freud (World Book Encyclopedia, 1965).

Symbolism is more than an immediate response to a symbol, says Beres (1965), and "without the capacity to evoke the representation of an absent object there can be no symbolism." He describes the symbol as a manifest production of which the person is conscious. He also explains that the symbolized material

may be "easily available to consciousness, that is, preconscious, or repressed and unconscious" (Ibid.).

Symbolism involves a number of ego functions involved in a reciprocal relationship to other ego functions which may be conscious. The ego functions mediate and delay the response from instinctual drives or from the external world, by binding their psychic energy. "Primary process discharge is replaced by secondary process. The bound psychic energy, no longer mobile must be attached to (cathect) an internal organization which can be evoked and discharged later" (Ibid.) called mental representations.

Symbolization is an unconscious mental process operating by association and based on similarity and abstract representation, whereby one object comes to stand for another, through some part, quality or aspect which the two have in common. The symbol carries, in more or less disguised form, the emotional feelings vested in the initial object (World Book Encyclopedia, 1965).

Symbol formation is a symbolic process not present at birth, which develops along with the growth of ego functions (perception, memory, learning, conceptualization, and the reality and organizing functions) (Beres and Joseph, 1970).

2. Evolution of symbols.

Psychoanalyst, Dr. Lawrence Kubie (1978), discusses the evolution of symbols, from those pertaining to the diffuse body reprints of infancy to more specific abstraction, metaphors and representations of adult consciousness.

He lists three processes of symbol formation, which are continuous, and simultaneous on a conscious or preconscious level, and whose representation, either direct or indirect, will always be literal, allegoric, and also symbolic in the dreamlike or psychoanalytic stage.

1. abstraction of experience as in concept formation.
2. various linguistic representation in which an aspect of preconscious functioning, the relation between the original concept, and the symbol remains relatively transparent.
3. A manifest representation of an unconscious latent idea i.e., the relation between the symbol and referent remains inaccessible to introspection.

Concepts and their symbolic representations have both internal (bodily) and external reference. The symbolic process thus bridges the inner and outer world . . . the "I" and the non "I" (Ibid.).

Kubie (1978) says that the body is a referent for symbol formation beginning with the infant experiencing its psychic needs as changed aspects of its own body,--so that the gradual accretion of knowledge and the structure of the adult's life must always be related to this initial experience.

3. Perceptual experiences.

Beres (1965) lists a description of perceptual experiences, that underlie all complex mental functioning such as thinking and fantasizing:

- | | |
|---------------|--|
| First level: | 1. Sense data (response of kinesthetic, vision, hearing, taste and smell). |
| | 2. Neurobiological phenomenon--internal, external stimuli. |
| Second level: | Primary sensations organized into percepts. |
| Third level: | Percepts independent of immediate sensory percepts. |

The first level of perceptual experiences which are the basis of all mental functioning, such as thinking and fantasizing, requires response to sensory data, (which is the response of the sensory nerve endings to temperature, pain, touch, proprioception and pressure) which are experienced from inside the body and

externally from the environment. Beres describes sensation on this level as neurophysiological, and preperceptual.

"At the second level, these primary sensations are organized into percepts" explains Beres (Ibid.) and "registered in the brain as Gestalts or configurations of space, form and colour." They are received as signals or cues depending on their direct stimulation and may be called mental registrations or memory traces.

On the third level only does perception become a mental representation, of something that is not directly stimulated by the senses. This final stage is the last and least understood kind of reality, which exists only in man. Symbolism is just one kind of mental representation, but very crucial to the propagation of "images, fantasies, thoughts, concepts, dreams, hallucinations, symptoms and language" (Beres, 1965).

Reality and organizing functions are required as well, to complete the process which research by Piaget (1951) shows occurs in syncretic, concrete fashion. Only later does it progress to an abstract, conceptual mode. A child can learn to open a box. Later it reveals its understanding of "openness" by opening and closing its mouth. Soon it learns to replace the concrete, gestural act with the word "open" (Werner and Kaplan, 1963).

A certain level of cognitive functioning is required to evoke an absent object which enables the symbol former to perceive and retain the mental image. Piaget called it "object permanency" and the psychoanalysts labelled it as "libidinal object constancy" (Wilson, 1987).

"In order to be able to perceive and hold an object the child must be able to distinguish between reality and fantasy, the difference between the substitute object and the symbolic. The substitute," says Beres (1965) "is equal to the

original object and the symbolic represents the original object but is known to be different."

Disturbances can occur in any one or all three levels of the perceptual-conceptual ego function. Either at the level of the patient's ability to perceive undistorted external stimuli; and/or during his ability to build undistorted concepts from his perceptions of these stimuli; and/or in his ability to represent or express these concepts in undistorted, translatable symbols.

Disturbances in the reality function of the ego, is an essential element in the development of pathology in the symbolic process. Perception, memory, learning and conceptualization must be sufficiently developed for symbol formation to occur (Beres, 1965).

4. Psychosomatic symbolization.

Symbolic formation and distortions--Psychosomatic disorders

The symbolic process with its multipolar conscious, preconscious and unconscious linkages, provide us with projective pathways for language and distant imagery at one end and introjective pathways for somatic dysfunction at the other. (Kubie, 1978)

Emotional tensions which are generated through psychological experiences are ordinarily expressed through the symbolic process of speech, language and sensory imagery. However, if there is a dysfunction in symbolization psychosomatic symptoms can be produced by the expression of emotional tensions through "the language of the body, that is, demonstrated as a disturbance of sensatic or somatomuscular or vegetative functions, or through distorted combinations of these processes called conversion hysteria, somatization or organ neurosis" (Ibid.).

Kubie believes that in the psychosomatic patient the symbolism takes place on a physical level. The physical symptom comes to represent the conflict symbol, which is inexpressible in games, songs and dreams.

Taylor (1987) however, believes that the reduced capacity for symbolic functioning, that is characteristic of the alexithymic is due to very early pre-neurotic functioning, and that "the somatic symptoms of the alexithymic patients have no symbolic meaning and should not be misconstrued as bodily metaphors for emotion."

This contrasts with the symbolic expression in conversion disorders of conflicts via sensorimotor symptoms by the neurotic who can represent conflict psychically.

Kubie believes that concepts and symbols structure how the adult lives.

It is this that gives the symbolic process its bridging functions and no matter what metaphorical term we use to describe it . . . whether we speak of it as internalization and externalization, as introjection, incorporation, identification or projection, without the multiple anchorage of symbolic process none of these familiar transmutations could take place at all . . . either consciously or unconsciously--on a purely psychological level or with the body involvements of the psychosomatic process. (Kubie, 1978)

Beres and Joseph (1970) suggests that Winnicott's concept of the transitional object refers to the transition from substitute to symbolic object, and that the patient can be helped to reexperience and resolve early problems through therapeutic symbolic play.

The symbol when defined "as a representational object that can be evoked in the absence of immediate stimulus" is a critical link between the world of reality (as stimulus) and human behaviour, thought and fantasy (as response).

Beres (1965) states that "Ego functions operate in symbol formation and the expression of symbols, and in turn symbolism makes possible the develop-

ment of human language, the complexity of object relationships, and the establishment of ideals and morality, and the awareness of a future and a past as well as a present."

6. Art therapy and symbols

Laurie Wilson, art therapist (1987) states that through art therapy "inner mental representations may be objectified through becoming externalised in concrete form," rather than being activated by intra-psychic conflict through the autonomic nervous system into a structural dysfunction or disease.

Naumberg explains how the use of "the image in art therapy permits expression of dreams, fantasies and inner experiences that occur as pictures, rather than words, and that pictured projections of unconscious material escape censorship more easily than do verbal expression so that the therapeutic process is speeded up" (Ulman, 1987).

Edith Kramer (Rubins, 1987) believes that "the aim of art is the making of a symbolic object that contains and communicates an idea." Brown and Aystreib (1987) describe art therapy as a "concrete and symbolic nature of modalities" via which the ego can be helped to master and integrate affects that are powerful and overwhelming.

By understanding symbol formation and their relationship to the development of ego functions, the art therapist can aid the individual who is deficient in symbol formation.

The section on art therapy will deal with developmental issues, object relations approach, and exercises which may help the alexithymic to develop the capacity to symbolize by making images.

VI. A. DEVELOPMENTAL TREATMENT APPROACH

Developmental limitations in early childhood have been considered as possible contributing factors to the alexithymic condition (Taylor, 1987). Pre-neurotic pathology, object relations and self psychology theories have been suggested by Taylor (1986) as the means of access to the problems of psychic deficits, an inability to form abstract symbols and the inability to form intimate non-symbiotic object relations, that plague the alexithymic individual.

Traditional psychoanalytic views of unconscious drive related conflicts as the basis of problems in human behavior have been replaced by the notion that disease susceptible individuals not only have to contend with these drives, but with "psychic defects" (Taylor, 1986) which make them vulnerable to separation and loss, feelings of hopelessness, and that "their object relationships are relied upon to carry out certain vital psychological functions" (Ibid.).

Winnicott was one of the first psychoanalysts to attribute the pathology of psychosomatic disorders to pre-neurotic pathology in the early mother-child relationships, and to focus on the importance of the development of object relations in the promotion and formation of the infant's psychic structure of the mind.

Object relations theorists and self psychologists conceptualize that the establishment of the interactional mother-child system is what organizes and regulates the infant's behavior and physiology from birth, from its early biological, neurophysiological and behavioral beginnings. Later the shift is towards a more psychological level as the infant's mind develops the capacity to form symbols, and use language and becomes aware of being separate from mother (Ibid.). These theorists also emphasize the importance of the infant's use of

transitional objects during the course of normal development to facilitate the emergence of the infant's self-regulatory capacities and the ability to tolerate separation from the mother.

Taylor (1986) credits deficits in the early mother child relationship, and the failure to create and internalize a transitional object for leaving a child with "structural psychic deficits and residues of unresolved symbiosis and separation-individuation which compromise his/her future object relationships. The unconscious representational worlds of these children remain at primitive levels, there are deficits in cognitive-symbolic functioning which may result in alexithymia, and there is an increased susceptibility to disease" (Ibid.).

1. Object relations.

Object relations and self psychology theorists' dyadic view of the mother-child interactional relationship system outlines a sequence of early object relations that parallel the infant's development of a self-regulatory system.

Mahler's (1968) view which shall be utilized in the art therapy section, deals with the infant from its autistic stage at birth, and its subsequent symbiotic phase, which is followed by four subphases of separation-individuation. This last stage should culminate in the infant's differentiation from mother.

The unfolding of object relations is accompanied by the maturation of cognitive processes and the infant's early images of good and bad objects and are gradually transformed into mental representations of self and objects which are stable and separate. Successful completion of separation-individuation results in a cohesive psychic structure, an ability to form abstract symbols and a capacity for establishing intimate non symbiotic object relationships through life. (Taylor, 1986)

Sometimes evidence of psychic deficits is localised and masked by neurotic functioning levels, but therapists may detect residues of symbiosis or even

autistic phenomena after extensive psychoanalysis, in psychosomatics who may appear normal or merely neurotic (Ibid.).

2. Winnicott's contributions.

Classical psychoanalysis was capable of dealing with neurosis, but not with problems which had their origin in preneurotic pathology.

Winnicott's contributions to object relations theories, developed in the late 1940's, deals with problems in the area of early mother-child relationships.

Mother provides a holding type of environment in which the infant can organize his own experiences, based on mother's organized perceptions of him. Winnicott describes a developmental progression which progresses from the child's "undifferentiated and incipient state" at birth to the child's capacity to be alone in the presence of the mother, which unfolds into the child's capacity to hold the positive object in memory whether the mother is present physically or not, and be able to be a nurturing parent to self (Lewis, 1987).

Greenberg and Mitchell (1983) describe how the mother's anticipation of the infant's needs allow the baby to maintain the illusion that the mother's breast is part of the infant. During that "moment of illusion" the child hallucinates that he has created the object, and experiences himself as omnipotent, the source of all creation. When the mother meets the child's needs he becomes attuned to his own bodily functions and impulses, which become the basis for the healthy development and solidity of self.

There is a developmental progression where the child learns to be alone in the presence of mother, encouraged by "a non demanding presence" says Winnicott (1971). The child begins to communicate his needs through gestures, movements and signals. If the mother fails to respond to his needs and actual-

ize these gestures, the child's hallucinatory experiences are undercut and his belief in his omnipotence is constricted. "This," says Greenberg and Mitchell (1983), "drives a wedge between the evolution of the psyche and its somatic underpinnings."

Another function mother provides is in her mirroring, which provides "the infant with a reflection of his own experience and gestures, despite their fragmented and formless qualities" (Ibid.).

3. A self psychology approach.

Kohut (1971) describes mirroring as "an empathetic responsiveness of the self object." This self object differs from Winnicott's. This self object is required for early mirroring, Lachman-Chapin (1987) explains, and differs from a true object. It refers to a person who exists as an entity to be valued and related to. A brief explanation on self psychology will clarify the differences.

At about 18 months of age between the symbiotic and rapprochement stages, as delineated by Mahler, which marks the beginning of individuation, Kohut (1971) places the establishment of the archaic "grandiose self" and the effect of maternal shortcomings as a cause in the development of psychopathology that leads to the development of the narcissistic personality.

Lachman-Chapin (1987) describes Kohut's (1971) theories. When the equilibrium of the original merger with mother fails (at the end of Mahler's symbiotic phase and the beginning of the rapprochement stage of individuation), the child begins to replace the perfection by establishing "a grandiose and exhibitionistic self: the grandiose self" (Kohut, 1971) and by adopting an "I-am-perfect" view of self. He then gives over "that previous perfection to an admired, omnipotent (transitional) self-object: the idealized parent image" (Ibid.). This

second view is what Lachman-Chapin described in simpler terms as a "you-are-perfect-and-I-am-part-of-you" view of the idealized parent.

The idealized imago of the parent also undergoes a transformation when it becomes internalized and takes the form of conscience and moral guide. If the development is flawed, says Lachman-Chapin (1987), then the child will continue to seek for the "perfect" other to help guide and lead him.

Generally these views are tamed if development proceeds normally. The child uses the psychic energy invested in viewing him or herself as omnipotent and perfect to begin doing things to gain attention and admiration. He satisfies his narcissistic needs by age appropriate actions, which he feels are safe, and are mirrored to him by the responsive "gleam in his mother's eye."

If there are developmental problems he will persist in attention getting behavior while remaining passive or by engaging in exhibitionistic behavior that will never satisfy his infantile longings.

During therapy in adult life, a patient who has deficiencies in the area of the development of the grandiose self will develop what Kohut calls "mirror transference" in order to seek confirmation of the grandiosity which he/she did not receive from his/her maternal figure.

Theorists like Winnicott focus on earlier infantile phases of the presymbiotic and symbiotic relationship with mother, which denotes an entirely different meaning to the term self object. They refer to mother satisfying her own narcissistic needs by "projecting usually the devalued parts of herself, her bad introjects (Giovacchini, 1984) onto the child" (Lachman-Chapin, 1987).

Now, to return to those early diffuse states and Winnicott's developmental progression theories . . . The infant begins to awaken from the quiescent state and begins to respond to what is asked of him, and to the things that are

provided for him. There is a fragmentation and split of what Winnicott calls the "true self", and a compliant "false self" emerges. This false self utilizes its cognitive functions to anticipate and react to the environmental impingements. Winnicott (1949) says that this results "in an overactivity of mind and separation of cognitive processes from any affective or somatic groundings" (Greenberg and Mitchell, 1983).

As the child begins to exercise his growing active ego functions he begins to learn the reality of the outside world and the limits of his powers, and becomes aware of the independent existence of others (Ibid.).

4. Transitional objects.

Transitional objects are the intermediary between his inner subjective world and others who are separate outside. At about 4 months the child creates a transitional object (blanket, teddy bear) which is neither under magical hallucinatory control, nor under outside control. The objects are not of importance themselves, it is the infant's relationship to the object that is crucial. It becomes a symbol for the part object (breast) and stands for mother.

Object relating is a subjective and projective experience in which the child maintains an illusionary control over the other. The child experiences the object as separate and out of his subjective control and begins to "destroy" it, placing it out of his omnipotent control because he is aware that he has destroyed it.

"Thus the child 'uses' and 'destroys' the object because it has become real, and the object becomes real because it has been 'used' and 'destroyed'." Winnicott refers to that as "object usage" (Ibid.).

It is crucial that the object survives, and because the mother does not retaliate, the child may experience unconcerned usage which helps him to

establish a belief that there are resilient others outside of his omnipotent control.

"Good-enough mothering" makes it possible for the child to exist and not react, to exist in a creative, healthy environment. Mother makes possible the affective shift from infantile dependence to independence and the cognitive shift from omnipotent conception to realistic perception, resulting, as Winnicott (1971) writes; "so that individuals can live creatively and feel that life is worth living or else they cannot live creatively and are doubtful about the value of living."

5. Transitional space.

Transitional experience takes place in the transitional space, Winnicott (1971) refers to it as "the area that is allowed to the infant between primary creativity and objective perception based on reality testing."

Thoughts and musings may exist and wander about in that transitional space without concern nor threat from the outside world that they will lead into a totally subjective world away from the real world altogether. It's a space where Greenberg and Mitchell (1983) say we are permitted to reach deep into our own private wellsprings "of thoughts and imagery without being held accountable for them in the harsh light of objective reality."

Transitional phenomena represent those early illusional stages "without which there is no meaning for the human being in the idea of a relationship with an object that is perceived by others as external to that being" (Ibid.).

In the child, this transitional experience is rooted in the child's capacity to play, while in the adult it is expressed in the capacity to play with one's thoughts, fantasies and ideas in a creative way (Ibid.).

6. Symbolic play.

Winnicott says that the therapist and patient must both be prepared to play in order to recover early creativity and recreate the transitional space so necessary to bridge inner and outer realities. Taylor (1986) advocates this approach for verbal therapy.

Through symbolic play, when used in art therapy, the patients are helped to organize their psychological space within the art form and the art relationship.

This puts creativity within the context of human development.

To summarize:

The origins of illusion provide the foundation for the creation of the transitional space of inner and outer reality. In this space the child at first maintains the illusion that the world is his/hers and that he/she can maintain the blissful state of oneness. Only gradually is this illusion of oneness reorganized to take in the demands of outer reality. The goal of development is not one of giving up illusion however, but one of developing the skills and techniques to make our illusions reality. Creativity within the context of human relationships permits one's inner imaginative world to become congruent with the outside so that each person shapes his/her destiny. (Robbins, 1987)

CHAPTER THREE

I. ART THERAPY

Commencing with a description of art therapy as a base we can explore its more complex possibilities as a therapeutic intervention with the alexithymic, incorporating the treatment considerations previously documented from alexithymic researchers. We will attempt to understand how the process of art therapy can help the alexithymic who is deficient in the ability to symbolize, to acquire mental representations that may eventually result in an ability to verbalize and express emotions.

1. Definitions.

Art therapy, like the concept of alexithymia, had its roots within the psychoanalytic movement, "and was used as an adjunct to amplify verbal communication and to provide interpretation of symbolic content derived from images produced by the patients" (Oster/Gould, 1987). Simply stated, art therapy is the use of visual art materials in an attempt to assist integration or re-integration of personality.

Today the term "art therapy" is used to designate widely varying processes in education, rehabilitation and psychotherapy. The Association des art-thérapeutes du Québec Inc., states that art therapy: "facilitates self-expression and communication through art for the alleviation of emotional stress; encourages both verbal and non-verbal communication of a person's perceptions and feelings; and occurs in the context of a therapeutic relationship which assists the

constructive integration of emotional material tapped through the artwork; can be used in either a primary or adjunctive capacity; and is one of the creative arts therapies, along with dance-movement therapy, drama therapy and music therapy."

It also can be employed as a valuable diagnostic tool, by fostering from the unconscious, the production of spontaneous, verbally inexpressible symbolic images that are permanent and available to the patient and therapist for inspection and introspection.

Art and images have been used as a diagnostic tool in projective tests such as the Thematic Apperception Test (TAT), the Rorschach, the House-Tree-Person and the Rosenzweig Picture Frustration Study, to name just a few.

The American Art Therapy Association (AATA) describes two major American approaches. First, "the use of art as therapy implies that the creative process can be a means both of reconciling conflicts and fostering self awareness and personal growth." Edith Kramer believes that the production of art helps to rechannel, to sublimate sexual energy and drives that are aggressive through a process of sublimation. Most art therapists do not accede to Kramer's view that the production of art is in itself healing, but believe that there must be, in addition, an interpretative element.

The second AATA method states, "when using art as a vehicle for psychotherapy, both the product and associative references may be used in an effort to help the individual find a more compatible relationship between his inner and outer worlds" (Feder and Feder, 1981). This latter approach was adhered to by Margaret Naumberg.

Actually both Kramer and Naumberg were utilizing Freud's theories on personality, but employed them differently in the practice of art therapy.

Kramer adhered to Freud's principles of sublimation while Naumberg emulated the technique of association and interpretation.

Theoretical considerations in art therapy include not only Freudian psychoanalysis and its alternate versions, but Jungian analysis, as well as developmental object relations theory, Gestalt therapy, humanistic existential philosophies, cognitive therapy, behaviour therapy. As well, there are "eclectic" approaches which depend on the versatility of the art therapist, who is innately a creative person. Regardless of theoretical origin, there is a consensus that art therapy deals with "creative impulses and emotional expression" (Ibid.)

Robbins (1986) states that "the integration of verbal and nonverbal therapies is the acknowledgement in a third alternative trend, creative expressive analysis, that one cannot deal in imagery without words, and reversibly in words without imagery."

2. Psychodynamic foundations.

Art therapy in America had its theoretical beginnings rooted in Freudian psychodynamic theory, which is also the birthplace of research of the alexithymia concept.

Margaret Naumberg pioneered art therapy in the 1940's as a therapeutic modality by using the patients' spontaneous art to elicit conflictual themes for interpretation. The images dealt with the data of dreams, fantasies, fears, conflicts and childhood memories (Naumberg, 1980). Believing that every individual, whether trained or untrained as an artist, has a latent capacity to project his psychic conflicts into visual form, Naumberg discovered that her patients became more verbally articulate when confronted with those pictures. "Through the use of graphic or plastic expression, those who were originally

blocked in speech, often began to verbalize in order to explain their art productions" (Ibid.).

She explained that this "objectified picturization" acted as an immediate symbolic communication, and that these unconscious forms could escape censoring repression more easily than verbal expression, which was a more familiar mode of communication for the patient. Thus, in art therapy, the primary source material created secondary process thinking and verbalization.

3. The process of art therapy.

Primary and secondary processes.

Robbins (1986) explains that what is occurring in the therapeutic artist patient is a vacillation between two different cognitive styles or ego states. One is right hemisphere orientation prevailed over by a receptive state in which there is a suspension of attention and a fading of rational goal orientation.

In the psychoanalytical explanation, this shifting from conscious-secondary to unconscious primary process thinking is the result of the ego giving up its control and allowing the unconscious to be tapped and surface. Robbins likens this to a shifting "to our early experiential form and state in which energy is diffuse and consciousness nondifferentiated."

In neurological terms this is referred to as the alpha or theta state, which can be achieved through play and repetitive stimuli (Robbins, 1986).

Because of the unblocking of restrictions imposed by the rationale of society's mores, an energy or sense of power is experienced. To have any meaning this newly found power must have a communicative value. Robbins explains "Therefore the shift to a reality perspective governed by order and logic, harmony and balance must take place."

This shift into the other cognitive (conscious) style may take place slowly and gradually for some, or with sudden insight for others. At this point the patient is confronted and often surprised by the observing ego which challenges and perceives.

With a new, fresh left hemispheric orientation, Robbins believes that patients can be assisted by the therapist to discover new metaphoric ways of expression, and to risk exposing their vulnerable inner core, so that inner and outer realities may find some congruence (Ibid.).

When the symbols of both therapist and patient interact, during a therapeutic dialogue, a new field of force, of energy, is discovered in which the developmental tasks of separation and individuation exist. "This mutual conenesthetic experience sometimes makes therapy a transcendant experience" concludes Robbins (Ibid.).

It is in the creative act, says Ulman (1987), that "the conflicts can be re-experienced, resolved and integrated."

Defining creativity is difficult. The term has been associated with processes of the brain and behaviour and on the continuum of cognitive-affective function. It may be explained as the ability to construct something new, a transformation or reshaping, or rearrangement and integration of physical and mental material that already exists. Luongo and Robbins (1986) point out the necessity for both imagination and the spiritual-energy of the creator's inner life to bring originality to the works produced during the act of creativity.

With the support of the art therapist who knows when to direct and when to retreat, in a constantly evolving relationship, perhaps there exists a possibility for the alexithymic to make more meaningful contact with life.

4. Therapeutic work.

The art therapist may therefore become, as Taylor (1984) suggests, "many things to his patients." By providing an empathetic response in the therapeutic situation, the therapist may help the patient to compensate for early failure of empathy on the part of parental figures.

The alexithymic patient requires a great deal of support in his challenge to the world. If he encounters approbation rather than punishment, the release of tension may well serve as a basis for motivation to delve deeper in exploration and self discovery.

Taylor admonishes that it is always important to treat the alexithymic's "defense prison" with considerable caution. The art therapist may make use of his countertransference responses, as Taylor (1984) advocates, to gain access into the primitive life of those alexithymic patients who use projective identification extensively. He suggests that the therapist assume the role of the "mother" by becoming the "thinking apparatus of her baby" and contain the patient's projective identifications and transform them into symbolic thoughts, that may be given to the patient as interpretations, and even interpret the way the severe alexithymic patient uses language to discharge unbearable psychic states as a defense mechanism to destroy meaning.

Robbins (1986) suggests that he uses creatively his own conscious and pre-conscious symbolism, based on his own early relationship with his mother. This sensory-motor dyad between mother and child is one in which perception is primarily visual, such as being looked at (Winnicott's "mirroring phase") but which encompasses other senses such as touching and cooing sounds.

The art therapist must always be alert to nonverbal clues if he wishes to strengthen the relationship and establish a deeper level of communication with his patient.

During the therapeutic situation both therapist and patient labour to create a primary network of cueing and recueing. Robbins calls the mother-infant relationship "conenesthetic" as it occurs at such an early level of response that the autonomic nervous system is the controlling influence and therefore it has an unconscious and visceral quality about it.

Robbins says "Some adults retain this capacity for visceral responsiveness, in which communication stays on a subtle, intuitive level and is attuned to a host of sensory cues" (Robbins, 1986).

Robbins (Ibid.) shares his inner feelings as he interacts with a woman patient and describes the complex interaction of "objective and subjective realities that create a psychological space between two people from the beginning of therapy."

He writes, "I experience the patient's inner representations of her past expressed in the present. I sense, feel, see the affects, moods and attitudes originally connected to her past relationships as they are organized and represented in images and pictures . . . Her drawings are like soft, sensual fragments, reaching out to say 'Hold me.'"

He continues, "My internal mother, father and child touch these of the patient at points of similar experience, perception and feeling as we get to know each other."

"Art adds a dimension to this engagement, sometimes the art mirrors or deepens what is already going on in the relationship. In other instances the art form may offer something diametrically opposed to the verbal dialogue. This

added dimension gives a new perspective on our mental relationships as it brings us to new levels of consciousness" (Robbins, 1986).

The beginnings.

It is possible when beginning art therapy that the patient may regress to early modes of experiencing parental authority, and may fear that the authoritative therapist may try to control his originality of expression. The alexithymic might react with his usual deficient style of defense mechanisms and be unable to cope.

However Naumberg (1980) explains that with the development of positive transference, the patient begins to understand that his spontaneous art productions are uniquely his own. Via free association and recovery of the source of his images' creation, the patient may be helped to eventually uncover their inner meaning.

The verification of the meanings of these symbolic expressions take place in art therapy most frequently during the transference relation by an accepting therapist. The patient "begins to express in images what he dares not put into words" (Naumberg 1980).

With this novel mode of communication, a triadic relationship of sender, message and receiver emerges. Both patient and therapist interrelate and interact with the message or image that has been produced by the patient.

In the art therapy process, the transference and countertransference may be deferred unto the image thereby diffusing these issues. The image can become the 'symbolic speech', and the treatment depends on the development of the transference relation and on a continuous effort to obtain the patient's own interpretations of his symbolic designs. (Ulman, 1975)

5. The role of the image.

The image which is produced in art therapy, "is a likeness, picture or idea of something not present in the sensory field. It is not an isolated element in a synthetic process. It is a spontaneous, creative, imaginative act, inclusive of signs, thoughts, feelings and sensations" (Luongo, Robbins, 1986).

Image formation is viewed psychodynamically and cognitively as a symbolic acquisition which evolves from simple to more complex in a process of differentiation that is gradual, manifesting in the cognitive style of the right hemisphere of the brain which is nonverbal, imaginative and analogical (Ibid.).

Jung saw art as a valuable device with which to capture fleeting dream images which he could not understand. "I painted it in order to impress it on my memory", he has said (Feder and Feder, 1981).

If an art product is seen as "a frozen fragment of a dream" it enables the art therapist to deal with the reproduction of an image rather than the verbal translation of a dream (Ibid.).

In fact, psychologist Mardi Horowitz (1978) claims that the visual image may be far superior than the inexpressible verbal image in evoking childhood memories, repressed memories and fantasies that are inaccessible to the conscious mind.

She defines an image "as a separate and distinct representation of a sensuously experienced object or event in the absence of an actual stimulation that could have caused it. The sensory experience may be related to any one of the senses" (Ibid.).

Her definition seems to paraphrase that of Beres and Joseph's (1970) and seems to underline the potential of working with the image with the alexithymic patient.

Horowitz offers the following rationale to the question of why one would utilize therapy that would increase the use of image formation rather than therapies that encourage the continued employment of lexical thought.

First, she says, using images will short circuit repression and elicit expression of ideas that have been warded off. Second, she says, "our aim is to short circuit the partial repression involved in the complex defense of isolation and undoing," and, this is the part relevant to the cognitive-affective disturbance of the alexithymic, "in order to uncover the emotion rousing properties of thought" (Horowitz, 1978). Art therapy is the therapy of images.

According to Wilson (1987) the use of an image, which is an external symbolic representation, permits a distance to be created between the individual and his conflict. Therefore the art therapy process is less threatening to the patient, providing a familiar and more comfortable manner of relating for the alexithymic who tends to avoid intimacy.

If a patient tells art therapist Rosemary Gordon that "he has no imagery", she believes that this is due to a lack of awareness, an unconsciousness of imagery precipitated by a fear of feelings. One patient admitted his fear of imaging an object that was in a sick, damaged condition, because he believed that this process of imaging would freeze or fix the object into a permanent state, like in a photograph, and that it would entrap the object (person) and prevent healing and repair. The image, in effect, had been endowed by the patient with a magical omnipotence! (Gordon, 1985).

Art therapy is a malleable mode of therapy, adaptable to fit the principles of the major therapies, too numerous to mention here in detail. I would like to illustrate the "liveliness" of the image by the way Edith Wallace uses Jung's active imagining approach in dealing and interacting with art images. The

patient engages in actively imagining with the image "by looking, noticing and seeing", during which the patient is fully awake, unlike in dreams and witness to what is happening. Wallace (1987) reveals how this participation with the image is that "which makes the psyche speak, bringing to light that which was hidden in the dark, either doing damaged or left unused."

This symbolic image bridges both levels of the psyche. Through the conscious active imaging, the ego may be brought to bear on the unconscious image, giving it visual form and by interpretation and meaning, can be integrated into life. (Edwards, 1987)

The art product is permanent, unchanging, and offers us "the pleasure of witnessing the process of transformation, where in its final form, derived from the primitive source of creative impulse, it can be contemplated to the depth of complex contradictory and primitive emotions. (Kramer, 1987)

The art product, besides documenting the therapeutic changes, may be used in diagnosis. Projective art therapy tests, such as the Buck's House-Tree-Person, can reveal a person's conceptualization of the world, his relationship with people and his personal sense of body image.

For example, McDougall (1982) mentioned that the alexithymic may view his body as if he were disassociated from it. The art graphics will reveal that information. Verbalization after these projective tests may provide the therapist with further insights and may possibly impart to the patient his depicted distorted sense of self.

Art therapist John Bitchnell (1984) points out that in art therapy, even though the authorship of the image is undeniable, as in painting, there is scope for ambiguity since one can be represented as an animal or even an object, and the patient can make the character's actions ambivalent and unclear if he feels unsafe to describe what the image reveals to him.

The alexithymic may feel more comfortable with this kind of defense. However, despite the patient's attempts to cover up or suppress what is emerging from his art work, the form and style of his work is indelibly his own and may reveal much about him to the trained art therapist.

The elements of art such as the line, colour, shape, structure and use of space within his painting or drawing are elements that reveal how he patterns his life. His behaviour during the creative process also provides significant clues to the art therapist.

"The imagery in art therapy helps us to classify, to abstract, to relate present perceptions to past experiences and tolerate present frustration or the sake of future satisfaction" explains art therapist Rosemary Gordon (1985).

Image as symbol. If the image produces strong affect, then Jung would designate it as symbolic. The patient need not even comment. Jung felt that "the symbolic image is its own explanation: the unconscious does not lie, and it is only the ego which sometimes needs to defend itself against the truth" (Edwards, 1987).

6. Symbols and symbolism in art therapy.

Wilson (1985a) calls "visual imagery which is the quintessential stuff of symbolism", and the process of symbolization an important and integral part of the raw material with which the art therapist works.

We must remember that Beres (1965) says that in order for symbol formation to become possible, certain ego functions, which are not present at birth, such as perception, memory, learning, conceptualization and the organization of reality, must be developed. If the reality function of the ego is disturbed, pathology may develop.

In the segment on symbols and symbol formation we discussed the evolution of earliest symbolic functioning from a syncretic-concrete fashion into an abstract, conceptual mode. Beres (Ibid.) also credited perceptual experiences as the underlying factor in thinking and fantasizing.

It is only at the third level that perception is independent of the immediate stimulation of the sense and becomes a mental representation of something that is not actually present and becomes a symbol.

"Mental representations, according to psychoanalytic psychology mediate psychic functioning" (Wilson, 1985b).

When dealing with the alexithymic patient, we must consider Taylor's (1986) explanation that people with a high susceptibility to disease have psychic deficits in addition to unconscious drive related conflicts, and cognitive-symbolic functioning deficits. Wilson (1985a) recommends that we can help patients with impaired symbolic functions (and consequent defective ego functioning) by involving them in the making of visual images in order to develop their capacity to symbolize. Art symbols, Wilson believes, can also aid in the development of language which is a symbolic system shared with visual images.

Art symbols serve the function of helping label perceptions with words so that individuals can make their perceptions usable again and again. Language can therefore make a new area of vicarious experience available. Silver (1987) says "Like linguistic symbols, art symbols can label perceptions and experiences."

Wilson (1985b) believes that one of the crucial concerns for the art therapist is to determine if, and what part of the patient's art work (which is a symbolic vehicle and therefore conscious) is derived from unconscious material, and whether the patient is aware of its symbolic meaning. She also questions how awareness of the symbol can be brought about and what could be the

possible consequences of mitigating that. She also wonders if the externalization of inner mental representations from the unconscious into concrete visual form will bring that form into conscious awareness, or change it in any other way. She claims that there are no simple answers to these questions.

Lachman-Chapin says that the investment in producing an art object shifts from "the person who is still almost oneself" to a sense of pride in being watched over by "others", real others, as one produces. Real others then, are objects separate from oneself. Narcissistic investment, in the art product, helps to individuate the patient (Haesler, 1983).

While describing the therapeutic and diagnostic possibilities of art therapy, I have mentioned briefly several of the theoretical concepts. As in the use of verbal therapies, approaches must be modified to deal with the specific cognitive-affective problems of the alexithymic.

Art therapy, I believe, is capable of bridging and linking together many elements that are significant for the alexithymic.

II. ART THERAPY--A DEVELOPMENTAL APPROACH

It is especially critical to think developmentally when working with those functioning at the earliest, presymbolic stages of artistic expression--a time when neither insight nor sublimation (the two most common goals in art therapy) is likely to be possible: (Aach-Feldman/Kunkle-Miller, 1987)

Art therapists Aach-Feldman and Kunkle-Miller (1987) use the developmental approach to art therapy with a handicapped and disabled population whose development is not proceeding according to "normal" expectations. Based on a Piagetian model it focuses on the "sensorimotor" (birth to two years) and "preoperational" (two to seven years) phases in the normally developing child.

They attribute a deficiency in developmental tasks at the sensorimotor phases of development as the reason for their clients' impaired capacity for attachment and differentiation of self.

For the preoperational phases the focus is on helping clients to organize and discriminate basic sensory and motor responses with an aim towards enabling them to develop representation and symbolization leading to more autonomous functioning.

Deficits in the patient's development may be detected and revealed in behavior during the art therapy sessions by observation of the client's facial expressions and affective responses, and his closeness or distance to the art object and the therapist. A poor sense of differentiation "may be indicated by (1) a poor awareness of people (i.e., severely limited responsiveness and initiative, verbally and non verbally); (2) poor awareness of objects (i.e., not setting or recognizing boundaries in use of (art materials)" (Ibid.).

Major theories of developmental art therapy are available in Judith Rubin's book (1987) which lists the expected normal skills in art as well as

strategies which may be utilized to meet the needs of developmentally delayed clients. The ideas here can be implemented and adapted for the alexithymic population.

1. Object relations approach.

Understanding object relations and the use of transitional objects is crucial to the art therapist's formulation of therapeutic approaches. It helps us comprehend the developmental tasks which confront the alexithymic. Wilson (1987) believes the ability to symbolize is fundamental to almost all civilized activity, and that the making of visual images will help patients with impaired symbolic functions, and consequent defective functioning of the ego, to develop their capacity to symbolize.

Object relations refers to the developmental capacity of the ego to internalize interpersonal experiences which gradually form the intrapsychic structure of the infant. (Nathans and Fleming, 1981)

Early mental representations are essentially dyadic, the self and object, which reflect the original mother-child relationship. Later they develop into multiple internal and external relationships. Beginning as a synthesis of Freud's instinct theory, by Melanie Klein, and later developed by Fairbairn, Guntrip and Winnicott, object relations theory viewed the individual as a product of internal and external environments.

Robbins (1987) describes Winnicott's theoretical approach to these early mother-child relationships as the way in which individuals handle inner and outer space.

Robbins (Ibid.) identifies the "object", in object relations theory, as "the who and what in which a person's libidinal energy is invested, the reservoir of

life that is part sexual, part aggressive, but is more than either, that motivates us to reach out and make contact with the world."

One's personal resources of imagery and the capacity for imaginative, creative living is dependent on experiences with object constancy and the quality of personal object relations. For the expressive analyst the creative act is one of discovering lost images of the past so that new meanings are apprehended in the conception of self and reality. (Luongo, Robbins, 1986)

Eigen and Robbins (1986) say that object relations are symbolically mediated. "Symbols and object relations necessarily reflect, reinforce, stimulate and extend each other. Creative acts of symbolic expression may summarize, distill or carry the quality of object relations forward or vice versa. They are mutually dependent copenetrating aspects of the psychological field" (Ibid.).

Art therapy in this mode takes place in a setting where past and present merge, where objective and subjective realities create a psychological space in which the therapist and patient interrelate on many levels. The art can contain and reflect internal object relations and their defenses and developmental problems (Robbins, 1987).

Object relations theory. Margaret Mahler (1968) incorporates Freud's theory of drives, but emphasis is placed on the first three years of life, and the early mother-child relationship and interaction in shaping personality, where as Mahler says, the foundations of an inside me and you are laid down (Ibid.).

2. Mahler's theories.

After the normal stage of autism at birth, which Mahler describes as a blissful oneness with mother, the infant at three months, moves into a process of attachment which Mahler calls symbiosis. "Slowly, out of an undifferentiated mass, the me and you inside of the child becomes defined. As we trace the

crucial stages of symbiosis, where mother and child struggle with separateness and sameness, individuation and differentiation are born, and the child proceeds through the subphases of hatching, practicing and rapprochement. The child's growth from symbiosis to separation and individuation culminates in the achievement of identity and object constancy" (Robbins, 1987).

At this point in time, which occurs at about the age of two and a half years in normal development, the child should have a firm sense of self and differentiated other, and should be able to relate to people as wholes, rather than satisfiers of needs. Significantly the child should be able to tolerate ambivalence, having mended the splits of good and bad, and to maintain a narcissistic balance by a form of self feeding and self affirmation that is uniquely its own (Ibid.).

Symbolic play. Winnicott (1971) says that the therapist and patient must both be prepared to play in order to recover early creativity and recreate the transitional space so necessary to bridge inner and outer realities.

Taylor (1984) suggests "using Winnicott's notion" to the therapist who must work with the alexithymic, to engage "playfully" with the patient so that this may expand the patient's imaginative life by prompting further development of the patient's own capacity for "playing with thoughts." Robbins (1987) would concur, as Taylor is referring to "Winnicott's conceptualization of creativity and play that help tie together the threads of developmental theory, the use of art, and therapeutic techniques."

Through symbolic play, the patients are helped to organize their psychological space within the art form and the art relationship.

Findings by Bower in 1966 indicate that the development of an infant's visual skills precedes the development of its auditory skills. Therefore Robbins

(1986) concludes, "it would appear that art therapy, which entails the creation of imagery may be a more effective means of getting at issues involving earliest object relations than would the use of an auditory medium."

Robbins (Ibid.) conceives of the art therapy process as taking place "in an energy field of positive and negative vectors associated with projected and introjected identifications. The nature of this ever-changing field is communicated through non-verbal imagery, physical sensation and affect mood states, as well as verbal metaphor. In treatment this complex field of energy ebbs and flows, going through a process of gestalt organization."

This illusional space, wherein the art therapy occurs, seems to me to be that same transitional space that Winnicott refers to, or even the "psychological space" which is effected between psychoanalyst and patient.

Within the art therapy framework, there are two levels of interaction. The first, within the interpersonal relationship between patient and therapist. The second in concert with the art as a reflective container which mirrors the internal object relations and their associated defenses and problems of development. Although the application of object relations theory is relatively new in art therapy, it offers limitless possibilities for the alexithymic, as we may see from its use in various stages of development.

III. ART THERAPY--DEVELOPMENTAL STAGES

Each developmental stage generates its own clinical picture, with its own particular pains and anxieties, which is recreated in the therapeutic relationship. The therapist must be able to differentiate among the patient's problems and help promote new solutions and new potentialities, and hopefully to help promote a sense of the self being reborn.

Very often during art therapy it is possible to observe drawings that are representative of Mahler's phases and subphases of the process of separation and individuation. However, Nathans and Flemig (1981) remind us that these phases do not necessarily unfold in a unilateral sequence, but tend to be repetitive and even regressive, depending on the individual's psychological needs.

For the final segment of this thesis I have taken artistic license and compiled some art therapy exercises and approaches, along with their rationale, which may be applicable for each developmental stage. They are not intended to supply "recipes" of techniques, but merely to outline suggestions that may provide the art therapist with impetus for "play" with clients who demonstrate extreme dependency and disorientation and may need help to develop cognitive skills and ego strengths. Each art therapist, who is a creative person in his/her own right may incorporate these suggestions into his/her personal style of therapy.

I will suggest how art materials may be used to explore sensory data, how to foster reciprocity by mirroring, and the use of other expressive modalities such as music and movement.

Autistic phase (birth to three months).

Robbins suggests that for patients with autistic psychosis, who suffered extreme deficiencies in the normal autistic phase, therapy requires structure and sensory contact, and a capturing of rhythm in disrhythmic patients.

Lewis (1987) suggests that frequently there is "no other" out there who can nurture and enable the autistic to grow. Unfortunately organic impairment here may curtail or confuse mediation and organization by a maternal object of the patient's body rhythms which are fragmented and disynchronous.

Symbiosis (three months).

During the symbiotic stage, which occurs between four and six months, "the me and you inside the child becomes defined" (Robbins, 1987) and issues revolve around attachment, separateness and sameness. The child must also learn to self hold. The therapist's (mother's) ability to create a holding environment here is crucial. Scribble drawings, gesture drawings may be used. Dyadic drawing and movement are crucial in aiding the confusion and fragmentation move towards more form and the beginning of the formation of character (Robbins, 1987).

Because they have been traumatized in the stage when self and other have not been clearly defined, these patients require structure and boundaries as well as the help of the therapist' mirroring to help them in defining and clarifying the worlds of image and outer reality.

EXERCISE: Gesture Drawings

Materials: Paper, markers or oil pastels

Instructions: The client is encouraged to relax and draw lines or scribbles on the paper. He may stop when the drawing seems to be complete to him. Variations may include drawing with closed eyes, or using the non dominant hand. The client is asked to discover patterns, shapes and ideas suggested by the scribbles and asked to enhance or develop his findings.

Rationale: Gesture or scribble drawings are often used to begin art therapy treatment. They are non-threatening tasks which can help to relax the patient's defenses. Because they are spontaneous they may be compared to verbal therapy in psychoanalysis. James Denny (Ulman and Dachinger, 1976) believes this to be a very "liberating" exercise, and I find it can be an "icebreaker" with a new group or individual.

If the client does a series of scribble drawings, they may be compared for development and changes in colour, pressure, movement, etc. Gestures are the first primitive kinesics of movement recreated here. They are the first method of communication utilized by the infant to express his needs to the external world.

Eleanor Ulman (Ibid.) uses the scribble drawing as part of a series of four diagnostic procedures with psychiatric patients.

EXERCISE: Scribble Drawing

Materials: Gray construction paper, 18 by 24 inches, hard pastels in a range of 12 colours. A floor easel (to encourage freedom of movement).

Step One: Free drawing. The client is instructed to make a drawing of his choice with the materials. If no theme is forthcoming from the patient, the therapist may rattle off a list of suggestions.

Step Two: The patient is instructed to do physical movements with his body only, to pretend to draw imaginary lines, and then circles, gesticulating in the air, up and across and around the blank page.

Then the patient is instructed to pick up the pastels and actually reproduce these movements on the paper. He is encouraged to move freely although the size of the page is restrictive.

Rationale: Ulman claims that this segment reveals much about the patient's personal style and "hints at characteristics as conformity, rebellion, perseveration, degrees of tension and investment of energy".(Ibid.).

This also helps to demonstrate that there is a relationship between the production of lines and the movement of the body as the instrument to create them. This can start the connection to the body as a tool of expression.

Step Three: The patient is asked to close his eyes and make a rhythmic drawing or scribble repeating the same free hand, swinging movements used in the previous one.

After completing the drawing the patient is instructed to remove it from the easel and place it on the floor. He then walks around it to see what accidental shapes have emerged. He is asked to select an image or set of images and develop them further into a picture.

Step Four: The patient may choose whether to begin with another scribble, or do a free drawing. His choice may indicate to the therapist whether he has enjoyed the liberating effect and spontaneity of the scribble or whether he is more at ease in a situation where he can control the images.

Rationale: This exercise by Ulman has other ramifications aside from the attempt to relax the patient in the early sessions, to learn about his style of communication, and possibly discover the emergence of imagery from the unconscious.

From a cognitive point of view, body-felt experience and movement interaction are the primary source of learning, the most fundamental level or organizing and integrating developmental phases, through "enactive cognition". This early symbiotic phase was described by Winnicott as being "pre-verbal, un verbalized and un verbalizable" (Winnicott, 1971, p. 130) because the central nervous stage has not sufficiently developed for more sophisticated verbal memories, and so the infant responds with unconsciously derived body sensations and movements which help in eliciting needed remembering and reexperiencing of object relations phenomena. (Lewis, 1987)

Seeing the object related dynamic may help those who cannot face an embodied, experimental exercise through movement and dance. Seeing it on paper may provide the first step towards acknowledging and reexperiencing emotionally charged phenomena (Ibid.).

Attunement of body adjustments, rhythms and breathing is said, by Penny Lewis, to be important in the symbiotic stage. The chaos, confusion and fragmentation can be represented in dramatic and sand play themes as well as

in drawings. "in this orbit the 'good enough' object may be able to modulate the disparate perceptual motor pathways and help to organize impulses in preparation for ego adaptation and relationships (Ibid.).

Psychosomatic Gestalt. "Handling serves personalization and facilitates the formation of a psychosomatic gestalt. Faulty handling in infancy produces body-ego splitting and in the adult results in a lack of experience of the reality of being, and in bodily functions that are not experienced as part of self" (Ibid.). It can be represented by poor muscle tone and coordination.

Techniques used by Aach-Feldman and Kunkle-Miller (1987) may be adapted for the alexithymic. Patients with organicity and poor ego control have often required teaching and practice in various sensations and movements. Prior to attempting to use actual art materials they practice movements such as opening and closing, and stretching their fingers. These movements are analogous to the ballet dancer's warm up exercises before her performance.

If they require it, because of developmental or physical handicaps, pre-art materials such as leaves, noodles, flour, beads, sand may be used before the patients progress to the use of actual art media such as clay, crayons, paints and plasticine.

Robbins (1987) reminds the therapist to be alert to the psychopathic's game plan that is entered into at that symbiotic stage, as well as that of the borderline who is stuck in the rapprochement stage of separation and individuation. While "feeding" them with art materials and love in the hope of helping them, they literally consume both art materials and patience. The therapist must also not be taken in by the mood swings between devaluation and overvaluation, and good and bad. These patients are also adept at splitting a therapeutic team.

Separation-individuation: Differentiation subphase.

Mahler's next phase of separation-individuation, according to Lewis (1987), starts with differentiation when, the "body image shifts from an interoceptive belly focus towards a sense of body periphery, a needed requirement for body-ego formation occurs. These internal belly sensations serve to become the origin of feeling of self around which a sense of identity will become established" says Mahler.

Themes depicting emptiness and fullness can emerge in paintings and sculptures, and gradually, the child perceives the "I and not I" phenomenon that Kubie discusses earlier in psychosomatic symptom formation. The child is seen and recognized by the other and through this reflective process feels viewed and loved as a separate entity and a sense of being (which is the sense against which the alexithymic defends himself) and a sense of dimensionality and existence develops (Ibid). The investment of energy in the art product and subsequent sense of accomplishment can aid in this process.

Separation-individuation: Practicing subphase.

Locomotion characterizes this developmental stage, which Lewis (Ibid.) describes as when the toddler crawls and walks away from mother, returning to her for assurance and love. Artistic and spatial distance, created by having patients choreograph approaching and distancing of the therapist, recreates that early childhood experience. They practice this phase, with an object that responds to what Kohut (1978) calls their "innate sense of vigor, greatness and perfection."

Liquid finger paints, as well as a sand play box for wet sand can encourage drive related components and themes of holding on, letting go and

smearing, in the presence of the affirming therapist. Through freedom of expression, the patient can develop a sense of self worth.

Dyadic drawings are useful in the practicing subphase of separation and individuation.

EXERCISE: Dyadic drawing

Materials: Paper, markers, crayons or hard pastels.

Instructions: Patient and therapist share the drawing space and have a nonverbal dialogue with the images.

Rationale: They create an environment on the paper where they begin to build a sense of trust in each other. This shared task provides a safe, supportive method of encouragement and involvement. The patient may begin to move up against the therapist's image, touching it, bumping, retreating, returning and even imitating it in an orchestration of moves that recreate his early fears of separation and his need for mirroring.

The patient and the therapist may share other activities such as wood-working or creating a sculpture from clay or plasticine. Joel Barg of the Douglas Hospital is credited with documenting the above exercise in Arthur Robbin's (1976) book on creative art therapy. This book features many other art therapy exercises which may be adapted to the needs of the alexithymic.

During the shift from pre-symbolic play to symbolic expression, differentiation of feelings, sensorimotor development and the ability to create a basic symbol takes place.

Aach-Feldman and Kunkle-Miller (1987) state that "symbolism is egocentric, focusing on representation of the individual's subjective reality." Language is developing, and thoughts and feelings can now be labelled and expressed. Development of these skills will permit more autonomy.

Colours as emotions.

The art element of colour is one of the most obvious areas in which to assign meaning to sensations and emotions. Colour-coded terms are often used to describe feelings. A person may be "green with envy", "blue with sadness" or in an "I saw red" state of rage.

For example, if we select the word "blue", we can attribute five types of meanings or dimensions, according to art psychologists Hans and Shulamith Kreitler (Feder and Feder, 1981). They list them:

1. Body expression: blue is constrictive and binding.
2. Sensations and feelings: blue is cold (or sad, for me).
3. General abstractions: blue is spiritual, although if carried to an extreme, it may be moralistic, as in blue laws.
4. Metaphoric: blue is like the world beyond.
5. "True symbols" in which contrasts and solutions are presented simultaneously (blue is a fusion of heavenly peace and the destructive fire of lightning).

Meanings of colours may be culturally based as well, and each individual has his personal subjective reaction.

We also respond to colours with our senses. We can feel and register an actual change in body temperature in response to the warmth of reds, oranges and yellows, and to the coolness of blues and greens. Faber Birren (Ibid.), a colour consultant studying colour perception notes that colours can also affect the neuromuscular system. Red increases bodily tension and stimulates the autonomic nervous system, while blues and greens appear to release body tension.

Other sensation crossovers, called synesthesia, extend to dark colours like black and brown appearing to have weightiness, or the creation of receding distance-by blues or advancing by reds.

Rorschach saw the perception of colour as a clue to the control of emotions. Testing of the alexithymic variables based on his principles was discussed in assessment tests earlier. Some researchers believe that sensitivity to colour is an even greater indicator of emotion than form and shape because the response to colour is emotional rather than intellectual (Feder and Feder, 1981). The Zierer Technique has been used to utilize response to colour as an important aspect in the analysis and measurement of anxiety and/or aggression and "awareness of coping ability vis-a-vis conflicting contingencies" (Ibid.).

Attempts to standardize responses to colours have fared the same fate as testing for alexithymia, as emotional actions are difficult to quantify, but years of observations have resulted in interesting theories. However, Irene Champernowne, noted British art therapist warns the therapist not to take fragmentary colour clues and come to any big conclusions (Ibid.).

To conclude this segment on colours as feelings, I would like to include two very basic colour exercises.

EXERCISE: Colours as feelings

Materials: Paper, hard pastels, watercolour, paints.

Instructions: The patient is asked to describe and paint the colour of his feelings. If he cannot visualize them the therapist may have him look at art pictures. The art forms may evoke feelings that the patient and therapist can discuss (Robbins and Luongo, 1986)

Rationale: The art therapist begins to teach the patient how to label his perceptions and feelings. In persons needing to develop the capacity to verbalize art therapy permits the transition from primary process to secondary process.

Helen Landgarten suggests the following.

EXERCISE: Collage to express an emotion

Materials: Magazine pictures, glue, scissors, paint, pastels.

Instructions: Clients are encouraged to select, cut out and paste down pictures that clearly reflect an emotion, for example--anger. They are then asked to write a dialogue for each character.

Rationale: Landgarten utilizes this exercise for "ventilation, acceptance and assimilation of strong, negative emotion" (Robbins, Sibley, 1976).

An exercise devised to help a person identify and get in touch with his feelings is often used by art therapists.

EXERCISE: Draw a situation to depict feelings

Materials: Paper and crayons.

Instructions: Draw yourself in a situation that is joyful, or stressful, helpless, controlling, etc.

Rationale: The issue involved in this exercise suggested by Myra Levick in Arthur Robbin's (1976) book is the observation of ego defense mechanisms and/or responses to a specific situation. Again, I must stress Taylor's proposition that it is not the ability to express emotion, but the ability to cope with stress that is

the problem for the alexithymic. New coping strategies may be attempted in the presence of a supportive art therapist.

Meditational techniques are being used by therapists Stamatelos and Mott (1986) with developmentally delayed persons in a program called Habilitative Arts Therapy (HAT). They have discovered, in their work, that "clients considered rigid and concrete thinkers can successfully engage in the creative process." They believe that there is a strong relationship between the unconscious primary processing of information called incubation and the process of meditation (upon something) which is a conscious function that attempts to stimulate primary process and bring it into consciousness and awareness. The difference is in awareness and interest. They refer to incubation and meditation as the "underside and surface of the same medium" (Ibid.).

They have found that a combination of meditation-like techniques and the utilization of art forms as a means of expression can help retrieve image that is latent. Meditation brings about enhancement of the creative process by a psychic liberation that will aid the needed growth in developmentally delayed persons.

Stamatelos and Mott's (1986) techniques are not specifically directive as in guided imagery, very deep hypnotic type relaxation, or directed daydreams. They have only guidelines, rather than rules for their HAT meditational techniques. Music and movement are often incorporated, making it a holistic experience.

The procedure which asks one to empty one's mind and concentrate (meditate) on object stimulation, in this case instance music, is a form of Concentrative Meditation that allows for the free flow of mental imagery. (Ibid.)

Incubation will occur simultaneously with concentrative meditation. The combination of movement and dance will help enhance the emergence of imagery. Art activities follow these stimulating experiences to retrieve imagery. Thus, they believe that it is possible for awareness to replace rigid thought processes. Developmentally delayed persons may be capable of symbolization, creativity and self insight when these activities are provided.

Another exercise used to help an individual communicate with his inner world is suggested by Efrem Weitzman. (Robbins and Sibley, 1976).

EXERCISE: Meditative drawing

Materials: Paper, markers.

Directions: The patient is asked to close his eyes, to relax his body and concentrate on the sensations of the body until clear images emerge in his mind. He is then asked to draw abstractly to communicate this experience.

Rationale: The inner sensations of the body are reflected in the quality of line and choice of colours, thereby demonstrating the feasibility and ability of the art as a vehicle for communication and expression. Music, known to affect the body's autonomic nervous system, can be incorporated with this exercise. Listening to music has been known to produce changes in the body's physiology, mood and general mental health. A person's blood flow, blood pressure, breathing, pulse rate and posture were affected (Feder and Feder, 1981).

Music and movement are often used by expressive therapists in a groups situation to aid in clarification and sensitization of emotions, didactic movement, and socialization. Participants can be in a group, yet be uniquely individual.

Later, the members are asked to recreate their experiences through art media. The exercises culminate in group discussion, which may provide alexithymics with an opportunity to do more than express their emotions. They may begin to understand them.

Self psychology approach.

Between the stages of Mahler's symbiotic phase and the rapprochement stage which marks the beginnings of individuation, Kohut (1966) places the beginnings of narcissistic development and theories which are the core of his self psychology approach.

Both the use of "mirroring" techniques and the therapist's use of the countertransference to gain access to the patient's inner life advocated by Taylor (1977) are derived from Kohut's theory of self psychology. Both techniques are also utilized by art therapist Mildred Lachman-Chapin.

This art therapy mirroring relationship can provide a crucial reparative opportunity for the patient whose narcissistic problems lie in faulty infantile development of that early age appropriate grandiose self image, developed to replace the perfection of his previous merger with mother. The child requires the approval and admiration from his mother in order to make him feel safe and effective. Lachman-Chapin (1987) states that without the mirroring, reflective "gleam in the mother's eye" (Kohut, 1966) the child will not gain the ability to satisfy its narcissistic longings.

Kohut, like Winnicott believed that doing creative artistic productions would help relieve tensions and pain, by providing a means of discharging and expressing them, rather than keeping them internally within the body/mind.

The tension would be transformed into a self-regulatory mechanism; one that was operative with the transitional object.

Art and creativity was not only seen by Kohut as a means of tension reduction but as a means of building ego strengths. "Art can be used as a form of exhibition, as a way to create, to be magic, to be understood, admired, affirmed" (Lachman-Chapin, 1987).

She believes that the artwork can become a self object for the patient, shifting the focus from the therapist as sole self-object, unto his own self object creation. The therapist provides the empathetic response, considered by Kohut to be curing, and the first steps towards individuation are taken.

After she has spoken with the patient, and the patient is busy creating, Lachman-Chapin provides a mirroring, empathetic response to her patient in a rather unique manner, by doing artwork herself. She and the patient work alone and do not look at each other's work. She reveals that the form could be either a representational drawing, an abstract configuration or even a clay figure or shape. She focuses on the client's issues and works spontaneously.

When the art productions are completed they consider and discuss the client's work first and then look at her's.

Although the client's work may elicit associations and responses in Lachman-Chapin sometimes she may respond simply by showing her own artwork. She calls this communication method daring, because it is a documented visual product of her preconscious response dictated by her own artistic proficiency and clinical experience. She believes that this enhances the sense of reality in the patient with whom the therapist is relating. It confronts and provides the therapist with personal issues of countertransference which must be dealt with in order to further the therapeutic relationship.

Rapprochement.

At about 18 months, Mahler would say that the rapprochement phase begins, ("the terrible twos") and Lewis reminds us how it reflects themes of power and control, autonomy and assertion, and self presentation.

These recreate the anal sadistic rhythms which need to predominate in the need to create autonomy from the object, through the capacity to hold and retain for the eventual expulsion in service to production, power and independence. (Lewis, 1987)

Clay, papier mache, flour water and salt mixtures, a kind of play dough, can aid the patient's expression of impulse control. In dyadic drawing mentioned previously, he can "playfully" bump against the therapist's lines.

Lewis (Ibid.) states that secondary narcissistic formations during the rapprochement phase "serve the need to maintain mother as providing an environment for growth, gradually split the self and object into "good and bad" parts (i.e., good or bad self, good or bad object). The mother's fluctuating rewarding and withholding aspects, in borderline conditions are transferred unto the therapist.

Robbins (1987) explains that failure of integration and self cohesion at this stage result in narcissistic and borderline personality problems. The task of autonomy is retreated from but treated differently by both personality types, "The borderline trends towards fusion states and a pervasive use of splitting good and bad in his search for the ideal, whereas the narcissistic personality takes refuge in a grandiose self. Although differing in form, there is in both an attempt to return to the perfection of an early state of oneness with mother" (Robbins, 1987).

This stage is of particular interest to us because affective disorders are associated with failures at the rapprochement stage. The dilemma of the existence of good and bad in the same space has not been resolved. The patients believe that the good and nurturing remain outside, while their hunger and greed, which is the opposite, remains inside.

The development of symbolization with art therapy.

The development of symbolization begins during the preoperational phase (two to seven years) when the approach to art materials "characterized discrimination and organization of basic sensory and motor responses, and thinking is not yet part of an organized structure" (Aach-Feldman/Kunkle-Miller, 1987) yet progression towards representation and symbolism is observed. "This symbolism is egocentric, focusing on representation of the individual's subjective reality. During this phase, language is developing, allowing the labelling of thoughts and feelings, thereby facilitating the therapeutic process. As all of these skills develop, the individual is both capable and desirous of more autonomous functioning" (Ibid.).

The problem of treating the alexithymic who is deficient in the ability to symbolize may be approached developmentally by fostering the promotion of imitation, association and approximation. Art therapists Aach-Feldman and Kunkle-Miller (Ibid.) define and describe the three processes.

Imitation requires the perception of physical or behavioral characteristics and the invention of simple forms of equivalence through enactment (discoveries of similarities). These perceptions must be "linked up" or associated with the medium or art process, in order to transform them into graphic or plastic symbol expressions. Approximation of the features of people and objects becomes possible, once an association of feelings and ideas with created forms has occurred. The presymbolic client frequently has difficulty with abstract thinking processes like imitation and association. Producing

symbolic forms and articulating features is often complex, frustrating, and confusing, because of deficits in motor coordination, ego development or intellect.

The therapist can promote simulation of life experiences through the use of art materials and aid in the development of imitation skills. Dramatic play may be used to help the client imitate and simulate an event such as eating, or an object like a car, or even people. In this way, the client can begin to relate a "form" with something he is experiencing and begin to understand how to represent and abstract, which is the first step towards symbolization.

The therapist can offer direction and support in order to start the patient to associate known feelings, objects and events with the process and products produced in art therapy. Together, they can explore and discuss the visual, tactile and kinesthetic aspects of the art experience. Lines and shapes that emerge like faces or objects may also elicit associations.

Finally, in order to promote the production of the symbolic, it is necessary to develop skills in approximation, so that the client may discriminate between the qualitative and quantitative characteristics of items that are significant. Three dimensional objects have been used as "conceptual references" with emotionally disturbed mentally retarded individuals. Clay is an effective medium. When art therapy is adapted for the alexithymic's problems, such as the association of self and the environment, the production of symbolic imagery can represent affective concerns. The development of imitation, association and approximation may aid in the development of symbolism (Aach-Feldman/Kunkle-Miller, 1987).

Separation-individuation.

At about 2 1/2 years the child's growth from symbiosis to separation should culminate in the achievement of an identity. The child should have a strong sense of self, differentiated from others, and be able to relate to others as wholes rather than satisfiers of needs.

Object constancy. Thus in the presence of the "good enough" mother (therapist), within the art therapy setting which facilitates the maturation process, the therapeutic expressive creativity results in a "child" who has a realistic positive sense of self, and a capacity to interact with the world, and an ability to realistically assess both good and bad in self and others.

With object constancy comes a gradual development of the capacity for even more sophisticated object relations. The self can be experienced as both good and bad, and the capacity to love and hate others and explore the continuum between these affectual polarities can be observed. (Lewis, 1987)

This explains the developmental progression from, what Winnicott (1971) (Greenberg and Mitchell, 1983) refers to as a child's capacity to be alone in the absence of the mother, to the capacity to hold the positive object in memory and experience her continuously whether she is physically present or removed from his presence. The child is able to care for itself, and to be a nurturing parent to oneself.

IV. CONCLUSION

We have examined the alexithymia concept within the context of psychosomatic symptom formation, and on the basis of its physiological (neurophysiology) and psychological (psychodynamic) derivation.

Although we can describe its characteristics, the nature of alexithymia is still disputed, because of difficulties in measurement.

We must still find answers to the questions about its innateness versus its reactivity; its fixity versus its variance in severity; its permanence versus its transience.

Freyberger's distinction between "primary" alexithymia as a character trait, and "secondary" alexithymia as a state which emerges as a response to a traumatic experience, may be a beginning towards the refinement of its classification.

Lesser (1981) referred to it as a "phenomenologically devised classical construct." Nemiah (Ibid.) discussed alexithymia in the context of ego defense mechanisms of repression and denial, while Shipko (1982) described it as a "homeostatic mechanism caused by a "functional disconnection" of cerebral hemisphere which allows one to be stimulus motivated rather than unconsciously motivated." In the same vein, Hoppe (Lesser, 1982) called it a "functional commissurotomy" and also a "language disorder" in split brain patients.

Catchlove (1987) called it a "state" applying it to chronic pain patients with alexithymic characteristics even though their somatic system rather than the autonomic system is involved.

It is "a social phenomenon" decreed researchers Smith (1983), Borens et al (1977), Cremerius, (1977) and Overbeck (1977), writes Keltiganas-Jarvinen (1985).

Alexithymia is a "cluster of characteristics" say Acklin and Alexander (1988). It is a style, "a cognitive-affective style" counter Taylor and Bagby (1988) "that affects the way the individuals experience and express their emotions." They also described it as a "hypothetical personality construct" (Ibid.).

Testing and measurement methods of alexithymia include observer rated questionnaires, self-scoring and projective tests. Taylor (1988) projects that our understanding of hypochondriasis and somatization, one of medicine's unsolved problems, will be aided with new multimethod measurement approaches that avoid past methodological limitations.

Lesser and Lesser (1984) caution against the danger of the reification of this clinically derived concept into a supposed entity of sharply defined characteristics. Further research is needed to establish alexithymia as a valid entity.

Wolff (1977) states that coining the term alexithymia does not mean that we have discovered a new object or structure, but rather that we have recognized certain functional psychological disturbances, worth studying for their significance in individual patients and in the difference of so-called normal people, or neurotics, who do communicate symbolic material in the form of thoughts, feelings, fantasies and dreams.

Similarly, alexithymia must not be considered as an all-or-none phenomenon, as pointed out by Dr. Heiberg's genetic studies, because it is important to recognize that there are various degrees and varieties of alexithymic characteristics in different individuals which may vary in different degrees at various times in the same person's life (Wolff, 1977). It has also been discovered that alexithy-

mic characteristics are not uniform across psychosomatic disorders (Acklin and Alexander, 1988).

The difficulties in treating the psychosomatic-alexithymic with psychoanalytic, psychodynamic therapy have been well documented. These modes of insight-oriented therapy are contraindicated unless they are modified with an educative and supportive focus. The discovery of the alexithymic characteristics in a wide range of medical and psychiatric problems has changed traditional treatment approaches. Krystal (1982) claimed the alexithymia concept has probably been one of the most important single factors to diminish the success of psychoanalysis and psychodynamic therapy (Taylor, 1984).

Freud's classical "talking cure" for treatment of psychosomatics has become outdated and we see the shift in therapy from content to form of communication (Taylor, 1986). It becomes apparent that there is the need for a vehicle for the "task of rebuilding rather than uncovering the disparate systems of emotional functioning" (Robbins, 1987).

Alexithymic characteristics reveal an inability to express emotions verbally, difficulty in the ability to symbolize and a paucity of fantasies. Our exploration of the psychosomatic syndrome and personality structure (McDougall, 1982) traces the alexithymics' problems back to the nonverbal, preneurotic developmental stages and early mother-child relationship deficits.

The obvious choice of treatment recommended would be a developmental approach based on object relations and self psychology theory, where it is theorized that the early mother-child relationship is what "organizes and promotes the focus of psychic structure in the infant" (Taylor, 1986). The alexithymic must deal with both drive related conflicts and psychic deficits (Ibid.). Research on treatment approaches by developmental theorists has

ascertained the necessity of extending "our understanding of how early physiological experiences and bodily sensations acquired mental representation as feelings and thoughts that eventually result in a language for expressing the emotions" (Taylor, 1984).

Through a review of the literature, we have been made aware of the importance of the development of the infant's capacity for symbolic formation. We have traced the evolution from early presymbolic neurophysiological processes to the development of ego functions that interact to produce mental representations of something that is not actually present, and which then becomes a symbol. It is these mental representations that mediate psychic functioning. When they are evoked to consciousness they appear as images, fantasies and thoughts (Beres, 1965).

Kramer (1987) says that development in the pathology of symbolic process is due to the disturbance in the reality function of the ego. Ego functions are involved in symbol formation and the expression of symbols, says Beres (1965). In turn symbolism makes the development of human language possible.

We can also see the relevance of the application of Winnicott's theories of the formation of transitional objects and the importance of object relations in aiding the individual to handle that "which is objectively perceived and that which is subjectively perceived of" (Winnicott, 1971). That early nonverbal, nonverbalizable stage is where "the origins of illusion provide the foundation for creation of the transitional space of inner and outer reality" (Robbins, 1987). It is creativity within the context of human relationships that permits the inner subjective, "imaginative world to become congruent with the outside so that each person shapes his/her destiny" (Ibid.). Symbolic play is advocated to retrieve this real creativity.

Because these experiences occur during a nonverbal stage, expressive arts therapies that do not rely solely on verbal therapeutic techniques, can aid the needed transformation and formation of normal self and object representation. Focus is on making preverbal experiences explicit, through the transference/countertransference relationship, expressive reexperiencing and symbolic enactment within the transitional space of "playing" (Lewis, 1986).

What we say and how we say it is what counts, and art shows the unity of the two (Henzel, 1984). All pictorial expression is symbolic which would justify the use of art therapy as a nonverbal, creative, image making mode of therapeutic treatment for the alexithymic. Art therapy images escape censorship more easily, permitting primary process material from the unconscious to surface for verbal interpretation and integration.

Art therapy combined with other expressive modalities appears to be a mode of treatment which can promote new levels of perceptual organization, by helping the patient to reexperience and express the past through images and symbols, through art, dance, drama and movement which help to expand the boundaries of objective reality. Like language, art symbols can aid in helping to label perceptions and experience (Silver, 1987).

The field of art therapy involves the study of emotions and the expression of affects, as well as provide a means of linking outer realities with the inner self.

These experiences can be further clarified because an external container is provided for them in the written word and the image, which can be filled with symbolic meaning and potency, as they occur in the transitional space.

The artwork, plays a leading role in art therapy, as a permanent representation of the image. Its presence in the art therapy session diffuses the

transference/countertransference, wherein a great many problems exist for both the alexithymic patient, and the therapist.

There are considerations of other art therapy approaches, such as the use of active imagining in Jungian, the sublimation in Kramer's theories, the teaching-learning cognitive and behavioral models, and actual enactment with the image, in the gestalt art therapy. The possibilities are limited only by the therapist's approach and his understanding of the alexithymic phenomenon.

Alexithymia does exist, regardless of where its origins can be traced, or whether it is viewed as a deficit in neurological functioning, or as a psychodynamic issue of development, or whether we consider it from a social or interpersonal viewpoint.

"No baby is born alexithymic" asserts McDougall (1982). "Feelings are not disavowed, they do not exist" say Sifneos (1974). Nemiah tells us that although they may sob, they do not understand the meaning of these emotions, because as Taylor (1984) reminds us, it is not the ability to express feelings that is the alexithymic's problem, but the ability to cope with and derive information from them.

While the multidisciplinary researchers' studies converge in an attempt to validate the construct of alexithymia, one is left with esoterical, perhaps philosophical questions. We lack research and insight into the personal meaning of the experience of being to a greater or lesser extent, alexithymic.

What does it mean to be alexithymic, to be disassociated from self, devoid of inner liveliness? Does a person miss what he has never known? Can the alexithymic ever capture the feeling of "intentionality" which art therapist Mala Betensky (1987) says occurs when a patient looks at his therapeutic artwork?

Intentionality means that I am intent on the thing I am looking at . . . it begins to exist for me more than it did before. It is becoming important to me. Now it means something to me. At times a meaning becomes vital to my existence, to my being. (Mala Betensky, 1987)

Betensky also claims that "intentionality also means that our consciousness always relates to somebody, to something". Therefore it is reality oriented, and because the intentionality of consciousness resides in the body it can help explain how man is oriented to the world. Relating to the world through all our senses our whole body becomes conscious (Ibid.).

Jung says that when something acquires meaning by virtue of our affective response to it, it then becomes symbolic. Then life has meaning.

Lesser and Lesser (1984) say that "alexithymia may serve as a nidus around which various disciplines can interface." Research on alexithymia has bridged the separate fields of neurobiology and psychoanalysis, and made an impact on understanding of symbol formation. Art therapy seems capable of complimenting and converging with the two fields by providing methods to help develop symbolization (by imitation, association and approximation) through an alternative mode of nonverbal, symbolic expression.

Art therapy can make connections between many elements that are significant to the alexithymic. Art therapy is a marriage between art and therapy; between the verbal and nonverbal; facilitates the process from primary to secondary thinking; aids in the development and interweaving of self and other (the self object of Kohut's self psychology theories) and provides a bridge between internal and external realities.

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