Challenges in treating patients with psychosomatic disorders: some patterns of resistance

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Abstract:

The treatment of people suffering from psychosomatic disorders poses important clinical challenges to psychoanalytic practice, including early abandonment, difficulties in engagement and superficial involvement in the treatment. The lack of systematic research on the subject suggests that a better understanding of the resistances and dynamics involved in such episodes is needed. Using supervision group to study treatments and inspired by action-research paradigm, this paper presents the results of an 18-month mixed-method qualitative clinical research on treating 22 cases. Thematic analysis revealed a frequent pattern of resistance to experience emotions that presented in two states: failure of repression (thin-skin) and massive repression (thick-skin). Narcissistic dynamics in the therapeutic relationship taking the form of ‘resistance to transference’ and a tendency to action were evident in both presentations. Symmetric and complementary counter-transference reactions, which compromised treatment, were also identified. Some technical implications are highlighted, such as the need to focus in the recovery of the patient’s actual emotional experience and to understand such experience in the context of the ‘here and now’ of the therapeutic encounter. These findings suggest the need for a
flexible approach to therapeutic work that moves between an ‘intrapsychic’ and a ‘relational’ focus.

**Keywords:** psychosomatic disorders; resistance; defences; narcissistic transference; counter-transference resistance

A middle-aged man, referred by a neurologist, said that he had been suffering for years from back pain so intense that he limped and walked bent over. Despite this, he continued working. He felt appreciated by the owners of the company where he had been working for the last 16 years. A hard worker, he had always been willing to stay late and do extra hours even on Sundays, nevertheless he feared losing his job. He looked tired and seemed resentful about his fragile situation at work. He said, ‘No one is indispensable, we all are exchangeable’: he thought that if he missed just one day, he would be replaced. By the end of the session he asked for a medical leave certificate, evidencing that he had confused the therapist with a psychiatrist. The therapist invited him to start psychotherapy, pointing out his difficulty in giving himself a break and suggesting this might be contributing to his illness. He turned down the offer.

A middle-aged woman, encouraged by friends, consulted after being diagnosed with a serious autoimmune disease. She thought it might be related to stress she had been experiencing for the last few years. During this period, she had set aside a fairly successful career to dedicate her life to the care of her husband who had developed dementia and lost all his fortune as a result of being defrauded by associates. She looked exhausted, bitter and resentful when describing her everyday routine, which consisted of teaching many undergraduate courses and then going back home to care for her husband, who no longer seemed to recognise her. She said her best moments were just before falling asleep when she threw herself over the bed after finishing her daily routine. She had completed what she thought was a successful analysis many years ago, during a period of life when she had time to create and enjoy the blossoming of her career. After two interviews talking about her experience, including her ambivalence about putting her husband in nursing care, she told the therapist that she could not go on, that coming to therapy made her feel worse, as she now had strong headaches.

These two short vignettes intend to illustrate a clinical group of patients affected by severe and impairing physical symptoms or illnesses that are referred for psychological treatment because standard medical investigations and treatments have failed to adequately account for or relieve their symptoms and because there are grounds to believe that
psychological problems are contributing to their suffering. Most are referred by physicians, some by a relative or a friend and occasionally some self-refer, impelled by a suspicion that their illness relates to their emotional life.

The association between emotional distress and their physical health problems is frequently evident to the medical staff or the concerned relative that encourages the appointment, but this link is seldom evident to the patients. When confronted with emotional issues and their relation with physical problems, they are often reluctant to explore these links, seeking instead an immediate, concrete solution for their discomfort.

Such people can be labelled as having psychosomatic disorders, encompassing some disorders listed as somatoform disorders in DSM-IV-tr (APA, 2000) and psychological factors affecting medical conditions. This classification is consistent with propositions put forward by some psychoanalytic authors (Marty, 1990; McDougall, 1989) who have noted a group of patients for which the development and maintenance of physical disorders seems closely related to prominent features in their psychological functioning and also accords with some criteria proposed to identify significant psychosomatic disorders for research purposes (Fabbri, Fava, Sirri, & Wise, 2007; Fava et al., 1995).

Effective psychotherapeutic work with this clinical group poses an ethical dilemma and important challenges to standard psychoanalytic practice. It poses an ethical dilemma because therapists willing to help such patients are often confronted with the fact that they are not interested in a talking cure. They may have reluctantly accepted a referral from a desperate physician, but the engagement with treatment is at best a kind of passive compliance with demand and they often show clear resistance to any suggestion that the somatic experience has a psychological dimension. While a psychological intervention may provide a real prospect of relieving the patient of her or his symptoms, the therapist will also be aware that a standard psychoanalytic treatment can also bring more distress at an emotional and physical level (Dejours, 1992; McDougall, 1989; Sami-Ali, 2000).

This dilemma is not just an ethical issue. It also provides the initial technical challenge for the treatment: too much desire to help on the part of the therapist may simply heighten the resistance of the patient, and too little desire prevents the necessary engagement, hindering the development of transference-countertransference phenomena.

The argument of this paper is that an effective response to both the ethical and the technical difficulties associated with therapeutic engagement with this clinical group requires an understanding of the characteristics and sources of resistance to treatment.
Investigating resistance to treatment among patients with psychosomatic disorders

The clinical part of this research\(^1\) took place in a university clinic in Santiago, Chile and involved the treatment of 22 adult patients, 17 women and 5 men ranging from 19 to 70 years of age (average 33, median 28), by four psychoanalytic therapists, two women and two men (the first author being one). Written consent to participate in the study was obtained at intake interview in accordance with two ethical committees protocols and included permission to record the sessions and to publish the material. Treatment duration ranged from 1 to 49 weekly sessions with an average of 15 and median of 11.

During an 18-month period (August 2010 – January 2012) therapists reported and discussed their cases in a supervision group to identify prevalent resistances in the group of patients and to obtain ongoing feedback with specific focus on management of resistances. The research work in the supervision group was inspired by the ‘action research’ tradition (Ashburner, Meyer, Cotter, Young, & Ansell, 2004; Koch, Arhar, & Rumrill, 2004; Law, 2007), which we believe is congruent with many psychoanalytic ideas. The clinical sessions and supervision groups meetings were recorded. A secondary process of detailed analysis of the collected data was undertaken to crosscheck and deepen the initial findings obtained through consultation with the supervision group. In this secondary analysis, the second and third author acted as auditors of the process, assisting the first author to classify and organise resistances.

The patients were treated with psychoanalytic psychotherapy, to promote insight into psychological conflicts and patterns associated with their emotional and somatic problems. The treatments included analysis of transference and use of counter-transference experience, with some emphasis discussed in the corresponding section of the paper. The development of the treatments and in particular the identification and utilisation of clinical strategies to manage resistance took place through active and ongoing engagement with the supervision group.

The focus of the research was informed by previous clinical experience in which, as illustrated by the vignettes, the therapist encounters threats to engagement, continuation or effectiveness of the psychotherapeutic treatment in this clinical group, justifying the focus on resistances as the strategic priority.

Our reference point for the identification, description and organisation of resistances was the Freudian classification (Freud, 1926): resistances based in defensive action, those
manifesting in the therapeutic relationship, those associated with secondary gain from illness, those based on repetition compulsion and, finally, those associated with self-punitive tendencies. This classification provided the model to be tested by the research team by determining the ‘goodness of fit’ with the clinical experience.

Thematic extraction made use of saturation criterion; that is, data analysis ended when the variations afforded by new cases repeatedly failed to substantially add to the categories identified in previous cases.

The identified themes fell into three broad categories: resistances based in defensive action, those manifesting in the therapeutic relationship and those based on repetition compulsion. Resistances associated with secondary gain from illness and with self-punitive tendencies were also identified but only in single cases, so they were not included in this report. All treatments showed certain levels and combinations of the proposed resistances; however, to illustrate the findings we have selected cases that show the primary or dominant type of resistance at a certain point of the treatment.

**Resistance to experience emotions**

An older man suffering from cancer and other problems such as hypertension, bruxism, throat discomfort and hypersensitivity in his eyes came to therapy interested in finding out the possible relation between early childhood experiences and his current cancer. He found out about the research project and volunteered. He came regularly, always on time, showed an intellectual interest in the matter but would politely turn down any suggestion made by the therapist about issues distressing him. Early on in the treatment the therapist became aware of times when his eyes became red and he shed some tears. He did not associate any feelings with this experience, denying that he was crying and explaining it as a physiological over-sensitivity. With time it became clear that his tearfulness increased at sensitive moments, and after a year in treatment he was able to acknowledge feeling sad, distressed and pessimistic, although he regretted these feelings as they made him feel weak and unmanly.

The analysis of his ‘watering eyes’ (Zalidis, 2010) provided a signpost to a defensive armour aimed at avoiding the experience of emotions such as sadness and despair, which made him very anxious and seriously undermined his self-esteem. The patient exerted a strict control over his emotions and denied any relation between his emotional functioning and some somatic manifestations. The case required major effort to get through his
protective armour, resembling Rosenfeld’s description of ‘thick-skinned’ patients (Rosenfeld, 1987).

A young woman attended the clinic following recommendation by a friend. She reported feeling tired and depressed, suffering from blurred vision, backaches and irritable bowel. When asked to identify the moment she started having these problems, she spoke about a spontaneous abortion she had experienced a few months earlier in which she felt abandoned by her partner. She felt bitter and resentful towards him and wanted to break up, but was reluctant to do so because she felt scared of being left alone.

Remembering this episode made her very angry, feeling that he really did not care about her, raising doubts about her own feelings about him and also bringing back to life her fears of ending up alone. The next session she reported that she had felt ‘uptight’ after the first session, with an acute backache and feeling very touchy and irritable. She complained about being weepy and grumpy, like a ‘spoiled brat’. She could not remember what had been discussed and, when reminded, she dismissed the argument with the boyfriend saying it was all in the past and attributed her backache to a bad-seating position. The dynamic repeated in the third session after which she cancelled the next appointment announcing she was not coming back, that therapy made her feel worse: she felt physically unwell, depressed and very irritable, and had decided to seek psychiatric help.

In this case, the recollection of distressing life events and the exploration of the emotional surroundings of the onset of her illness had overwhelmed her, making her feel irritable and sad. As the dynamic continued without resolution, her somatic distress also increased (Dejours, 1992).

This description resembles Rosenfeld’s description of ‘thin-skinned’ patients (Rosenfeld, 1987) in which a fragile defensive equilibrium is shattered by what seem simple therapeutic interventions such as asking questions, posing issues or reflecting emotional contents. The interventions, however benign in intent or style, were experienced as traumatic and provoke strong defensive reactions.

These two cases exemplify two distinct clinical states we observed in regard to a shared source of resistance: the inability to tolerate emotional experiences. In the first state, there was scarce evidence of distress suggesting effective defence against conscious awareness of emotional responses. The interest in therapy was instrumental or intellectual and therapy was tolerable but not very effective due to the strength and effectiveness of defences. In the second state defences were fragile and heightened and intolerable
emotional responses were easily elicited. Therapy provoked unbearable distress resulting in its rejection.

Some cases showed a stable fixation to a single presentation, others showed alternations between both states, suggesting an intimate relation between the rigidity of defence and its failure. The kind of defensive effort observed ranged from conscious and deliberate efforts to put down some emotional reactions, with clarity about the reasons to undertake such efforts, to instances in which the patient was completely unaware of doing it or of the rationale behind it. These descriptions fit with the classical definitions of suppression and repression (Laplanche & Pontalis, 1973), suggesting a continuum between these two mechanisms.

Both clinical presentations shared the rejection of the experiencing of certain emotions. The association between the emotional distress, the situation that provoked it and the contingent physical manifestations were also rejected. The exploration of these links provided understanding of the emotional and psychosomatic dimension of such episodes to the therapist but not to the patient.

In both clinical presentations, the defensive effort (well accomplished or not) seemed part of a character formation in which ego ideals that favour strict affect subjugation, stoicism, adaptation, independence, efficiency and pragmatism have a prominent place. This is consistent with characterisations proposed for psychosomatic patients such as ‘over-adaptation’ (Liberman, Grassano de Piccolo, Nevorak de Dimant, Pistiner de Cortinã¬s, & Roitman de Woscoboinik, 1993), ‘pseudo normality’ (McDougall, 1989), ‘type A personality’ (Friedman & Rosenman, 1959) and ‘self-made man’ (Maldavsky, 1992). The main instigator of defensive activity seemed to be the exposure to severe criticism and the risk of repetition of trauma and narcissistic injuries related to failure to live up to these ideals.

The effectiveness of this defensive armour might also account for the extent to which thoughts, memories and fantasies were absent from consciousness. Sometimes repression resulted in dissociation between speech and the sensations evoked by speech (McDougall, 1984), so the discourse evoked compassion in the clinician but not necessarily in the patient.

Thought content frequently focused on factual information, external perceptions, concrete or banal details of situations and on strategies to deal with practical matters. This content can be understood as the anticathexis that underpins the repressive process. When
successful, a concrete or banal version of external reality, devoid of symbolic links, seems to be invested with interest so as to reinforce the disregard for subjective reality.

To summarise, we observed two distinct states in repression resistance: the ‘thick skinned’ type, which was effective in avoiding distressing emotions, exercising a massive and effective defensive effort that rendered therapeutic interventions sterile, making engagement with therapy very difficult other than in a superficial manner; and the ‘thin skinned’ type, with a failure of defences, so that the person was easily overwhelmed with distress, and rejected the help that was offered as even careful interventions disturbed their fragile defensive equilibrium. Common to both presentations was the rejection of important parts of their emotional reality and the disregard of the link between emotional distress and physical ailments, a rejection supported by ego ideals apparently opposed to dependence and to the acknowledgment of emotional needs.

**Resistance to transference (or narcissistic resistances)**

A young man presenting a series of symptoms such as urticaria, backaches, headaches and irritable bowel, reacted with a mix of anxiety, confusion and frustration when told by the therapist that he seemed to have a tone of resignation when affirming his intention to complete his graduate degree. After initial denial he acknowledged that he feared coming to sessions and repeat over and over the same doubts he had about finishing his studies. He realised he was afraid of boring the therapist and being dismissed as an impossible patient, so he felt compelled to show a resolute attitude.

This breakthrough came after many months exploring similar impasses. At the start of the treatment, he had no clarity about his feelings in sessions, getting very anxious, confused and blocked when the therapist raised the subject. Later on he was able to recognise feeling anxious, doubtful and confused, although still tried to put down these feelings as they made him feel ashamed and unworthy.

In this therapy a common position was observed towards the therapist, a position that hardly fits with the classical conception of transference (Breuer & Freud, 1893 – 1895; Greenson, 1967), that is with the patient experiencing the therapeutic relationship in the light of unconscious memories, reliving anew past childhood conflicts with the therapist as protagonist. Instead of positive signs of a meaningful relation with the therapist, we observed negative signs in terms of a lack of interest or an impersonal engagement in the relationship, as if the therapist was no one in particular, in what appeared as variations of a narcissistic transference (Kohut, 1987).
This detached pattern took the form of over-formality, instrumental engagement or an over-adaptive attitude (Liberman et al., 1993; McDougall, 1989), including a mimicry of compliance and collaboration that prevented the deepening of therapeutic work. The relation in the two cases discussed in the previous section showed this narcissistic quality: the ‘thick-skinned’ older man was invariably friendly and denied the evident differences he had with the therapist, the ‘thin-skinned’ young woman disguised her despair and irritation portraying a light and optimistic spirit. The narcissism in the relationship ranged from lack of interest to open and active rejection of the therapist as someone different, with paranoid manifestations.

This lack of emotional involvement with the therapist can be understood as the relational correlate of the patient’s defensiveness against emotions. In some cases this position was rigid and impenetrable; in others it was more permeable as shown with the young man at the start of this section, in which it was possible to work it through in order to recover his capacity to recognise some emotional states and understand their relational meaning.

Affects always contain an idea or sensory image (Freud, 1915); they are responses to a real or fantasised relation with an object (even a self-object as Kohut stresses), so they are never just meaningless processes of motor discharge. Ultimately even the most primitive affective reactions have a transference dimension (Freud, 1926). This implies that restoration of an emotional response also means the restoration of a relationship.

In this process the consideration of countertransference reactions was of upmost value as signs that could potentially inform the therapist about the patient’s emotional movements, a particularly difficult task to sustain given the patient’s denial of any emotional bond. The active exploration of hints and non-verbal signs shown by the patient especially in the boundaries of the therapeutic encounter (before and after the sessions, in exchanges between sessions and in reaction to the previous sessions) was also of particular utility. The young man described in this section showed a faint shudder, a slight hesitation before starting to talk in each session. Exploration showed that he did not feel free to associate; he felt constrained and forced to say something to his therapist.

In contrast with classical transference analysis, the treatment of the actual determinants of the emotional reactions of the patient, in the here and now of the therapeutic relation, was of strategic priority and the exploration of the relational determinants of emotional reactions occupied most of the therapeutic process. In accordance with what others have proposed (Sami-Ali, 2000), the therapeutic process with these patients advances through the recovery or opening of their imaginary life that expresses itself, among other
manifestations, in the recognition, assumption and understanding of the transference dimension of the relation with the therapist. So we worked with the supposition that even if at first the patient related in a distant and self-centred way the working through of emotional manifestations and dispositions, taken as relational manifestations, could eventually give way to the emergence and recognition of transference.

It is fair to say that this strategic approach is useful for different groups of patients, but we found it is particularly important with psychosomatic patients. They require extensive help recognising and tolerating what they are currently experiencing and to explore its relation with the here-and-now of the therapeutic encounter before exploration of the historical roots of their difficulties made any sense.

Tendency to action

A patient in her twenties sought help because she felt intense pain in different parts of her body that increased a few months before the consultation, when she ended a 10-year relationship with a boyfriend and changed jobs to flee from a turbulent love affair with her boss. She could not recognise that these two events might have any significance or relation to her physical distress, instead, engaging in accelerated narrations of events that were full of banal details, and in which significant emotional issues were constantly insinuated but, when pointed out to her, were not acknowledged. Her life seemed to be a permanent race to respond to work demands experienced as beyond her capacity, with frequent episodes of alcohol intoxication and accident proneness. When she could not stand it anymore, she abandoned her new job as she had done with the previous one. She reported feeling relieved by talking in therapy, but appeared to be able to take little that was meaningful from the conversations. She treated her emotions as burdens to be purged through talking or anesthetised through alcohol, depriving them of their quality. Beside the pain, she complained of feeling tired, empty of energy or interest, as if suffering a loss of vitality.

As manifested in this and the other cases presented in this paper, common to many psychosomatic patients is a type of resistance that involves the tendency to engage in actions demanding immediate discharge, to seek an urgent and concrete solution when discomfort arises (Atkins, 1968; Lefebvre, 1988; Sperling, 1968). Confrontation of the irrationality of this, discussion of its possible causes or attempts to voluntarily control it have no relevant effect: the imperative to do something, to get rid of discomfort by talking, working, exercising, fleeing, taking substances, submitting to practical procedures, medical
or other, overrides any attempt to think over the situation, thereby opposing psychoanalytic work.

A charge or tension seems to build up, demanding some kind of alleviation: an action to discharge by physical means, or in its passive version, to submit to the action of others to change the inner experience of unrest. This tension increases in particular when emotionally laden topics emerge in the treatment. Some authors (Maldavsky, 1992; Marty, 1990) have explained this tension as the expression of the insoluble somatic correlate of emotions that have been abolished from consciousness. So getting rid of this tension without consciously acknowledging the emotions involved seems to be an integral part of a complex defensive strategy. McDougall (1989) adds that the motor discharge is a strategy to disperse feelings. Marty (1990) includes this tendency as central in his ‘behavioural neurosis’ concept in which action is paramount as consequence of poor mentalisation.

Our experience shows that this tendency to abandon primitive patterns of discharge is very hard to modify, requiring a constant work of reflecting back to the patients their repetitions (Freud, 1926), to unveil the different disguises and rationalisations that conceal these repetitive patterns, and exploring the unconscious motivations that support them. As many of these habits have become egosyntonic they require a tactful but active effort to confront and explore their purpose and consequences, in the line of Reich’s technique on character analysis (Reich, 1933).

### Detachment and defensiveness from the therapist

By proposing a category of resistance coming from the therapist we want to stress some of the common ways through which the therapist participated in the previously described resistances or posed their own resistances to the analytic work.

In the preparation of the research, some of the therapists not familiar with this clinical group showed a characteristic resistance to the analytic work: colluding with the patient’s dissociation of emotional and body manifestations. This appeared as tacit exclusion of body manifestations and related associations from the treatment, ignoring them as possible signs of emotional life. Many factors may account for this dissociation: personal, cultural, theoretical, institutional and the effect of the patient’s defensive manoeuvres.

This symmetrical response to the patient’s dissociations (Stelzer, 1989) involved the denial of the patient’s suffering and of the emotional dimension of the bodily ailments (Strean, 1988) so sparing the therapist of distressing experiences of intolerable and unsolvable conflicts.
We also found ourselves falling into the opposite risk, that is, taking for granted the patient’s capacity to bear and acknowledge subjective states that became evident to the therapist. Sometimes we reflected prematurely or in a poorly timed way certain emotional states that the patients were not able to tolerate, thus stirring resistance reactions. This false empathic reaction can be attributed to the perception of non-verbal cues (gestures, tone of voice) related to emotional states rejected by the patient. This unadjusted reaction also occurred in cases in which speech was dissociated from emotions, that is, discourse dealt with emotional contents not actually experienced by the patient. This situation represented an empathic challenge for therapists as they had to discern the level of contact the patient had with the emotions insinuated by non-verbal communication or alluded to in speech. This problem probably relates to the symbolic hollowness (Liberman et al., 1993) or lack of symbolism (Nevorak, 1989) noted in the verbalisations of these patients.

Therapists were exposed to empathetically experience emotional movements of the patient that neither participant was aware of. This problem has previously been addressed in concepts such as projective identification (Klein, 1946) and role-responsiveness (Sandler, 1976). The monitoring of the level of emotional or somatic stress that the therapist may endure (Redfearn, 2000) while playing complementary roles in complex relational patterns or when contagion of veiled emotional states occur (D. Maldavsky, personal communication, 24 June 2009) becomes very important, and the aid of supervision is of upmost value.

Boredom, covert rejection and withdrawal were common reactions to patients' lack of interest in establishing a meaningful therapeutic relation (Redfearn, 2000). In these symmetric and talionic responses the therapist dealt with frustration by exacerbating distance, relating intellectually and focusing on her or his own narcissistic needs (Wilson, 2003). Apart from representing resistances to the treatment, these can be understood as defensive reactions aimed at preserving some level of wellbeing in very difficult interpersonal contexts. For example, a therapist reported in supervision that he had lost two cases in a short span of time. The review of his experience showed that he had assumed a disaffected stance towards them as a way of avoiding responding in an aggressive manner to the frustrating lack of commitment of one patient and the direct disdain showed by the other. In both cases, the therapist felt obliged to ‘behave’ as a good therapist, showing a communion with the kind of ideals governing these patients. The
patients were eventually ‘expelled’ from treatment by unconscious omissions such as avoiding discussion of relational impasses in therapy and not returning phone calls.

The patient’s need to control the therapist to avoid disturbances to her or his narcissistic equilibrium had in some cases a complementary reaction, with the analyst feeling nullified, numb, or paralysed (Dejours, 1992), provoking a stagnation of the process or defensive reactions from the therapist: the unempathic response of over-interpreting the patient’s manifestations was sometimes an attempt by the therapist to remain active and ‘alive’ in this difficult interpersonal context, specifically when faced with lack of associations (Békei, Chevnik, D’Alvia, & Maladesky, 1988; Butler & Rollnick, 1996). This response in turn had the risk of prompting defensiveness from patients feeling overloaded with ‘undigested’ thoughts.

**Discussion: the concept of resistance, Freud’s classification of resistances and the specificity of resistances**

The concept of resistance has historically enjoyed wide acceptance, to the point of resistance analysis being considered central to psychoanalytic treatment (Greenson, 1967), but relational and intersubjective developments have raised criticisms about its ‘isolated-mind’ implications, as it may foster the neglect of the therapist’s contribution in the staging of therapeutic difficulties (Beutler, Moleiro, & Talebi, 2002; Hanna, 2007; Moyers & Rollnick, 2002; Van Denburg & Kiesler, 2002).

In our experience it is possible to work with the concept in a productive way if resistance is considered in a wider definition, that is, as situated manifestations in the clinical setting that necessarily involve a particular definition of the tasks and aims of treatment to take shape (Renik, 1995), thus underlining the role the therapist’s desires and expectations have upon the onset of patient’s resistances (Renik, 1995; Wilson, 2003). From this wider perspective, both patient and therapist might contribute to the staging of resistance.

The classification of resistances necessarily leads to over-simplification, which contrasts with the complexity we observed where all the cases we studied showed combinations of different resistances, forming singular and complex patterns that interwove in coherent ways. At the same time, we noted a certain fluidity of resistance phenomena such that different resistances may be evident at different times within the treatment and sometimes even at different points within a single session, so their individualisation still seems a useful step in the process of their analytic resolution.
We found that the focus on particular types of resistances reflected particular emphasis encompassed in the evolving understanding of the therapeutic process. Many times we started focusing on discrete defensive reactions and particular psychological dynamics of the patient, and as the process advanced we found ourselves shifting to a wider scope in which these reactions fit in relational phenomena in which the therapist had a role. The thoughtful use of transference and counter-transference concepts, that is, without the supposition of any particular causal direction, allowed the management of resistances through the understanding of how and why each party participated in such events.

In this study we applied Freud’s classification of resistances, so the question about the ‘quality of fit’ of this model with the resistances observed in clinical experience and reported by other authors was important. We found that it was possible to identify reasonably clear instances of each type of resistance described by Freud. Although in this paper we focused on the presentation of three types, we found that all five forms of resistance described by Freud were adequate to encompass most of the observed resistances. However it does not follow that Freud’s classification is necessarily the most effective way of describing the resistance to treatment of patients with psychosomatic disorders.

About the question of whether the resistances encountered with this group of patients are distinctive from those found in other clinical groups, we think they are characteristic of, but not necessarily specific to this group, as they resemble phenomena observed by authors (Kernberg, 2007; Shaffer & Simoneau, 2001) in other groups such as narcissistic and addictive disorders.

We were able to identify some characteristic modalities of resistance. In regard to repression resistance, we encountered two states: massive and effective repression of emotional experience, and failure of repression with overwhelming of the ego. In both cases the common feature was the rejection of the experience of distressing emotions, the disregard of the link between emotional distress and physical ailments, and the influence over the repressive process of ego ideals emphasising autonomy, adaptability and rejection of emotiveness. In regard to transference resistance, we found a predominance of narcissistic transference or resistance to transference, with defensiveness in recognising emotional involvement in the analytic relation. Regarding id resistances, we observed a general tendency to seek relief of tension through discharge in action or through passive submission to actions of others to obtain alleviation. These three types of resistance seemed to coincide and have an intimate relation, forming a character pattern.
The specificities of resistances in this clinical group seem to reside in their overall strength and perhaps in some particular contents. As stated before, some specific ego ideals regarding affect subjugation, stoicism and independence seem to underpin the general and individual selection of feelings as objects of repression. The narcissistic withdrawal in the therapeutic relationship seems intimately related with the rejection of affects and their inherent relational dimension, determined by the same ego ideals.

Certain features observed in some patients, such as the lack of awareness about distressing emotions (Marty, 1990; McDougall, 1989; Sifneos, 1973), the lack of awareness about the relationship between somatic symptoms and emotional experience (Shorter, Abbey, Gillies, Singh, & Lipowski, 1992) and the lack of autonomous motivation to seek psychological help (Burke, 1998; Milch, 1998) were closely related to their resistance and are central aspects of what has been conceptualised in different traditions as alexithymia (Pirlot & Corcos, 2012; Sifneos, 1973; Taylor, 2000) and operatory thinking (Marty & de M’Uzan, 2010).

The link between resistance to psychotherapy and alexithymia has been understood in different ways: as the manifestation of a neurophysiologic incapacity (Nemiah, 1975), as the result of a psychological developmental deficiency related to failure in the containing and specular function of the maternal object (Nevorak, 1989), and as the outcome of defensive actions (Maldavsky, 2005; Sami-Ali, 1996), and has also been linked with early trauma and disruption in the development of affect regulation process (Bucci, 1997; Krystal & Krystal, 1988). The characteristics of our study and clinical setting, that is, an 18-month study mostly covering the initial stages of therapeutic processes whose intensity was of one session per week, might have highlighted the relationship of resistance with defensive action, perhaps over-shadowing the relation of resistance with early trauma and developmental problems.

Despite the absence of a standardised measure, we found that most patients showed different degrees of alexithymia, with some cases in which it was prominent to the point of becoming a general trait encompassing most emotional functioning whilst in other cases it appeared specifically linked to certain themes or emotional experiences.

The use of a wide definition for psychosomatic conditions meant grouping patients that not only presented disparate somatic disorders, but different psychological features as well. Apart from the features that were frequent and common, patients were far from homogeneous in terms of other psychological features and their overall functioning (that
ranged from neurotic to borderline), suggesting that the idea of a psychosomatic personality or structure is improbable.

Despite the identification of frequent and coincident types of resistances (rejection of emotiveness, narcissistic transference and tendency to action), not all patients fit with this pattern. No particular resistance presentation was noticeable with regard to age or gender, although if the small number of cases is considered, the descriptions here presented can only aspire to a limited level of generalisability and exhaustiveness.

The decision regarding the type of patients we studied also implied that the psychological specificities that have been proposed for different somatic disorders such as immune, gastric or circulatory disorders (Alexander, 1987; Friedman & Rosenman, 1959; Sami-Ali, 2000) were not considered.

Notwithstanding these limitations, we believe that the descriptions presented in this paper offer valuable elements to understand the kind of clinical difficulties encountered with this clinical group in order to initiate the study of the best therapeutic strategies to deal with them. Our findings also suggest interesting lines of research, such as the relationship between success and failure of defences and the emergence of somatic distress and symptoms, and the relationship between different states of despair, insoluble conflicts and depressive phenomena with defensive functioning. We also think that these descriptions can also be helpful to approach the understanding of therapeutic difficulties encountered in other clinical groups, in which similarities with psychosomatic patients have been identified (Maldavsky, 1992), such as addictive, anti-social and self-injuring patients.

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1. PhD research project at the University of Queensland, Australia.

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