Psychodynamic psychotherapy for patients with functional somatic disorders and the road to recovery

Patrick Luyten, PhD[a,b] *and Peter Fonagy, PhD*[b]

[a] Faculty of Psychology and Educational Sciences, University of Leuven, Leuven, Belgium

[b] Research Department of Clinical, Educational and Health Psychology, University College London, UK

in press in: *American Journal of Psychotherapy*

Highlights

- Recent advances in the understanding and treatment of FSDs from a psychodynamic perspective open up important new avenues for the treatment of these patients.
- Basic treatment principles of dynamic interpersonal therapy, an integrative psychodynamic treatment that has been adapted for patients with FSDs, are outlined to illustrate these advances using the example of the treatment of a female patient with chronic widespread pain and irritable bowel syndrome.

Abstract

Patients presenting with functional somatic disorders (FSDs) are very common in clinical practice. These patients are often considered to be "difficult to treat". Recent advances in the understanding and treatment of FSDs that open up important new avenues for the treatment of these patients are summarized in this paper. Findings concerning the role of three related key biobehavioral systems that seem to be centrally implicated in FSDs from a psychodynamic perspective (i.e., the attachment system, the mentalizing system, and impairments in epistemic trust) are discussed, as well as empirical evidence supporting the efficacy of psychodynamic psychotherapy in FSDs. Finally, the basic treatment principles of dynamic interpersonal therapy, an integrative psychodynamic treatment that has been adapted for patients with FSDs, are outlined based on a description of the treatment of a female patient with chronic widespread pain and irritable bowel syndrome.

Keywords: functional somatic disorder, somatic symptom disorder, psychosomatic, attachment, mentalizing, trauma, psychodynamic, psychoanalytic

Introduction

Patients presenting with persistent somatic complaints are very common. A meta-analysis comprising 32 studies in 24 countries (total $N = 70,085$ patients) found that approximately 30% of patients seen in primary care fulfill criteria for somatic symptom disorder and up to 50% of patients present with at least one somatic complaint (1). Psychotherapists often find these patients "hard to reach" or "difficult to treat". These labels are not entirely correct, as many of these patients are quite open to psychological treatment. Recent advances in our understanding of these patients and their treatment suggest that even the most severely affected patients and who that primarily attribute their symptoms to somatic causes can be successfully helped with psychotherapy, including psychodynamic psychotherapy (PDT). Indeed, there is increasing evidence for the effectiveness of PDT in this patient group (2-5). A recent meta-analysis of 17 randomized controlled trials showed that brief PDT was superior to minimal treatment, treatment as usual, and waitlist controls, with small to large effect sizes, and performed at least as well as other *bona fide* psychological therapies (6). Treatment results were maintained in the long term. Moreover, there is growing evidence for the effectiveness of multidisciplinary, multicomponent, psychodynamically oriented treatment programs for these patients (7). Consistent with these findings, PDT has been associated with changes in neural systems involved in FSDs, including the stress, reward, and mentalizing systems (8).

Here, we provide a brief overview of psychodynamic approaches to FSDs and describe the treatment principles of dynamic interpersonal therapy (DIT), an integrative PDT. We illustrate these principles with a brief clinical vignette.

An Attachment and Mentalizing Approach to FSDs

The nature of FSDs

FSDs are notably heterogeneous with respect to the role of psychological and biological factors implicated in their development. Hence, an important starting point of treatment is that it is typically impossible to determine the relative role of biological and psychological factors in an individual case. We have found it crucially important in this context to first and foremost acknowledge the reality of the patients' symptoms, and our lack of understanding and thus humility in relation to the patient with respect to the precise causation of his or her symptoms. In light of the increasing evidence for the role of biological factors in most if not all FSDs, such an attitude is also in line with our current knowledge of the pathogenesis of these disorders (3, 9, 10). Such interventions characteristically have both a normalizing and a validating effect on patients, who have often had to "prove" that were ill, have been told that their symptoms are "all in their head", and/or have had conflicts with health professionals about the origin of their complaints. It is therefore also imperative to ensure that the patient has undergone thorough medical screening.

Our approach focuses on three key areas that, in various combinations, may be implicated as predisposing, precipitating, or perpetuating factors: (a) attachment issues; (b) the capacity for (embodied) mentalizing—that is, the capacity to reflect on their own (embodied) self and others; and (c) the capacity for epistemic trust—the capacity to trust others (including clinicians) as a source of knowledge. Problems related to each of these factors may be implicated in the development of the disorder, but they may also result from or be exacerbated by somatic complaints. There is abundant research demonstrating the pernicious impact of FSDs on attachment, mentalizing, and epistemic trust, particularly in patients whose symptoms have become chronic (for a review, see (10)).

Attachment

From a neurobiological perspective, FSDs may be best conceptualized as reflecting a state of allostatic load as a result of prolonged physical and/or psychological stress and conflict (11). Allostatic load refers to a temporary or chronic disruption of the dynamic equilibrium (allostasis) that characterizes the human stress response and associated neurobiological systems (the stress, immune, and pain-regulating systems) and biomediators.

Attachment issues play a crucial role here as either a vulnerability factor or as a secondary factor. The attachment system is a biobehavioral system that is centrally involved in the stress response, as during development humans learn to seek proximity to attachment figures when confronted with distress. When attachment figures are available and responsive, the distress is typically down-regulated (see Figure 1) because the individual feels supported, cared for, and loved (12, 13). A mesocorticolimbic dopaminergic reward system underlies this process, as it generates the feeling of reward associated with secure attachment experiences and also down-regulates the stress system at both the biological (i.e., the hypothalamic–pituitary–adrenal axis and the sympathetic nervous system) and the behavioural level (14).

Chronic persistent somatic problems preclude the effective down-regulation of distress: proximity seeking provides, at best, only partial relief. Hence, as the normative down-regulation of distress increasingly fails, the individual resorts to secondary attachment strategies (15). These strategies comprise either hyperactivation of the attachment system, involving increasingly desperate efforts to find support and relief in others; deactivation of the attachment system, leading to a denial of distress and/or need for help and support; or a combination of the two. Secondary attachment strategies are non-conscious strategies that represent an attempt to adapt to the ever-increasing threat from within that is posed by the chronic fatigue and pain associated with FSDs. Although secondary attachment strategies

might bring some short-term relief, in the long run they negatively impact the patient's condition and particularly the patient's ability to seek help (including psychological help) from others and benefit from it (see Figure 1). Allostatic load further increases; in those who rely on attachment hyperactivating strategies, the individual desperately attempts to find support and relief but becomes increasingly disappointed in others, in particular health professionals (and even more so if they attempt to force a specific illness theory on the patient). For patients who primarily use attachment deactivating strategies, feelings of loneliness and bitterness emerge, and the "wear and tear" of allostatic load on the biological stress system and psychological capacities often lead to a complete breakdown, such that the patient feels completely overwhelmed, depressed, and anxious (16).

In patients with premorbid attachment problems in particular, this process may lead to negative idealization–denigration cycles; in the context of therapy, this results in intensive transference–countertransference issues where the therapist feels either idealized, denigrated, or even manipulated. These issues seem to be largely responsible for the "difficult-to-treat" label that is often given to patients with FSDs (17, 18). Yet, from the patients' perspective, their overreliance on secondary attachment strategies and the resulting behaviors are an understandable adaptation strategy.

Mentalizing

The combination of persistent somatic symptoms and the use of secondary attachment strategies characteristically erodes patients' mentalizing capacities—in particular, their capacity for embodied mentalizing. Embodied mentalizing involves the capacity to perceive and reflect on bodily signals (i.e., interoception) as representative of inner mental states and one's selfhood. Feelings of pain and fatigue progressively impair and distort this capacity as the body is increasingly conceived of as a hostile entity that threatens the coherence of the

self from within (19). In some patients, problems with embodied mentalizing may antedate the onset of FSD symptoms; in others, such problems arise as a consequence of debilitating pain and fatigue and/or are exacerbated by these symptoms. Consistent with these assumptions, research has demonstrated problems with both primary or secondary alexithymia (20) and emotional awareness (21) in patients with FSD. Impairments in (embodied) mentalizing characteristically give rise to the reactivation of non-mentalizing modes of experiencing the embodied self that all clinicians working with these patients are familiar with (see Box 1).

Epistemic Trust

Over the past few years, we have become acutely aware of the role of problems with epistemic trust, the capacity to trust others as a reliable source of knowledge about the world (including knowledge about one's symptoms). Many patients with FSDs, particularly those with a history of early adversity, show problems with epistemic trust before the onset of their functional somatic problems. These patients' distrust of others—including many health professionals—who argue that their complaits are wholly "psychosomatic" without any real, biological basis, further erodes their epistemic trust. As a result, many patients feel misunderstood and invalidated (22). Hence, the first therapeutic task when working with these patients is to validate the reality of their suffering and their symptoms. If this is not done, psychotherapeutic interventions will often be iatrogenetic because they increase the patients' feelings of invalidation and epistemic mistrust (23).

Treatment Approach

Dynamic Interpersonal Therapy for FSD (DIT-FSD) is an integrative PDT that focuses on the three core features of patients with FSD discussed above: (a) the (re)activation

of secondary attachment strategies to deal with persistent somatic problems, (b) the resulting impairments in (embodied) mentalizing, and (c) problems with epistemic trust (9, 24).

Because patients with FSDs are notably heterogeneous with respect to the nature and origins of their problems, the ability to tailor treatment to the patients' needs and capacities is a central feature of DIT-FSD. In more severely affected patients, there is typically a focus on reactivation of the capacity for (embodied) mentalizing before any work focusing on the content of the patient's dynamics can be done successfully. In DIT-FSD, this latter focus is based on the therapist and patient jointly formulating an interpersonal affective focus (IPAF)—a description of a recurring and often unconscious pattern of relating to the self and others that is linked to the onset and perpetuation of functional somatic problems.

Currently, DIT-FSD is offered in a 16-session format or, for more severely affected patients, in a 26-session format. The time-limited nature of the treatment provides patients with a holding environment while at the same time activating the patient's IPAF (e.g., "Why do I need such a long treatment? I have always been able to take care of things on my own" , or "16 sessions will be way too short, I need many more"). Of course, at the end of DIT-FSD, some patients may benefit from a longer treatment, but the aim of DIT-FSD itself is to empower the patient to continue his or her own treatment process as needed.

In what follows, we describe the 16-session format based on a brief summary of the treatment of Linda, a female patient with severe and chronic gastrointestinal problems (All case material has been disguised to protect the confidentiality of the patient).

The first phase of DIT-FSD (sessions 1–4) focuses on engaging the patient in treatment and jointly formulating an IPAF, however preliminary, as the focus of the treatment. Linda was referred to one of us (PL) after having suffered for years from severe and almost constant gastrointestinal problems. She was diagnosed with irritable bowel syndrome and chronic widespread pain, and had had numerous medical tests and

examinations in the past. Each time, she was told that her condition must largely be stress-related and she therefore needed to see a psychologist or psychiatrist.

In her intake interview, Linda told me that she had seen several psychologists, but none of them seemed to have understood her, as they all seemed to agree with the view that her symptoms and complaints were largely psychological in nature. Each time, after a few sessions, she terminated treatment. In DIT, this is seen as a cautionary tale: the patient "warns" the therapist not only what might re-occur in the therapeutic relationship ("People, including you as a therapist, do not understand me"), but also what might happen if the therapist is yet another person who does not understand her (she will end the treatment). As this template or pattern might also prove to be a central component of her IPAF, my initial response was a validating and normalizing one, expressing my surprise that both physicians and psychologists had not taken her seriously, and saying that it must have been terrible given that she clearly was in pain and felt desperate. In response, she started to cry. She then looked up and asked me whether I believed her. I told her that she did not need to convince me of the reality of her symptoms or of her feelings of desperation and depression because no one seemed to be able to help, or even understand, her.

Hence, my empathic validation of her feelings of invalidation and recognition of the reality of her suffering led to a relaxation of her epistemic vigilance and the emergence of an interest in what else I thought about her and her problems. Together, we were then able to discuss whether she had had that feeling of not being understood before. What followed was an attachment memory—that, as a child, she always had the feeling that she was "second best" and her parents, particularly her mother, preferred her sister. Throughout her childhood and adolescence, she had always attempted to be her "mother's darling", but she always seemed to fail to surpass her sister in this regard. She became desperate for her mother's attention and felt very anxious whenever her mother seemed to disapprove of something

Linda did or wanted. When she was 10 or 11, she began to develop gastrointestinal symptoms. When I asked how she felt as a child and a teenager, Linda responded that she felt constantly anxious and on her guard. When I asked whether this also might have taken its toll on her body (i.e. an embodied mentalizing focus), she responded that this was true: she always felt tense, as if there was a weight on her shoulders and a constant pressure in her stomach. I asked her whether she now felt the same tension and pressure, in the session; she responded that she had never thought of the connection between her anxious preoccupation with her mother and her gastrointestinal symptoms, but that now, in the here-and-now of the session, she felt that there must be a link between the two. In DIT-FSD, we do not force a specific illness theory upon the patient, but use interventions aimed at fostering embodied mentalizing, so that the patient begins to experience possible links between a repetitive interpersonal pattern and somatic symptoms through "micro-slicing" interpersonal events (i.e., undifferentiated mental states in relation to interpersonal events are explored in a step-by-step manner to break them down into specific mental states that are meaningfully linked to each other). This experience led Linda to talk about other relationship she had had in which this anxious pattern of wanting to be the one who is preferred over others recurred (with a teacher, a man who gave her lessons at a pony club, and two boyfriends she had dated before meeting her current partner). In her current relationship, she said that this pattern seemed to be somewhat less important because he was "extremely patient with her" (which could also be read as a cautionary tale).

In session 3, we were able to jointly arrive at a preliminary formulation of her IPAF. She saw herself as someone who was always there for others, caring for and helping them. However, she experienced others as being uncaring and as preferring other people, despite Linda doing her utmost to please them. This made her feel sad, lonely, and despondent, but also highly anxious because it meant, in her experience, that no one really cared for her and

that she was “all alone in the world” (an example of psychic equivalence functioning). Importantly, we were able to consider this pattern as an understandable adaptation strategy given the context in which she grew up. However, this strategy also had a large emotional and somatic cost: not only did she feel anxious and alone, but she always felt tense and on her guard, and she always felt as if there was “something on her stomach”, giving her cramps.

When we focused on her cramps and the feeling that there seemingly was always “something on her stomach”, she could, at first very cautiously and with a lot of shame, acknowledge that she also often felt frustrated and angry because others neglected her and did not understand her. She recalled, for instance, how one day she felt so tense, frustrated, and angry when her sister organized a barbecue for the whole family, that she had to leave early because she felt nauseated and had to vomit; she had left the barbecue without telling anyone, and also did not tell anyone that she felt unwell. Hence, her feelings of anger and frustration typically gave rise to high levels of bodily arousal and tension, which contributed to her gastrointestinal problems. Feelings of guilt inhibited her anger until the whole cycle started again. Linda, however, always had attributed her cramps to a somatic cause (an example of teleological functioning).

The second phase of DIT (sessions 5–12) involves a constant focus on how the IPAF recurs in the patient’s life. In addition, once the patient’s capacity to reflect on the negative impact of this repetitive pattern of thinking and feeling, and its link with presenting symptoms, has strengthened, the therapist and patient can jointly begin to consider alternative ways of relating to the self and others. This process is typically accompanied by an alleviation of the patient’s symptoms.

Although Linda initially remained somewhat reluctant to talk about her family of origin and current relationships, increasingly she began to feel, first in the sessions and then, as the treatment progressed, also in the wider world, how her feelings of not being seen and

not being understood weighed on her both symbolically and literally—that is, how she had always felt oppressed and suppressed and how this had led to a constant state of anxious tension. The emotional and physical cost of her expectation that others would not be there for her, and that they preferred others above herself, became increasingly clear. At this point in the course of therapy, both her general feeling of being tense and her more specific gastrointestinal problems began to improve markedly. Not only did she feel less of a need to be "preferred" by others, but she also reported feeling more relaxed in the company of others. Also, her almost endless worrying that others did not like her (because of something she said, didn't say, did or didn't do, leading to anxious thoughts of rejection and abandonment which often preoccupied her for days, an example of pretend mode functioning) considerably decreased. The fact that her partner continued to be very supportive and reassuring played an important role in this context. She also began to distance herself more from her mother and sister, and from friends who she felt exploited her tendency to care for others and always be there for them. In the middle phase of treatment, DIT uses the full spectrum of interventions typically used in PDT. This spectrum includes supportive interventions when needed, interventions that foster (embodied) mentalizing, insight-oriented interventions (i.e., clarification, challenge, and interpretation) and directive interventions to encourage the patient to bring about changes related to their IPAF.

In the ending phase (sessions 13–16), the focus is on empowering the patient so that he or she can continue the process of change after the end of treatment. The ending phase typically starts by the therapist sharing a draft "goodbye" letter that contains an overview of the patient's presenting problems, the jointly agreed IPAF formulation, the changes that have been achieved in treatment, and a summary of what is still to be achieved. The patient is then invited to read the letter out loud and to suggest any changes that he or she feels are needed. The letter provides another and important opportunity to work through the IPAF, as it

typically reactivates the patient's IPAF. Linda, for instance, became silent when handed the letter. She read the letter, seemingly without any emotion, and said she did not have any comments on it. When asked whether the letter conveyed the work that we had done together, she nodded this was the case. However, she added, as she knew the letter introduced the last phase of treatment, this left her feeling that I probably had enough of her and wanted to get rid of her, because there must be other and more interesting patients wanting to see me. When I suggested that perhaps this was the "old" pattern being reactivated, she nodded and said she was surprised that it could be still that powerful. This allowed us to explore in more depth how she would deal with similar experiences when her "old" pattern might be reactivated in the near future. We spent much of the final few sessions examining to what extent this old pattern was still active in her daily life, and to what extent she had already internalized other ways of looking at herself and others. By the end of the treatment, she was able to express gratitude towards me and the treatment; although she was still having occasional gastrointestinal problems, her symptoms had become markedly better. In the final session she wanted to discuss whether her symptoms had some biological roots and therefore might never resolve completely. She told me how she remembered that in our first session I had said that I believed her symptoms were real and not imagined, and how this had given her the feeling that I was truly listening to her and thus that perhaps I could help her (an example of the restoration of epistemic trust).

Conclusions

For many years, patients with FSDs were often considered to be "hard to reach" and "difficult to treat". However, these labels neglect the fact that this group of patients is notably heterogeneous, and many of these patients are quite open to psychological treatment. Moreover, the "hard to reach" character of a subset of these patients primarily resides in the

"eye of the beholder" (i.e., medical professionals and therapists). Many of these patients have grown up in an invalidating, traumatizing environment in which epistemic distrust and hypervigilance are, at least in the short term, adaptive. Combined with often severe attachment disruptions and impairments in embodied mentalizing, this adaptation strategy increasingly gives rise to considerable psychological and metabolic costs, particularly when combined with biological vulnerability. Moreover, invalidating responses by others, including mental health professionals who often (even with good intentions) attempt to force specific illness theories ("Stress must play an important role in your symptoms") on these patients, further increase the patients' epistemic vigilance.

However, once epistemic vigilance is lifted by an approach that begins by validating and normalizing the patient's adaptation strategy, as is typical of DIT-FSD and many other contemporary treatments, the road to recovery opens up, and even the most severely affected patients can make considerable therapeutic progress. However, it may take considerable time for these patients' FSD symptoms to fully resolve, particularly in more chronic cases, because of what seem to be deeply ingrained impairments in biological systems involved in the stress response that result from years of "wear and tear" on these systems, as well as deeply ingrained negative patterns of relating to the self and others.

References

1. Haller H, Cramer H, Lauche R, et al. Somatoform disorders and medically unexplained symptoms in primary care. Deutsches Ärzteblatt International. 2015; 112:279-287.

2. Abbass A, Kisely S, Kroenke K. Short-term psychodynamic psychotherapy for somatic disorders. Psychother Psychosom. 2009; 78:265-274.

3. Luyten P, Van Houdenhove B, Lemma A, et al. An attachment and mentalization-based approach to functional somatic disorders. Psychoanal Psychother. 2012; 26:121-140.

4. Sattel H, Lahmann C, Gundel H, et al. Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: randomised controlled trial. Br J Psychiatry. 2012; 200:60-67.

5. Guthrie E, Moghavemi A. Psychodynamic-interpersonal therapy: an overview of the treatment approach and evidence base. Psychodyn Psychiatry. 2013; 41:619-635.

6. Abbass AA, Town J, Holmes H, et al. Short-term psychodynamic psychotherapy for functional somatic disorders: A meta-analysis of randomized controlled trials. Psychother Psychosom. in press.

7. Koelen JA, Houtveen JH, Abbass A, et al. Effectiveness of psychotherapy for severe somatoform disorder: meta-analysis. Br J Psychiatry. 2014; 204:12-19.

8. Abbass A, Nowoweiski SJ, Bernier D, et al. Review of psychodynamic psychotherapy neuroimaging studies. Psychother Psychosom. 2014; 83:142-147.

9. Luyten P, Van Houdenhove B, Lemma A, et al. Vulnerability for functional somatic disorders: A contemporary psychodynamic approach. J Psychother Integr. 2013; 23:14-27.

10. Luyten P, De Meulemeester C, Fonagy P: Psychodynamic therapy in patients with somatic symptom disorder; in Contemporary psychodynamic psychotherapy: Evolving clinical practice. Edited by Kealy D, Ogrodniczuk JS. Philadelphia, PA, Academic Press; 2019. pp. 191-206.

11. McEwen BS. Physiology and neurobiology of stress and adaptation: Central role of the brain. Physiol Rev. 2007; 87:873-904.

12. Diamond D, Stovall-McClough C, Clarkin JF, et al. Patient-therapist attachment in the treatment of borderline personality disorder. Bull Menninger Clin. 2003; 67:227-259.

13. Sbarra DA, Hazan C. Coregulation, dysregulation, self-regulation: An integrative analysis and empirical agenda for understanding adult attachment, separation, loss, and recovery. Pers Soc Psychol Rev. 2008; 12:141-167.

14. Luyten P, Fonagy P. The stress-reward-mentalizing model of depression: An integrative developmental cascade approach to child and adolescent depressive disorder based on the Research Domain Criteria (RDoC) approach. Clin Psychol Rev. 2018; 64:87-98.

15. Mikulincer M, Shaver PR: Attachment in adulthood: Structure, dynamics and change. New York, NY, Guilford Press; 2007.

16. Maunder RG, Hunter JJ. Attachment relationships as determinants of physical health. J Am Acad Psychoanal Dyn Psychiatry. 2008; 36:11-32.

17. Luyten P, Mayes LC, Target M, et al.: Developmental research; in Textbook of Psychoanalysis. Edited by Gabbard GO, Litowitz B, Williams P. 2nd ed. Washington, DC, American Psychiatric Press; 2012. pp. 423-442.

18. Luyten P, Van Houdenhove B. Common and specific factors in the psychotherapeutic treatment of patients suffering from chronic fatigue and pain disorders. J Psychother Integr. 2013; 23:14-27.

19. Schattner E, Shahar G, Abu-Shakra M. "I used to dream of lupus as some sort of creature": Chronic illness as an internal object. Am J Orthopsychiatry. 2008; 78:466-472.

20. Taylor GJ, Bagby RM. Psychoanalysis and empirical research: The example of alexithymia. J Am Psychoanal Assoc. 2013; 61:99-133.

21. Lane RD, Quinlan DM, Schwartz GE, et al. The Levels of Emotional Awareness scale: A

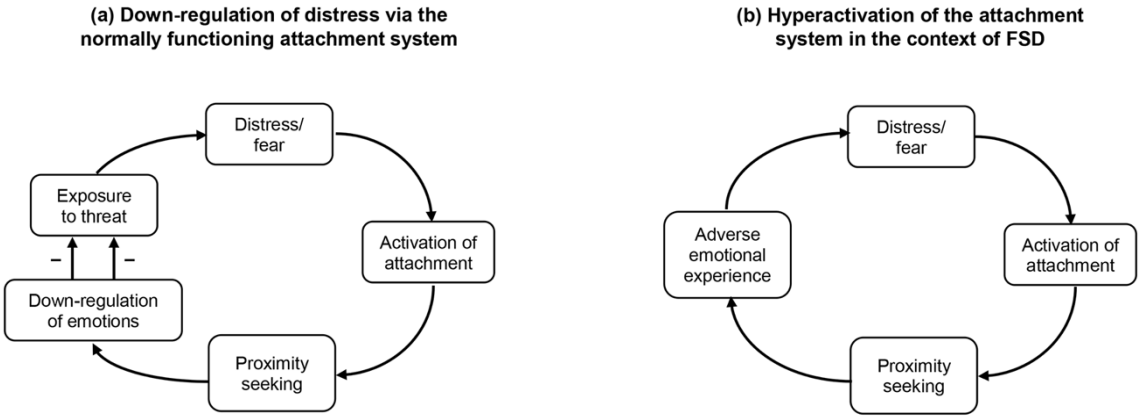
cognitive-developmental measure of emotion. J Pers Assess. 1990; 55:124-134.

22. Blom D, Thomaes S, Kool MB, et al. A combination of illness invalidation from the work environment and helplessness is associated with embitterment in patients with FM. Rheumatology. 2012; 51:347-353.

23. Luyten P, Abbass A. What is the evidence for specific factors in the psychotherapeutic treatment of fibromyalgia? Comment on "Is brief psychodynamic psychotherapy in primary fibromyalgia syndrome with concurrent depression an effective treatment? A randomized controlled trial". Gen Hosp Psychiatry. 2013; 35:675-676.

24. Luyten P, Fonagy P: An integrative, attachment-based approach to the management and treatment of patients with persistent somatic complaints; in Improving Patient Treatment with Attachment Theory A Guide for Primary Care Practitioners and Specialists. Edited by Hunter J, Maunder R. New York, NY, Springer; 2016. pp. 127-144.

Figure 1. The relationship between the attachment and stress-regulation systems



Box 1. Typical non-mentalizing modes in patients with functional somatic disorders

Psychic equivalence mode

- Inner (mental) and outer reality are equated; what I believe is real ("I think there is a virus causing my problems, so there must be a virus causing my problems")
- Therapeutic response: validating the patient's perspective while at the same time recognizing uncertainty and humility with regard to the precise causes of somatic problems

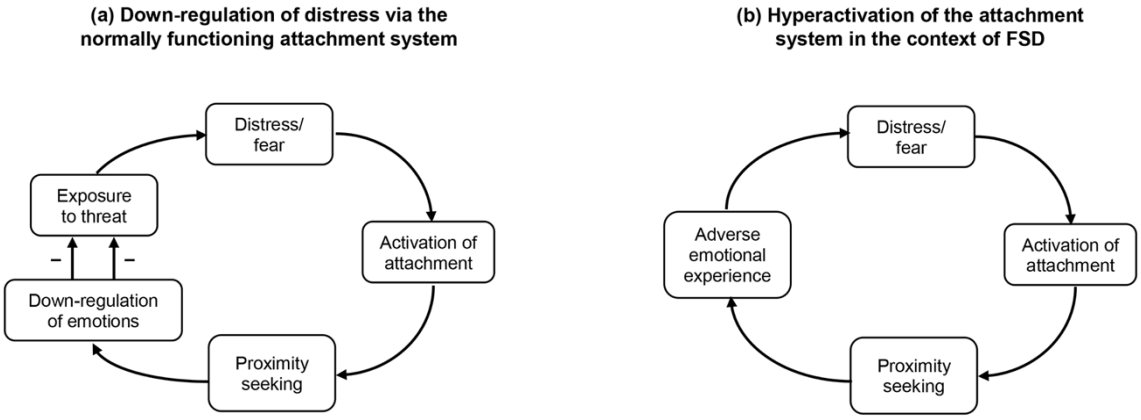
Teleological mode

- Only observable causes (e.g., severe physical abuse) or biological factors (e.g., a virus, tumor, or poisoning) can cause psychological and/or somatic complaints
- Therapeutic response: validation, then focus on the embodied experience of feelings related to somatic problems and how these feelings are connected with current (interpersonal) problems through "micro-slicing"

Pretend mode

- The patient's thoughts and feelings become decoupled from the external world and may give rise to excessive rumination and even dissociation of thought (hypermentalizing or pseudomentalizing)
- Therapeutic response: "rewinding" to when the patient lost the capacity and explore what interpersonal situation was reactivated that led to the loss of mentalizing (e.g., "I felt rejected again" or "I felt humiliated").

Figure 1. The relationship between the attachment and stress-regulation systems



Box 1. Typical non-mentalizing modes in patients with functional somatic disorders

Psychic equivalence mode

- Inner (mental) and outer reality are equated; what I believe is real ("I think there is a virus causing my problems, so there must be a virus causing my problems")
- Therapeutic response: validating the patient's perspective while at the same time recognizing uncertainty and humility with regard to the precise causes of somatic problems

Teleological mode

- Only observable causes (e.g., severe physical abuse) or biological factors (e.g., a virus, tumor, or poisoning) can cause psychological and/or somatic complaints
- Therapeutic response: validation, then focus on the embodied experience of feelings related to somatic problems and how these feelings are connected with current (interpersonal) problems through "micro-slicing"

Pretend mode

- The patient's thoughts and feelings become decoupled from the external world and may give rise to excessive rumination and even dissociation of thought (hypermentalizing or pseudomentalizing)
- Therapeutic response: "rewinding" to when the patient lost the capacity and explore what interpersonal situation was reactivated that led to the loss of mentalizing (e.g., "I felt rejected again" or "I felt humiliated").