Towards a view of health based on levels of integration and self-fulfilment: An alternative assessment model

Luigi Solano[*]

Abstract

The paper starts from a criticism of a clinical assessment based on the presence/absence of psychiatric symptoms, typically the DSM. This modality shows strong limits namely in the case of sudden and unexpected violent behaviours, of adhesion to terrorist groups or to criminal regimes, of somatic pathologies, of deficiencies in the development of functions. Utilising psychoanalytic, or psychoanalytically inspired literature, history documents, and clinical examples, a different assessment modality is proposed, both of pathological conditions and of the outcome of treatment: classification of levels of health is based on the degree of connection between different systems of the organism, which are also strongly related to the development of functions, such as dreaming, reflective capacity or affect regulation. Psychic, but also somatic symptoms often appear in this view not as the essence of pathology but as useful alarm signals and forms of communication; at any rate, they should be considered in conjunction with the proposed dimension.

Keywords: assessment; health; integration; self-fulfilment; development of functions.

[*] Member of the Italian Psychoanalytic Society; Professor at the Postgraduate School in Health Psychology, Department of Dynamic and Clinical Psychology, Sapienza University of Rome. Email: luigi.solano@uniroma1.it

Solano, L. (2019). Towards a view of health based on levels of integration and self-fulfilment: An alternative assessment model. *Rivista di Psicologia Clinica*, *1*, 11-27.
doi:10.14645/RPC.2019.1.731

I often say that mentally sane people do not kill.
But this is only my personal opinion.
Not fully an orthodox opinion.
No, not at all.
(George Simenon, 1953, author's translation)

Introduction: Newfound validity of psychological theories and insufficiency of a symptom-based "atheoretical" diagnosis

The main psychological theories – deriving from psychoanalysis, cognitive science, clinical cognitivism, systemic-relational orientations, neuroscience, developmental psychology – after many years of mutual discrediting are today showing a substantial convergence, though not officially declared and often covered by the use of different terms. Differently from thirty years ago, nobody today questions the existence of unconscious processes or of an internal world; on the other hand, nobody questions the importance of present, real relationships. Only organicist psychiatry and radical behaviourism remain outside this convergence.

At the same time, we witness full correspondence (with rare exceptions) of data deriving from the clinical setting with data deriving from empirical research (Bornstein, 2005; Lingiardi & Ponsi, 2013; Solano, 2005; Westen, 1998). Psychology, including psychoanalysis, has reached a scientific level which, though not comparable with the level of natural sciences such as classical physics (an ambition I believe we should definitely dismiss), makes it well susceptible to empirical investigation; this holds true to a degree which is much higher than in widely respected disciplines, such as economy or history, and comparable to that attainable in natural science in its more recent developments, such as quantum physics or chaos theories, where statements may only be probabilistic.

Psychology in general, and psychoanalysis in particular,[1] have supplied since the end of the nineteenth century a wide range of criteria, instruments and modalities for personal assessment. If we believe we are a science, we should feel fully justified in using our instruments of assessment also in 'official' scientific communications, rather than using in many cases a classification based on the *presence/absence of symptoms*. The most prominent example is the Diagnostic and Statistical Manual (DSM) in its various versions: a classification essentially based on agreement among 'experts'[2] (an agreement which changes on some points at every edition), irrespective of individuals' subjectivity, of their more general features (such as resources and achievements), of their relational world, of the meaning of symptoms themselves for a specific person; a classification which discards 120 years of psychological science, psychometrics included. DSM-4, as noticed by Lingiardi and Del Corno (2008) contained three additional axes 'for further studies': defensive functioning; global relational functioning; social and work functioning'. Contrary to expectations, none of this managed to get through to the main text of the DSM-5. Section III contains some reference to dimensional assessement and to 'alternative models for the assessment of personality disorders', which appear totally marginal in comparison to the other 1000 or so pages, which are totally categorical and symptom-based.

All this was justified in a search for 'atheoretical' criteria, this motivated in turn by a postulated 'babel' of psychological theories, described as discordant one from the other and void of scientific foundations. As discussed above, these assumptions hold true no more.

An extensive discussion around the present status of the debate around DSM (which is only quoted as an example) is beyond the scope of this paper. The subject I wish to address is the *total insufficiency of any diagnostic system based only on the presence or absence of psychiatric symptoms*, as employed not only by psychiatry, but also by common people. In addition, I will question a view of symptoms *only* as an indicator of distress, of pathology, while they may be considered, and have been considered by many authors, also as

[1] My position, in line with some passages of Freud's work, is that psychoanalysis is part of psychology, its substructure, perhaps the foundation of the whole (Freud, 1927a).

[2] It would have been extremely interesting if 'biological' psychiatry had produced a system of diagnostic classification based on neuroscientific research. This would have meant, however, renouncing the claim to atheoricity, which was the main device through which the DSM managed to assert itself as a universal 'neutral' classification system. Results of empirical research, moreover, may be questioned as to methods employed and disproven by further research, while a classification based on agreement among experts may in no way be disproven.

very useful and adaptive *forms of expression and communication* of distress itself, apt to prevent more severe damage.
I will now discuss a series of situations which, though quite different from each other, all strongly show the failure of symptom-based assessment.

'He seemed to be such a nice guy'

A first area where symptom-based psychiatric diagnosis shows its ultimate insufficiency is in cases of unexpected explosions of (generally domestic) violence**:** 'he (or she) seemed to be such a nice person' is the most usual phrase we hear repeated by friends, relatives and acquaintances. We may read, for instance, the words used by the village parish priest about a man who had just admitted slaughtering his wife and two young children with a kitchen knife: "See, you won't find anyone, not a single one, who might say: it could be expected. No one, I can assure you. Anyone would have sworn on Carlo. He was polite, careful, most sensitive with his and other children" (Verdelli, 2014, nd, author's translation).
I need to admit that until some time ago I tended to consider these kind of statements as coming from naive people, incapable of grasping anything in their fellow human beings beyond the most explicit appearance; I tended to think that any psychologist, even not particularly skilled, would have easily understood that something was wrong in that person even before the events.
If we stop and think for a minute, however, we discover that our naive people are in good company: even *after* these kind of events have taken place, a large part of psychology, of psychiatry and of public opinion starts discussing whether the killer was sane or not, and delegates this assessment to a psychiatric evaluation, which will commonly be based on the presence/absence of apparent symptoms. As if this latter kind of assessment could be more reliable than the presence of a gesture which from a different viewpoint we could consider a prototypical expression of insanity, with no need of confirmation, and not liable to confutation through different data.
Obviously another question is possible and important, from a legal point of view, which is whether a capacity of discernment was present at the moment of the crime; but I wish to emphasise that the two aspects do not overlap: a mentally sane person may be incapable of discernment in a given moment under the effects of drugs or alcohol, of recent trauma, of prolonged sleep deprivation; on the other hand no mental pathology, with the possible exception of deteriorated schizophrenia, definitely and permanently alters the capacity to be aware of the consequences of one's actions.

Terrorists and Nazi criminals

Another field where symptom-based psychiatric diagnosis appears to fail is that of terrorists and state criminals (in war and 'peace'). A paper published by Carol Beebe Tarantelli (2010), 'The Italian Red Brigades and the structure and dynamics of terrorist groups', reminds us of the repeated *failure to find macroscopic signs of manifest psychopathology*, or of a particular level of aggression, not only in members of the Red Brigades, but also in suicide bombers (Silke, 2003) and even in Nazi criminals tried at Nuremberg: people who had directed the planning and functioning of extermination camps where millions of innocent people were killed. This finding appeared from the beginning so disquieting that it was published only 35 years later (Borofsky & Brand, 1980). What reliability is offered by a type of assessment which records nothing, or almost nothing, in subjects we may consider as the most highly selected sample, the 'gold standard' of psychopathology? Were Nazi criminals mentally sane or are our instruments inadequate?
First of all, we have to recognise that we are not confronted with a generalised propensity to violence, but with an altered vision of the world, where most cherished values are felt as strongly threatened by someone: by Jews, in the case of Nazi criminals; by the 'International State of Multinationals', in the case of the Red Brigades. A loss of reality testing appears implied: but then, was this not the clearest indicator of psychopathology? Except here we are not confronted with grossly deluded or hallucinated individuals, but with a loss of reality testing which appears 'focal', limited to a very specific area, so that it may remain unapparent unless this area comes to the fore.
Group dynamics (such as those described by Freud in Group Psychology and Analysis of the Ego, 1921, and by Bion in Experiences in Groups, 1961) are certainly involved: Beebe Tarantelli describes the Red Brigades as a group founded on a fight/flight basic assumption, which ends up dominating thoughts and emotions of group members. Such assumption, as outlined above, gives origin to the fantasy of a state which is next to

destroy any form of opposition through violence, while the Red Brigades group is seen as the leading edge of a movement capable of preventing this terrible possibility. The individual Super-Ego (Freud, 1921) is replaced by this ideology, therefore any action carried out in its name is justified. Similar considerations may be put forward relating to nazi criminals.

A problem remains, however: there needs to be something also on an individual level differentiating those few thousands of individuals who joined terrorist groups in Italy from the millions of people who shared a strongly leftist ideology at the time but who, when the moment of choice came, took a different course? Beebe Tarantelli in her paper (2010) reminds us of the bionian term *valency,* taken from chemistry to indicate an individual's capacity for spontaneous and instinctive emotional combination with other individuals. We are confronted, therefore, with something far less apparent than what we use to name psychopathology, something having to do with areas of the mind which in different theoretical systems we may call *split off* (Freud, 1927b), *dissociated* (Bromberg, 1998; Bucci, 2007), *alexithymic* (Taylor, Bagby, & Parker, 1997; Solano, 2013), or *unresolved* (Main & Solomon, 1986); these areas may send very faint signals to the outside, unless the 'valency' combines with other 'free radicals' in the social environment, generating highly explosive compounds. Areas which may be revealed *through instruments capable of exploring not contents – which are more or less inaccessible – but modalities of functioning*: I am thinking of the Attachment Interview (George, Kaplan, & Main, 1996), capable of detecting 'unresolved' mental states or a low mental 'coherence'; of the Interview for Alexithymia (Bagby, Taylor, Parker, & Dicken, 2006; Taylor & Bagby, 2014), capable of detecting difficulties in contact with emotion, as a witness of disconnection among systems in the organism (Bucci, 1997a, 2007); of the Scale for Dissociative Experiences (Bernstein & Putnam, 1986).

We should remember that in Red Brigades' members and in Nazi criminals (Nielsen & Zizolfi, 2005) *macroscopic* signs of mental disease were not found, but something was found; what possibly we need to recognise is that in particular contexts a faint signal[3] may be indicative of *specific and limited* dissociated areas, which are difficult to access and may not give any external manifestations for a long time, until an encounter with a complementary valency in the environment, or possibly a new stimulus, produce an explosion. Niels Peter Nielsen, an Italian psychoanalyst of Danish origin, in his book on 'The Nazi mental *universe'* (2004) speaks of "intermittent' perverse areas" (p. 136): "A part of the mental apparatus prevails temporarily on another, which is ready to prevail in its turn when environmental and existential coordinates become favourable" (p. 161).

Careful revision of Rorschach protocols collected from Nazi officials while they were standing trial in Nuremberg (Nielsen & Zizolfi, 2005) confirmed the paucity (again, not the absence) of signals of 'psychopathology' as could be derived from the classical formal interpretation; but it did in fact find, through an exquisitely psychoanalytic analysis of contents – which was also put in relation *with the historical and biographical context*[4] – a series of specific features which could very appropriately be connected with the actions for which subjects were under trial: denial of difference between life and death; denial of differences between sexes and between species; devitalisation, affective detachment; splitting, ambiguity, copresence of opposite truths; omnipotence, focal disavowal of reality; masked aggression.

All these features relate to the above mentioned notions of splitting, alexithymia, dissociation, unresolved attachment; as I will discuss in the next paragraph, these may all be viewed in the superordinate dimension of severe *disconnection,* or dissociation. These features may also be found in the biographic information we have about the subjects involved (two examples from Nielsen & Zizolfi, 2005):

Hans Frank, condemned to death at Nuremberg, sent to extermination camps millions of Jews and common Polish citizens as Governor of Poland. In a speech, he stated he 'wished to guarantee justice without prejudice for the interest of force'; he expressed admiration for law, ethics and truth and at the same time for terror and violence; he did nothing to hide the enormous personal profits he derived from his position.

Hermann Goering, condemned to death at Nurnberg, member of the Nazi party since its beginning, was first the head of the SA, then of the SS, then of the Gestapo (which he created). All these organisations were involved in the persecution, torture and killing of political opponents all over Europe. Nominated by Hitler

[3] In the well-known film by Orson Welles *The Stranger*, a single, short sentence is sufficient to the clever investigator in order to identify the suspect as a Nazi criminal: 'Freud was not German, he was a Jew'. The comment of the investigator is 'Only a Nazi could say such a thing'. It is not a question of quantity, but of specificity.

[4] This fundamental aspect is totally disregarded by symptom-based assessment. The relationship with the examiner is also generally disregarded.

as his successor, they were together until the end, and so shared full responsibility for all deeds of the Nazi party. He took hold of immense riches from the occupied countries, including 1300 valuable paintings. Not personally involved in the Shoah, he considered it a question of little interest. On the opposite hand, he contributed greatly to a very enlightened code regulating hunting, aimed at sparing animals any unnecessary suffering. When arrested by the allies as a war criminal, he appeared astonished, defining himself as only a soldier who had done his duty.

Dissociation is also present throughout the description of Adolf Eichmann's personality in the well-known text *Eichmann in Jerusalem*: *A Report on the Banality of Evil* (Arendt, 1963). We encounter the sudden change, with no apparent conflict, from a project of creating a Jewish state in some remote area to a project of extermination; severe deficits of mentalisation, mostly in understanding other people's points of view, and allowing oneself to be influenced by them; detachment from reality; systematic self-deception; severe memory gaps: 'as if that story were recorded *on a different tape* in his memory, and there were no reasoning, argument, fact or idea that could modify that recording'. It may appear surprising that Arendt's text is sometimes quoted in support of the idea that Nazi criminals were more or less normal people, clearly confusing 'banality' or 'small-mindedness' with normality, or sanity.

One thought I wish to anticipate is that subjects who are capable of producing psychiatric symptoms (symptoms in a strict sense, not antisocial/criminal behaviours), which in some way give expression to dissociated areas, may end up being *less 'pathological'*, and above all less dangerous for self and others, than subjects who harbour 'silent' dissociated areas.

Level of connection/disconnection as a fundamental criterion for health assessment

My proposal is therefore to give fundamental importance in assessment to *levels of connection* (integration*)/disconnection* (dissociation). Use of this criterion may allow us to *discover pathology (or health) where symptom based assessment fails miserably,* as in the examples quoted above.

Consideration of levels of connection/disconnection may be considered implicit in most psychoanalytic models of mental functioning, where contact with experience, or with emotion, or with the internal world are considered central.

Bion (1962a, 1962b) describes his theory of thinking as the progressive translation in images (alfa elements) and words of an experience of reality which in the beginning is gross, formless, imbued with physical sensations and with confused emotions (beta elements). This capacity of translation/elaboration is considered at the basis of mental health.

Winnicott, in his well-known paper 'Fear of breakdown' (1974) speaks of psychotic defences, which we may define as dissociative, in order to avoid primitive agonies. These agonies are related to events which *have occurred, but have not been experienced*. The effect is described as a sense of futility, emptiness, or of non-existence. Ogden (2014), in a recent analysis of this paper, defines the effect of psychotic defences as 'unlived life'. The aim of analysis is therefore integration, what Winnicott called 'being alive' in his last lines (Parsons, 2016a; Winnicott, 1989). On preceding occasions (e.g. 2005) Ogden defined the aim of analytic work in helping the patient 'dream undreamt dreams and interrupted cries'.

Bromberg (1998, 2006), starting back from Janet and continuing Sullivan's and Mitchell's perspective, strongly emphasises the *multiple nature of self-states* and the ensuing need for their integration, therefore positing a link between (trauma-originated) dissociation and psychopathology.

Donnel Stern (1989) speaks of 'unformulated experience', which analysis may help in formulating.

Similarly, and in a more general way Wilma Bucci (Bucci, 1997a, 2007; Solano, 2010, 2013), in her Multiple Code Theory, defined health, both mental and physical, as based on *sufficient connections* between a non-symbolic system[5] and symbolic systems (verbal and non-verbal),[6] all defined as inseparably

[5] The Non-verbal Non-symbolic (Subsymbolic) System includes functions we are used to calling bodily functioning, procedural memory, implicit memory and physiological levels of emotion. It may be compared to Freud's primary process, to Matte Blanco's symmetrical and to Bion's beta elements/protomental. It should be stressed, however, that – differently from primary process, and possibly from some aspects of the other concepts as well – subsymbolic processes are not conceived as chaotic, are not oriented toward wish-fulfilment and are not segregated from reality, but are open to the outside world and continue to develop in complexity and scope throughout life. The Non-Symbolic system coordinates motor actions, from the simplest to the most refined, such as driving a car or playing tennis or football, and may therefore be viewed as endowed with a capability for organised thought, albeit non-symbolic and generally non-conscious thought. From the anatomical-physiological perspective, it corresponds to what is commonly called 'body',

comprising 'mental' and somatic aspects, in a unitarian body/mind perspective. Non-symbolic emotion needs to find a representation in images and words, so that it can be consciously felt, elaborated and regulated. Similar concepts are expressed in the construct of *alexithymia* (see Taylor et al., 1997, Taylor & Bagby, 2014; Solano, 2013), derived from that of *pensée opératoire* of the Paris psychosomatic school *(*Marty, M'Uzan, & David, 1963). Multiple Code Theory is more accurate in my view since it introduces (as does Bion) a symbolic non-verbal level (images) and clearly states the dual nature, both somatic and mental, of the systems involved.

Connection among different systems is neither automatic nor innate, but develops in the relationship with caretakers, through functions that were postulated in all relational psychoanalytic theories (reverie in Bion, holding in Winnicott, attunement in Infant Research etc.).

Pathology, both mental and physical, is viewed in the Multiple Code Theory (Bucci, 2007, 2016) as deriving from different levels of disconnection, close to the clinical concept of dissociation: "My claim is that such dissociative processes underlie all emotional disorders, whether or not a specific trauma is identified" (Bucci, 2007, p. 176). Connections may fail to form from the beginning, for traumatic reasons (Winnicott's 'primitive agonies', 1974) or anyhow for a deficit in primary relationships, or be interrupted later, on a conflictual basis (as described in the concepts of attacks on linking in Bion, or inhibition of reflective function in Fonagy). At a physiological level the disconnection may be conceptualised as between amygdala and hippocampus (episodic memory) and between amygdala and cortical areas.

Disconnection leads to memories of traumatic events being impressed only in the non-symbolic system, as widely recognised in neuroscience, albeit using different wordings, such as implicit memories, or body memories (e.g. van der Kolk, 1994; van der Kolk & Fisler, 1995).[7] From these memories non-symbolic arousal may arise in the absence of identification of the object who is or was the source of arousal: a *nameless arousal*, or, if we prefer, an unconscious arousal. Beyond individual history, disconnected non-symbolic arousal may have transgenerational origins (Faimberg, 2005).

Direct emergence of this arousal to consciousness, without the mediation of symbolic systems, may generate panic attacks or other disorders involving 'nameless anxiety', such as *pavor nocturnus*; it may bring about *uncontrolled acting* (such as 'crimes of passion'). A less massive, more chronic emergence, may bring about *somatic disorders*. Adaptive solutions are also possible, where non-symbolic arousal – though finding no connection with the original meaning – supplies the motivational drive for artistic expression, for commitment to a cause or to a relevant job, for mature religion (an analogy with the Freudian concept of sublimation could be suggested).

Efforts on the part of the subject *to find a* (spurious) *meaning* to arousal[8] will give origin to different *mental disorders*: attribution of arousal to an external persecutor will give rise to paranoid disorders; attribution to a somatic disease, to hypochondria; to an inanimate external object, to phobias; to subject's guilt, to depression, etc.

Efforts on the part of the subject to *sedate arousal* may give rise to:

- identification with the author of the trauma which was responsible for the disconnection, assuming the identity of a terrorist, warmonger, serial killer, ideologist and/or wilful agent of criminal governments. In Nielsen's (2004) description of the Nazi mind we find many elements which may be ascribed to disconnection: detachment from one's affective experience and more authentic self (Winnicott, 1960); a 'soul-less' life style; a lifeless language (alexithymia); an ambiguous

---

including brain areas linked to non-symbolic aspects of emotion, such as the amygdala, the autonomic nervous system and areas involved in mimicry and involuntary movements.

[6] The *Non-verbal Symbolic System* appears to be rather similar to Bion's alpha function since it generates or processes images, generally visual, which can be directly assembled in dreams or connected to verbal, symbolic representations. It may also be likened to the 'oneiric thought of wakefulness' as described by Antonino Ferro (2002) along Bionian lines, and to 'thought in images' as introduced by Botella and Botella (2001). Its anatomic-physiologic counterparts are the hippocampus and cortical visual areas. The *Verbal Symbolic System* includes verbal thought and language; it functions more or less according to the rules described by Freud as pertaining to the secondary process. It allows reflection on one's experience, identification and regulation of emotion experienced at other levels. It is based on superior cortical areas.

[7] The distinction of the organism in different systems proposed by Bucci affords a possible solution to a contradiction that may be noticed in Winnicott's Fear of Breakdown: how can an event which 'was not experienced' be recorded in memory? The contradiction may be solved if we admit that the event was recorded only in the subsymbolic system (which includes implicit memories), while 'psychotic defences' block the access to symbolic systems (episodic memories).

[8] The notion of a relentless quest for meaning inherent to non-symbolic arousal resonates with other psychoanalytic formulations: Freud (1926) speaks of 'ego's inclination to synthesis'; Roussillon (2015) of 'a compulsion to integrate'.

personality (Bléger, 1967); disavowal not of reality but of its meaning (= disconnection from symbolic systems).
- substance abuse, gambling, sexual promiscuity, disordered eating behaviours, paraphilias, addictive use of work (workaholics) or of physical activity.

Efforts on the part of the subject to *avoid arousal* may lead to:

- generalised avoidance of any experience entailing a risk of arousal: this implies renouncing any personal achievement, either totally (no job, no couple, no children) or partially (low commitment in work, passionless couple relationships, low interest in children). The concept is strongly remindful of that of *vie opératoire* (Smadja, 2001), a conceptual enlargement of the former *pensée opératoire* of the French school; of 'unlived life' as defined by Ogden (2014) following Winnicott (1974); of descriptions by Bollas (1987) of normotic and by Mc Dougall (1989) of normopathic individuals. Recognition of this defensive modality as one of the most maladaptive, while giving rise to no "positive" symptoms, is a very *firm basis for invalidating a psychiatric evaluation of mental health exclusively based on the presence/absence of the latter.*

As outlined above, non-symbolic arousal which finds neither a connection – either adequate or spurious – nor a form of sedation, nor an adaptive solution, may cause *somatic disorders* which will be proportional in severity to the degree of disconnection and of non-symbolic arousal. I wish to emphasise, however, that this form of expression *may be extremely valuable* (at least when the disorder does not appear fatal from the beginning) when compared to a total lack of expression. A somatic symptom may have the role of a *non-symbolic first communication* of an item of content which until then had not found any possibility of expression, a *first attempt at connection*, which may also bring help seeking from the outside (Bucci, 1997b). An adaptive and progressive value of somatic symptoms was also advocated by Winnicott (1949) and Smadja (2001) in the sense of an opening, of a search for meaning, of a search for internal and external connections. I have more extensively considered this aspect elsewhere (Solano, 2010).

In this framework one of the most maladaptive and most dangerous situations is when non-symbolic arousal finds no way of expression, not even on a somatic level: in these conditions an explosion may take the form of a *sudden and fatal somatic disease or of a sudden, uncontrolled, acting*, to the point of violent gestures against self and/or others, which appear unexpected and incomprehensible ('He was such a nice guy….'). It is well known that most gestures of this kind are perpetrated by people who had never had any contact with mental health professionals. A recent paper, with the evocative title 'Do bodies need to talk?' (Kotowicz, 2013) presented the case of a woman with a 'frozen body' who had never produced in her life any kind of somatic symptom or illness, not even a cold or flu: until her sudden, 'inexplicable' suicide.

The most unfavourable situation, in the presence of dissociated non-symbolic arousal, appears therefore *a total absence of symptoms*, since this implies either the definite sacrifice of life in order to avoid arousal, or a totally unstable balance with the constant risk of violent explosion. *Symptoms, either psychic or somatic*, appear on the contrary not as the essence of pathology but as *safety valves, alarm signals*, possibilities to communicate a condition of distress to oneself and to others. A clinical example will be given in the next paragraph.

Inclusion of bodily health in a global assessment

The possibility of non-symbolic arousal finding expression in somatic disorders entails that *phenomena taking place on a somatic level should be given a place in a global assessment,* and given sense in the context of the individual's past and/or present relational and life cycle situation. We may recognise that division of health between 'mental' and 'somatic' is an artefact which was introduced by positivist medicine in the second half of the nineteenth century. On the psychiatric side, the new DSM-5 has eliminated any reference to a psychosocial origin of somatic disorders, which was contained in (albeit controversial) terms such as 'Somatization disorders' or 'Somatoform disorders' of the preceding edition. We are left only with 'Somatic Symptom Disorder', referring essentially to mental distress deriving from somatic symptoms.

Disregard of psychosocial, relational contributions to somatic disease (and, of course, vice versa) brings great flaws to assessment and treatment. In an emblematic situation I reported elsewhere (Solano, 2013), a physician in charge of a patient who had gone through *fourteen episodes of acute pancreatitis* in the last three years, far from thinking that this man might benefit from psychological help, sent me the man's wife for anxiety problems. The notion that existential distress may subsume even severe somatic illness appears difficult to accept.

If, on the contrary, we coherently follow a unitary body-mind position (see e.g. De Toffoli, 2011, 2014), we should *assign somatic disorders* (both functional and organic) *an importance as signals of distress equal to that of psychic symptoms* (keeping in mind that a somatic signal is more remote from consciousness and therefore is witness to a lower level of connection, of contact with oneself). We should therefore include somatic disorders in a global, psychosomatic assessment. As described in the preceding paragraph, somatic symptoms may be viewed as witness to disconnection and, at the same time, as *efforts towards reconnection*, 'drawing the psyche from the mind back to the original intimate association with the soma' (Winnicott, 1949).
To illustrate this aspect I shall now present a clinical case which was seen in an experience of joint cooperation between family physicians and health psychologists which I have been supervising for more than 15 years (see e.g. Cordella et al., 2016; Solano, 2011, 2014). The report is by psychologist Dr. Pamela Strafella.

Ginevra is 15 and has two younger siblings. The physician informed me that she is having difficulties in school since 'she is shy; hair loss is also present. For these reasons, a specific meeting with me was organised.
Ginevra reports that a couple of months ago she rapidly lost her hair in an area of some square centimeters on the scalp and that a dermatologist of a well-known specialist centre formulated a diagnosis of alopecia, telling her 'it's your fault because you get stressed'[9] .
I try to modify this position, asking Ginevra to talk about her life situation, with the hypothesis that in this context (and not in her mind) 'stressful' elements might be present.
For two years, her father has worked in Salerno, a town around 300 km from Rome. He comes home on the weekend, but his relationship with the family, including Ginevra herself, is always more distant, disconnected, stereotyped; Ginevra feels she is not being understood, not being 'seen' by her father. While saying this she starts crying, but she immediately stops and apologises to me. Asked about the apology, she answers 'I don't like showing my weaknesses, and I don't want others worrying for me'.
The psychologist suggests the notion that if she does not express her emotions in words, and possibly communicates them to others, they may take the route of her body, causing disorders; on the other hand, losing her hair is a way her body has found to express some of the distress she feels.
A series of meetings are scheduled to continue the discussions about her situation. In the first one, Ginevra begins by saying she feels somewhat more relaxed; she is glad to come to these meetings since 'it has been a long time since I found someone listening to me'. She tells me that, since her father is absent during the work days, her mother is using her for support. Gradually, we discover that mentions of 'support' are euphemistic: in fact, the mother is flooding Ginevra with anxieties and conflicts involving her marital life, in a dimension of role-reversal, whereupon Ginevra acts as a container for her mother and cannot rely on her to contain her own problems, in a delicate phase of her life. A containment which she appears to have found in our meetings.
In the second of these meetings, in fact, she explains more specifically that, around the time of the onset of alopecia, her mother had discovered the presence of a woman in her husband's house in Salerno at 11pm, due to his failure to hang up the telephone correctly after a phone call with the family. The mother had immediately called Ginevra, who, in her protective role, had gone to listen to the phone, in order to spare her mother the suffering. 'She is a lonely woman, it is up to me, being the oldest daughter, to take care of her'. Following this episode, Ginevra had been involved in long hours of agonising discussions with her mother about what to do at this point (Divorce? Discuss? Forgive?).
Finding words for her situation allows Ginevra – in the following meetings - to become aware of the akwardness of her position with her mother: through accepting a certain amount of distress and even of jealousy - when mother, more appropriately, seeks help with some friends – she progressively manages to disengage herself and to focus her interest on age-related objects. Participation in a study holiday organised by her school helps her remarkably. Ginevra finds pleasure in exploring new areas of interest and new friendships, and in an increased competence in coming into contact with her feelings and needs, now that they have received recognition and validation. Mother and siblings now complain she is never at home. Her hair is growing back.

[9] It is obviously possible that the dermatologist did not use these very words. What remains undeniable is that this is Ginevra's feeling, and that when a health operator uses a psychosomatic model whereupon a content in the mind is manifested by the body, induction of guilt in a patient is a very frequent possibility. The model proposed in the preceding paragraph posits instead that somatic disorders may ensue when dissociated non-symbolic arousal (bodily activation) finds little or no connection with symbolic (mental) systems.

This case illustrates how a physical symptom, a non-symbolic arousal, may constitute an alarm signal, a movement towards development, in respect of a very unsatisfactory life situation, whereby a young girl was enmeshed in a symbiotic relationship with her mother, with little engagement with age-appropriate objects and activities.
An important notation is how this developmental value may be expressed *only when this symptom finds an adequate container* in meetings with the psychologist. A container which was certainly not found in the dermatologist's guilt-inducing explanations.

Empirical Evidence supporting the importance of connection/disconnection between systems for health

The most solid empirical evidence in this regard may be found in the literature on alexithymia (for a review see Taylor et al., 1997; Solano, 2013; Luminet, Bagby, & Taylor, 2018). This was initially defined as a difficulty in finding words for emotions (Nemiah, Freyberger, &Sifneos, 1976), then as a disconnection between physiological/behavioural and cognitive/experiential components of emotion (Taylor, 1994), and more recently, using Wilma Bucci's theory, as a dissociation between the subsymbolic representations of sensory experiences and patterns of autonomic arousal and symbolic images and words (Taylor, 2004, 2013).
Several investigations throughout the world have shown high levels of alexithymia associated with:

- different forms of *somatic pathology*, such as rheumatoid arthritis, diabetes, coronary pathology, inflammatory bowel diseases;
- a series of pathological behaviours where emotions which are not adequately regulated, processed, mentalised (being disconnected from symbolic levels) are expressed, or in other instances sedated, through *acting*: substance abuse, eating disorders; obesity, promiscuous and unsafe sexual behaviour, gambling;
- clinical situations where 'nameless anxiety' (non-symbolic arousal) *emerges as such,* as in panic attacks, or when anxiety, though somehow recognised in its origin, cannot be *adequately regulated*, as in PTSD.

All these studies suffer the flaw of being cross-sectional, and are therefore prone to the objection that alexithymia could be (perhaps defensively) induced by awareness of the disorder, rather than being at the root of the disorder itself. An answer to this kind of objection may be found in *prospective and semi-prospective studies*, where alexithymia is assessed in healthy (prospective) or disorder-unaware (semi-prospective) populations.
Mortality from all causes (Kauhanen, Kaplan, Cohen, Julkunen, & Salonen, 1996) or of cardiovascular origin (Tolmunen, Lehto, Heliste, Kurl, & Kauhanen, 2010) was found significantly increased in individuals with higher baseline alexithymia levels.
Tumour onset: Higher alexithymia levels predicted a final diagnosis of uterine (Todarello et al., 1997) or of breast cancer (Epifanio, Parello, & Sarno, 2005).
Atherosclerosis: Higher alexithymia levels were associated with a higher probability of presence of atherosclerotic plaques in the carotid artery, of which subjects were unaware (Grabe et al., 2010).
Sperm count: Alexithymia levels appeared negatively correlated with sperm count (De Gennaro et al., 2003; Morelli et al., 2000).

Self-fulfilment and development of functions as fundamental facets of integration, and therefore of health

Both these dimensions are linked with integration, with contact with oneself, one's basic emotions, needs and memories, all of which were described above as deriving from the connection between non-symbolic and symbolic systems; both these dimensions find no room in a diagnostic evaluation based on the presence/absence of 'positive' symptoms. I introduce a clinical example to show what kinds of paradox may be induced by such scotomisation.

'The son we'd all like to have'

The case is drawn from the same experience of joint cooperation between family physicians and health psychologists that was quoted earlier. In this context it is possible to witness in real time the difference

between a biomedical model, essentially based on the presence/absence of symptoms, and a psychological model which also or mainly considers the level of self-fulfilment and of development of functions. The case is reported in the first person by the psychologist, Dr. Barbara Coci (Solano, 2011):

It is my first day in the experience. Before the patient enters, the physician described him to me as 'The son we'd all like to have'. She also told me that *he is part of a very united family,* the three of them (he has no siblings) always come to visit together.
Federico is a 27-year-old boy, who comes to visit together with his mother and father. As a first thing, mother gives a report of her health problems in front of everybody, including very intimate problems: she starts from the thyroid to descend to her breasts and finally to her genitals.
She then continues with her son's health problems, while he has no possibility of uttering a word. She speaks of an 'abdominal tension', possibly an irritable colon syndrome. She attributes his symptoms to 'milk intolerance' (as if she were speaking of a baby).
While the physician examines Federico, mother talks more about him: he reads Sociology at university, and is really a nice boy, he studies all day, *he is always at home except for university activities, and never had a girlfriend.*
During all the encounter father does not say one word.
Once the family has left I tell the physician I am quite worried about the symbiotic dimension, the blurring of boundaries, which are present in this family, and I suggest that Federico presents with a deficit in maturation and individuation, a lack of involvement in activities pertaining to his developmental stage, which could be the precursors of possibly severe disorders.
The physician is astonished.

This encounter, which appears so dramatic to the psychologist, does not modify at first the physician's opinion about the 'united family' and the 'son we'd all like to have'. Family dynamics find no place in the DSM, nor do they find much room in psychiatric conferences mainly dedicated to the 'treatment' of some specific 'pathology'. The absence of complaints, tears, cries, other expressions of anxiety, a mask of great family harmony, all hinder the possibility that the physician might think of the possible presence of some problem deserving attention on his part, or on the part of a mental health specialist. It is true that the DSM-5 includes a Schizoid Personality Disorder and an Avoidant Personality Disorder, but it is not easy to envisage this possibility when Federico's behaviours are not brought as a problem. A thought of pathology is possible only inside *a model considering the extent of self-fulfilment as a basic criterion*.

Three months later, the father and mother are back in the physician's office. Federico is mentally absent, he now does not leave home for any reason. He is no longer studying, but spends most of his time on websites relating to science fiction. The parents let on that Federico possibly at times believes he is a character of this fiction. At this point, we can only advise the family to seek help from the Mental Health Services.

We may speculate that a model of assessment based on self-fulfilment and development of functions might have enabled the physician to understand that something was not going right ten or so years before. In the course of his experience with our group this physician became one of the keenest supporters of the presence of psychologists in primary health care.

Development of functions as an assessment criterion and as a primary aim of psychoanalytic treatment

The importance of an individual's functions as an assessment criterion and as an aim of clinical intervention is implicit in a series of post Freudian psychoanalytic theories, such as Bion's (development of alfa function and of the apparatus for thinking thoughts), Winnicott's (capacity for integration, for maintaining a potential space, for concern, for being alone), Ego Psychology (ego functions), Kohut's (capacity of utilising self-objects). Developmental clinical psychology has always been focused on this topic (see below, PDM).
Only recently, however, development of functions has explicitly been given a central position in psychoanalysis.[10] My list is of course personal and non-exhaustive.

[10] It is probably not casual that, parallel to interest in the development of functions, the importance of parental *neglect* has been brought to the fore; in more than one study this dimension proved harmful to the offspring more than abuse defined in a strict sense (Clarkin, Fonagy, Levy, & Bateman, 2015; Music, 2011). It is possible that neglect, even more than abuse, is specifically noxious in respect to the development of functions.

Renzo Carli (1987), on Bion's trace, indicated *growth of a capacity for thinking* as the main aim of psychoanalytic treatment, rather than the achievement of pre-definite developmental stages, such as genitality or depressive position.
Peter Fonagy and Mary Target (Fonagy, 1991; Fonagy & Target, 1998) highlighted the acquisition of a capacity for *mentalization* or reflective function as one of the most important developmental steps, its lack as a fundamental ingredient of psychopathology, its implementation as one of the main aims of treatment.
Gabbard and Westen (2003) in a review on therapeutic action, give wide space among the aims of psychoanalysis to the development of functions, ranging from self-reflection to affect tolerance and regulation, to self-soothing.
Antonino Ferro on several occasions (e.g. 2006) maintained that the analyst's task, especially in more complex situations, is to perform mental operations which patients are incapable of performing on their own, until this capacity is gradually interiorised by the patient. These operations may be synthesised by the terms *feeling, thinking, dreaming.*
Irene Ruggiero, in a recent panel presentation (2014) proposed a view of *adolescence as a function*, the aim of which is to insert and organise new experiences into pre-existing models of self and relationships, so allowing 'open and potentially creative attitudes – such as curiosity, doubt and surprise – to prevail on repetition and defensive rigidity'. This function needs to be activated first of all in the period we traditionally define as adolescence, in order to integrate puberal developments in the pre-existing self-representation, with ensuing relational modifications. It remains necessary, possibly essential, in order to deal with challenges linked to moments of the life cycle: involvement in work, in a couple relationship, birth of children, divorce (in some cases), menopause, retirement. Progressive development of this function becomes an aim of the psychoanalytic process.
Basilio Bonfiglio, in a presentation at the same panel (2014) drew attention as a basic function to the capacity of *connecting* 'basic sensory and emotional levels' with verbal and non-verbal representations, as a tool for reaching full *subjectivation*.
Michael Parsons, in a recent paper (2016b), put subjectivation, again viewed as full contact with all parts of the self, at the basis of an authentic 'inner authority'. He stressed how this position may only be acquired through 'a relationship with someone who values the spontaneity and inviduality of the growing child'; or of the patient, in analysis.
It can be claimed that all these theories, explicitly or implicitly, posit *connection between systems of the individual* (whatever name these may be given) *as the basis for the development of functions*.

Examples (by no means exhaustive) of diagnostic classification based on the development of functions

a) *Psychodiagnostic Psychodynamic Manual, PDM-2* (Lingiardi & Mc Williams, 2017), published as a joint effort of several North-American and other psychoanalytic associations. This manual, differently from the DSM, considers symptoms as an accessory aspect of personality disorders (P axis), and above all introduces an M axis, meaning profile of mental functioning. The latter includes an evaluation of different functions, such as capacity for regulation, attention and learning; capacity for relationships and intimacy; capacity of experiencing, expressing and communicating affects. Last but not least, in the assessment of children and adolescents *the M axis is defined as a priority* over the P axis. It could be suggested that the same criterion, or at least an equivalence in importance, could be extended to adults as well.
At any rate this manual, based on empirical research rather than on agreement among 'experts', is a total change when compared to DSM and would deserve greater diffusion among psychoanalysts and psychodinamically oriented clinicians.
b) *Handbook of Psychodynamic Approaches to Psychopathology*, edited by some of the most well-known research-oriented psychoanalysts (Luyten, Mayes, Fonagy, Target, & Blatt, 2015). Besides the undeniable merit of utilising only 11 diagnostic categories (instead of the hundreds contained in the DSM), it assigns remarkable importance to the development of different functions such as mentalization, affect regulation, quality of attachment, attention control.

Towards a view of pathology, or rather of health based on levels of integration and self-fulfilment

Elaboration of a new diagnostic system would be the task for a group, not a single individual, and possibly need a volume to be contained in. In the classification that follows, I only wish to outline the possible

consequences for assessment of the use of level of integration as a basic criterion, in substitution for the presence/absence of symptoms. Level of integration, as described above, is assumed to be also the foundation of many other functions, and to be the basis for self-fulfilment. Psychic and physical health are considered together. Of course it may not be easy to place all possible situations in one of the levels proposed, while intermediate situations may be present.

Level 1 *(Minimal Health)* = maximal disconnection of the Non-symbolic from Symbolic systems. The effort to avoid the emergence of (massive and violent) non-symbolic disconnected arousal may give rise to:

- Generalised avoidance of any experience which might activate dissociated contents (*Vie opératoire*, Smadja, 2001; *Unlived life*, Ogden, 2014);
- Severe dissociative disorders with a prevalence of negative or catatonic symptoms.

No 'positive' symptom is present. Except possibly in the case of schizophrenia, which implies deterioration, the *risk of a sudden, massive emergence of non-symbolic arousal is constantly present*: suicide; murder either 'passionate' or 'senseless' (serial killers); sudden appearance of fatal somatic diseases without any anticipation. A more gradual emergence may lead to adhesion to terrorist organisations or extreme political groups. In any case finding satisfaction in life, relationships and work appears impossible (minimal self-fulfilment).

Level 2 = Disconnected non-symbolic arousal may find expression mainly through:

- somatic pathologies, not immediately lethal;
- thoughtless acting, though non-murderous: drug or alcohol dependence, excessive food intake, eating disorders, sexual promiscuity, gambling, self-injuring.

Level 3 = Possibility of expressing disconnected non-symbolic arousal through different psychic symptoms, which may be viewed as a form of spurious symbolisation. We might include functional somatic disorders (including conversion symptoms) in this level. Distress may be more easily recognised both by the subject and by others, and a help request more easily activated. Final fate of the problem (and of the individual) is highly dependent on the *social response* to this modality of expression, in terms of stigma and of appropriateness and adequate timing of intervention. Self-fulfilment may be high, and coexist with various levels of even severe psychiatric pathology: some names that come to my mind are Giacomo Leopardi, Vincent Van Gogh, Virginia Woolf, John F. Nash [11].

Level 4 = Possibility of utilising non-symbolic arousal (though remaining disconnected from the original meaning) as a *motivational drive* to artistic expression, commitment to a cause or to a relevant job, mature religion.

Level 5 (*Optimal health*) = full contact with non-symbolic (emotional) arousal, maximal self-fulfilment.
The presence of this condition is more of an ideal of sanity: in actual reality, in some moments of life, event-related Non-Symbolic arousal overcomes our capacity for connection (or for mentalization, or the capacity of our alpha function), and we will develop psychic or somatic symptoms or acting.

Level of connection/disconnection may be assessed clinically and/or with instruments such as those quoted in the initial paragraphs (Attachment Interview, Interview for Alexithymia, Scale for Dissociative Experiences). We may also assess what I have here considered as direct derivatives of this capacity, such as reflection, affect regulation, dreaming; or related dimensions, such as self-fulfilment and development of functions.

Conclusions

This paper proposes in fact no substantial modification of what psychoanalytically inspired psychology conveyed to us in the last century or so. It tries to state clearly, and with firm belief, what many psychologists already are and do: in the field of assessment, utilising our instruments, and not those of

[11] I am not at all suggesting that psychiatric pathology is a prerequisite for creativity: several artists and scientists are not known for their psychopathology, and might approximate Level 5 in this classification: for instance Dante Alighieri, William Shakespeare, Johann Sebastian Bach, Andrea Camilleri.

academic, neo-kraepelinian psychiatry; in the field of treatment, defining our work as aimed not at elimination of symptoms (which we well know are alarm signals and not the problem) but at promoting the development of functions, in particular a capacity of connection between parts of the self, in whatever way we prefer to call these parts, and in whatever way we prefer to call this promotion: awakening the dreamer, developing alfa function, connecting basic sensory and emotional levels with verbal and non-verbal representations, and many others.
Last but not least, I believe that highlighting this aspect in our public image may favour social acceptance of psychoanalysis and of clinical psychology in general much more than a definition of our work mainly as a treatment of more and more severe forms of psychic distress (or worse, of 'mental illness'). A treatment which most people may recognise as highly useful – for someone else.

References

Arendt, H. (1963). *Eichmann in Jerusalem: a report on the banality of evil*. New York, NY, US: Viking Press.

Bagby, R.M., Taylor, G.J., Parker, J.D.A., & Dickens, S.E. (2006). The development of Toronto Structured Interview for Alexithymia: item selection, factor structure, reliability and concurrent validity. *Psychotherapy and Psychosomatics, 75*, 25-39. doi:10.1159/000089224

Beebe Tarantelli, C. (2010). The Italian Red Brigades and the structure and dynamics of terrorist groups. *International Journal of Psychoanalysis, 91*, 541-560. doi:10.1111/j.1745-8315.2010.00264.x

Bernstein, E. & Putnam, F.W. (1986). Development, Reliability, and Validity of a Dissociation Scale. *Journal of Nervous and Mental Disease, 174*, 727-735. doi:10.1097/00005053-198612000-00004

Bion, W.R. (1961). *Experiences in groups and other papers*. London, UK: Tavistock.

Bion, W.R. (1962a). A theory of thinking. *International Journal of Psychoanalysis, 43*, 306-310.

Bion, W.R. (1962b). *Learning from experience*. London, UK: Heinemann.

Bléger, J. (1967). *Simbiosis y ambiguedad, Estudio Psicoanalítico* [*Symbiosis and ambiguity, a psychoanalytic study*]. Buenos Aires, AR: Paidos.

Bollas, C. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known.* London, UK: Free Association Books.

Bonfiglio, B. (2014, May 22-25). *Divenire Soggetti. Panel: Configurazioni della mente nella teoria e nella tecnica* [*Becoming a subject. Panel: Configurations of the mind in theory and technique*]. Paper presented at the 17th National Conference of the Italian Psychoanalytic Society, Milan, Italy.

Bornstein, R.F. (2005). Reconnecting psychoanalysis to mainstream psychology: challenges and opportunities. *Psychoanalytic Psychology, 22,* 323-340. doi:10.1037/0736-9735.22.3.323

Borofsky, G.L., & Brand, D.J. (1980). Personality organization and psychological functioning of the Nuremberg war criminals: The Rorschach data. In J. Dimsdale (Ed.), *Survivors, victims and perpetrators: Essays on the Nazi holocaust* (pp. 359-403). New York, NY, US: Hemisphere.

Botella, C., & Botella, S. (2001). *La Figurabilité psychique* [*Psychic Figurability*]. Paris/Neuchâtel, FR: Delachaux & Niestlé.

Bromberg, P.M. (1998). *Standing in the spaces*. Hillsdale, NJ, US: The Analytic Press.

Bromberg, P.M. (2006). *Awakening the Dreamer*. Mawhwah, NJ, US: Analytic Press.

Bucci, W. (1997a). *Psychoanalysis and Cognitive Science*. *A Multiple Code Theory.* New York, NY, US: Guilford Press.

Bucci, W. (1997b). Symptoms and symbols: A multiple code theory of somatization. *Psychoanalytic Inquiry, 17*, 151-172. doi:10.1080/07351699709534117

Bucci, W. (2007). Dissociation from the perspective of multiple code theory, Part I: Psychological roots and implications for the psychoanalytic treatment. *Contemporary Psychoanalysis, 43*, 165-184. doi:10.1080/00107530.2007.10745903

Bucci, W. S. (2016). Divide and multiply: A multi-dimensional view of dissociative processes. In E. F. Howell & S. Itzkowitz (Eds.), *Relational perspectives book series. The dissociative mind in psychoanalysis: Understanding and working with trauma* (pp. 187-199). New York, NY, US: Routledge/Taylor & Francis Group.

Carli, R. (1987). *Psicologia clinica. Introduzione alla teoria ed alla tecnica* [Clinical Psychology. Introduction to the theory and technique]. Torino, IT: UTET.

Clarkin, J. F., Fonagy, P., Levy, K. N., & Bateman, A. (2015). Borderline personality disorder. In P. Luyten, L. C. Mayes, P. Fonagy, M. Target, & S. J. Blatt (Eds.), *Handbook of psychodynamic approaches to psychopathology* (pp. 353-380). New York, NY, US: The Guilford Press.

Cordella, B., Greco, F., Di Trani, M., Renzi, A., La Corte, C., & Solano, L. (2016). The Impact of Joint Consultation With Family Physicians on Perception of Psychologists. *Professional Psychology: Research and Practice, 47*, 102-109. doi:10.1037/pro0000064

De Gennaro, L., Balistreri, S., Lenzi, A., Lombardo, F., Ferrara, M., & Gandini, L. (2003). Psychosocial factors discriminate oligozoospermic from normozoospermic men. *Fertility and Sterility, 79*, 1571-1576. doi:10.1016/S0015-0282(03)00374-1

De Toffoli, C. (2011). The living body in the psychoanalytic experience. *Psychoanalytic Quarterly, 80*, 595-618. doi:10.1002/j.2167-4086.2011.tb00098.x

De Toffoli, C. (2014). *Transiti Corpo-Mente* [*Body – Mind Transitions*] Milano, IT: Franco Angeli.

Epifanio, M., Parello, M., & Sarno, L. (2005). Cancro e disregolazione affettiva: Uno studio empirico su un gruppo di donne affette da neoplasia mammaria [Cancer and affective dysregulation: An empirical study on a group of women with breast cancer]. In V. Caretti & D. La Barbera (Eds.), *Alessitimia, valutazione e trattamento* [*Alexithymia, assessment and treatment*] (pp. 143-174). Roma, IT: Astrolabio.

Faimberg, H. (2005). *The Telescoping of Generations: listening to the narcissistic links between generations*. London and New York: Routledge. doi:10.4324/9780203086988

Ferro, A. (2002). *Fattori di malattia, fattori guarigione* [*Seeds of illness, seeds of recovery*]. Milano, IT: Cortina.

Ferro, A. (2006). Clinical implication of Bion's thought. *International Journal of Psychoanalysis, 87*, 989-1003. doi:10.1516/8TG7-F1WU-RLG7-QUV1

Fonagy, P. (1991). Thinking about Thinking: Some Clinical and Theoretical Considerations in the Treatment of a Borderline Patient. *International Journal of Psychoanalysis, 72*, 639-656.

Fonagy, P., & Target, M. (1998). Mentalization and the Changing Aims of Child Psychoanalysis. *Psychoanalytic Dialogues, 8*, 87-114. doi:10.1080/10481889809539235

Freud S. (1927a). Concluding Remarks on the Question of Lay Analysis. *International Journal of Psycho-Analysis*, *8*, 392-401.

Freud, S. (1921). Group psychology and the analysis of the ego. In J. Strachey (Ed. & Trans.), *Standard edition of the complete psychological works of Sigmund Freud, XIIX* (pp. 69-143). London, UK: Hogarth Press.

Freud, S. (1926). Inhibitions, symptoms and anxiety. In J. Strachey (Ed. & Trans.), *Standard edition of the complete psychological works of Sigmund Freud, XX* (pp. 77-172). London, UK: Hogarth Press.

Freud, S. (1927). Fetishism. In J. Strachey (Ed. & Trans.), *Standard edition of the complete psychological works of Sigmund Freud, XXI* (pp. 147-157). London, UK: Hogarth Press.

Gabbard, G.O., & Westen D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis, 84*, 823-41. doi:10.1516/N4T0-4D5G-NNPL-H7NL

George, C., Kaplan, N., & Main, M. (1996). *Adult Attachment Interview Protocol*. Unpublished Manuscript (3rd ed.). Unpublished manuscript, University of California, Berkeley.

Grabe, H.J., Schwahn, C., Barnow, S., Spitzerd, C., John, U., Harald, J., … Völzkeb, H. (2010). Alexithymia, hypertension, and subclinical atherosclerosis in the general population. *Journal of Psychosomatic Research, 68*, 139-147. doi:10.1016/j.jpsychores.2009.07.015

Kauhanen, J., Kaplan, G.A., Cohen, R.D., Julkunen, J., & Salonen J.T. (1996), Alexithymia and risk of death in middle-aged men, *Journal of Psychosomatic Research*, *41*, 541-549. doi:10.1016/S0022-3999(96)00226-7

Kotowicz, Z. (2013, September 12-14). *Do bodies need to talk?* Paper presented at the 22nd World Congress in Psychosomatic Medicine, Lisboa, Portugal.

Lingiardi, V., & Del Corno, F. (2008). *Manuale Diagnostico Psicodinamico* [*Psychodynamic Diagnostic Manual*]. Milano: Raffaello Cortina.

Lingiardi, V., & Mc Williams, N. (Eds.) (2017). *Psychodynamic Diagnostic Manual*, *second edition*, *PDM-2*. New York, NY, US: The Guilford Press.

Lingiardi, V., & Ponsi, M. (2013). L'utilità della ricerca empirica per la psicoanalisi [The usefulness of empirical research for psychoanalysis]. *Rivista di Psicoanalisi*, *59*, 885-912.

Luminet, O., Bagby, R.M., & Taylor, G.J. (Eds.) (2018). *Alexithymia: Advances in Research, Theory, and Clinical Practice*. Cambridge, UK: Cambridge University Press. doi:10.1017/9781108241595

Luyten, P., Mayes, L.C., Fonagy, P., Target, M., & Blatt, S.J. (2015) (Eds.). *Handbook of Psychodynamic Approaches to Psychopathology*. New York & London: The Guilford Press.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Westport, CT, US: Ablex Publishing.

Marty, P., de M'Uzan, M., & David, C. (1963). *L'investigation psychosomatique* [*Psychosomatic investigation*]. Paris, FR: Presses Universitaires de France.

Mc Dougall, J. (1989). *Theatres of the body: A psychoanalytic approach to psychosomatic illness*. London, UK: Free Association Books.

Morelli, G., De Gennaro, L., Ferrara, M., Dondero, F., Lenzi, A., Lombardo, F., & Gandini L. (2000). Psychosocial factors and male seminal parameters. *Biological Psychology*, *53*, 1-11. doi:10.1016/S0301-0511(00)00041-7

Music, G. (2011). *Nurturing Natures. Attachment and children's emotional, sociocultural and brain development*. Hove and New York: Psychology Press. doi:10.4324/9780203843468

Nemiah, J.C., Freyberger, H., & Sifneos, P.E. (1976). Alexithymia: A view of the psychosomatic process. In O. W. Hill (Ed.), *Modern trends in psychosomatic medicine* (Vol. 3, pp. 430-439). London, UK: Butterworths.

Nielsen, N.P. (2004). *L'universo mentale "nazista"* [*The "Nazi" mental universe*]. Milano, IT: Franco Angeli.

Nielsen, N.P., & Zizolfi, S. (2005). *Rorschach a Norimberga: i gerarchi nazisti a processo fra memoria storica e riflessione psicoanalitica* [*Rorschach in Nuremberg: Nazi leaders on trial between historical memory and psychoanalytic reflection*]. Milano, IT: Franco Angeli.

Ogden, T.H. (2005). *This art of psychoanalysis. Dreaming undreamt dreams and Interrrupted Cries.* London, UK: Routledge. doi:10.1516/0020757041557575

Ogden, T.H. (2014). Fear of breakdown and the unlived life. *International Journal of Psychoanalysis, 95*, 205-223.doi:10.1111/1745-8315.12148

Parsons, M. (2016a, January 30-31). *Winnicott on being alive*. Paper presented at the meeting *Donald Winnicott e la Psicoanalisi del Futuro*, Rome, Italy.

Parsons, M. (2016b, March 17-20). *Authors of our own authority*. Paper presented at the 29th Annual Conference of the European Psychoanalytic Federation, Berlin, Germany.

Roussillon, R. (2015, February 14-15). *Foundations and Processes in the psychoanalytic encounter.* Paper presented at the Conference La Relazione Analitica, Bologna, Italy.

Ruggiero, I. (2014, May 22-25). *I vari tempi della soggettivazione. Panel: Configurazioni della mente nella teoria e nella tecnica* [*Different moments of subjectivation. Panel: Configurations of the mind in theory and technique*]. Paper presented at the 17th National Conference of the Italian Psychoanalytic Society, All'origine dell'esperienza psichica, divenire soggetti, Milano, Italy.

Silke, A. (2003). The psychology of suicidal terrorism. In A Silke (Ed.). *Terrorists, victims and society: Psychological perspectives on terrorism and its consequences* (pp. 93-108). London, UK: Wiley. doi:10.1002/9780470713600.ch5

Simenon, G. (1953). *Maigret a peur*. Paris, FR: Presses de la cité.

Smadja, C. (2001). *La vie opératoire: Etudes Psychoanalytiques* [*Operative life: Psychoanalytic Studies*]. Paris, FR: PUF.

Solano, L. (2005). Psicoanalisi e ricerca empirica nell'ambito della salute [Psychoanalysis and empirical health-related research]. *Rivista di Psicoanalisi*, *51*, 695-720.

Solano, L. (2010). Some thoughts between body and mind in the light of Wilma Bucci's Multiple Code Theory. *International Journal of Psychoanalysis*, *91*, 1445-1464. doi:10.1111/j.1745-8315.2010.00359.x

Solano, L. (2013). *Tra Mente e Corpo: Come si costruisce la Salute* [*Between mind and body: How health is built*] (New edition). Milano, IT: Raffaello Cortina.

Solano, L. (2014). Through symptoms to subjects: the family physician and the psychologist together in primary care. In R.N. Emde & M. Leutzinger-Bohleber (Eds.), *Early parenting and prevention of disorder* (pp. 309-327). London, UK: Karnac. doi:10.4324/9780429474064-17

Solano, L. (Ed.) (2011). *Dal Sintomo alla Persona: Medico e Psicologo insieme per l'assistenza di base* [*Through symptoms to subjects: the family physician and the psychologist together in primary care*]. Milano, IT: Franco Angeli.

Stern, D.B. (1989). The analyst's unformulated experience of the patient. *Contemporary Psychoanalysis, 25,* 1-33. doi:10.1080/00107530.1989.10746279

Taylor, G.J. (1994). The alexithymia construct: Conceptualization, validation, and relationship with basic dimensions of personality. *New Trends in Experimental and Clinical Psychiatry*, *10*(2), 61-74.

Taylor, G.J. (2004), Alexithymia: 25 years of theory and research. In I. Nyclicek, L. Temoshok & A. Vingerhoets (Eds), *Emotional Expression and health* (PP. 137-153). Hove and New York: Brunner-Routledge.

Taylor, G.J., & Bagby, R.M. (2014), Advances in Alexithymia Theory and Research. In G.J. Taylor, R.M. Bagby, V. Caretti & A. Schimmenti (Eds.), *La valutazione dell'Alessitimia con la TSIA* [*Assessment of alexithymia through the TSIA*] (pp. 77-97). Milano: Raffaello Cortina.

Taylor, G.J., Bagby, R.M., & Parker, J.M.A. (1997). *Disorders of affect regulation*. Cambridge, UK: Cambridge University Press. doi:10.1017/CBO9780511526831

Todarello, O., Casamassima, A., Daniele, S., Marinaccio, M., Fanciullo, F., Valentino, L. … Marinaccio L. (1997). Alexithymia, immunity and cervical intraepithelial neoplasia: Replication. *Psychotherapy and Psychosomatics, 66*, 208-213.

Tolmunen, T., Lehto, S.M., Heliste, M., Kurl, S., & Kauhanen, J. (2010). Alexithymia is associated with increased cardiovascular mortality in middle-aged Finnish men. *Psychosomatic Medicine, 72*, 187-191. doi:10.1097/PSY.0b013e3181c65d00

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*, 253-265. doi:10.3109/10673229409017088

van der Kolk, B.A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress, 8*, 505-525. doi:10.1007/BF02102887

Verdelli, C. (2014, June 20). Nel paese dell'uomo nero che si faceva chiamare papà [In the country of the boogeyman who called himself dad]. La Repubblica. Retrieved from https://ricerca.repubblica.it/repubblica/archivio/

Westen, D. (1998). The Scientific Legacy of Sigmund Freud: Toward a psychodynamically informed Psychological Science. *Psychological Bulletin, 124*, 333-371. doi:10.1037/0033-2909.124.3.333

Winnicott, C. (1989). D.W.W.: A Reflection. In C. Winnicott, R. Shepherd & M. Davis (Eds.), *Psycho-analytic explorations* (pp. 1-18). London, UK: Karnac.

Winnicott, D.W. (1949, December 14). *Mind and its relation to the psyche-soma*. Paper presented at the medical section of the British Psychological Society, London, United Kingdom.

Winnicott, D.W. (1960). Ego distortion in terms of true and false self. In D.W. Winnicott (Ed.), *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development* (pp. 140-152). London, UK: The Hogarth Press and the Institute of Psycho-Analysis. doi:10.4324/9780429482410-12

Winnicott, D.W. (1974). Fear of breakdown. *International Review of Psychoanalysis, 1*, 103-107.