An integrative, attachment-based approach to the management and treatment of patients with persistent somatic complaints

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Introduction

Many patients seen in clinical practice present with fatigue and pain-related problems either as a primary complaint or secondary to medical or psychiatric conditions (Fischhoff and Wessely 2003). These complaints are often labeled as *psychosomatic* or *somatoform*. However, these terms inappropriately emphasize the primacy of psychological factors or attributions in the causation of these disorders. They are also based on obsolete models of the relationship between body and mind, and often rightfully meet with resistance in patients (Dimsdale et al. 2013, Luyten and Van Houdenhove 2013, Luyten et al. 2013). For the same reason, the notion of "medically unexplained syndromes" is not really helpful for most patients, particularly because a wide range of biological and psychosocial factors have been shown to be involved in the etiology and pathophysiology of these syndromes. The introduction in DSM-5 of the category of somatic symptom disorder (SSD) represents a major leap forward in this area (Dimsdale et al. 2013), although its definition still emphasizes disproportionate cognition and affect of the patient with regard to his or her symptoms; these may in fact not always be that disproportionate as they may reflect an understandable response to persistent and often insufficiently understood symptoms. The notion of functional somatic disorders (FSDs) is often used in this context, and to good avail, as patients with these conditions show dysregulations of neurobiological systems and neural circuits involved in fatigue and pain processing, dysregulations which may become chronic. For clinical purposes, it may be simply preferable to refer to these patients as *patients presenting with persistent somatic complaints that have not responded to treatments and/or that have been insufficiently understood*.

Patients presenting with these problems are often considered to be "difficult to treat", but it is important to realize that this patient group is very heterogeneous. Furthermore, as we will argue in this chapter, current evidence-based treatments often do not adequately take

into account existing knowledge concerning interpersonal and attachment issues in the treatment of these disorders; this is not only of psychological importance, as there is an intrinsic relationship between stress regulation and the attachment system. In this chapter, we present an integrative, broad attachment-based approach to the understanding, management, and treatment of these disorders.

Recent research on stress has led to renewed attention to the importance of early adversity and later stress in these patients. This research has also led to a new focus on what clinicians often find to be the most important issue for many of these patients – their interpersonal problems, both in relationships with significant others and with healthcare professionals. Contemporary attachment theory provides a theoretical framework that not only helps us to understand these issues but, more importantly, also provides important leads with regard to management and intervention. The take-home message of this chapter is that contemporary attachment theory helps us to understand these patients better. This helps us to establish a better relationship with these patients, which in turn leads patients to better understand what is happening to them. This greatly increases adherence to treatment, with consequent effects on the course of their presenting problems and how they influence the patients' lives.

This chapter begins by outlining a broad attachment approach to these patients. We focus on three specific features of patients who present with persistent somatic complaints: (a) attachment issues; (b) problems related to (embodied) mentalizing, that is, the capacity to reflect on their own embodied self and others, and (c) problems with epistemic trust – the capacity to trust others as a source of knowledge about the world and, in particular, about their presenting problems. We then discuss the implications of this attachment-based approach for intervention, considering general management principles as well as more

specialized treatment approaches that have evolved from a base of contemporary attachment approaches.

Classification and diagnosis

The disorders that can be considered to be FSDs comprise a wide variety of conditions affecting different body systems, which may be seen by healthcare professionals in different medical specialties. These conditions include, but are not limited to, chronic fatigue syndrome (CFS; internal medicine) and fibromyalgia (rheumatology), irritable bowel syndrome (IBS; gastroenterology); chronic pelvic pain (gynecology); non-cardiac chest pain (cardiology); tension headache (neurology); hyperventilation syndrome (respiratory medicine), and multiple chemical sensitivity (internal medicine) (Fischhoff and Wessely 2003, Wessely and White 2004). There is considerable controversy regarding whether these disorders are indeed distinct entities or represent different presentations of a common functional somatic syndrome, and whether they are caused purely by biological factors or by a combination of biological and psychological factors. These debates, which are based more on ideological than scientific arguments, have done little to improve our knowledge of the etiology, course and treatment of the FSDs.

While the disorders listed above have different characteristic presentations, there is considerable evidence to suggest that the FSDs are not individual isolated disorders. There is both high comorbidity among these disorders and high familial coaggregation (i.e., it is relatively common to find members of the same family showing symptoms of the same or different FSDs) (Aggarwal et al. 2006, Anda et al. 2006). In addition, the high comorbidity between FSDs and affective disorders such as depression and anxiety (Arnold et al. 2006, Pae et al. 2008) has led to the suggestion that the FSDs are also part of a spectrum of affective disorders (Hudson et al. 2004, Hudson et al. 2003, Hudson and Pope 1996).

Taken together, FSDs are highly prevalent. The prevalence of FSDs in the general population is estimated to be 4%, and up to 9% of patients in tertiary care present with more than one FSD (Bass and May 2002). For individual disorders, estimates of prevalence range between 0.5 and 2.5% for CFS (Afari and Buchwald 2003, Reeves et al. 2007), approximately 5% for fibromyalgia (Branco 2008, Lawrence et al. 2008, Spaeth 2009), and as high as 11.2% for IBS (Lovell and Ford 2012). The true prevalence of the FSDs remains unknown, as they are diagnosed on the basis of consensus diagnostic categories. However, the medical, economic and psychosocial costs associated with these disorders are known to be significant (Afari and Buchwald 2003, Annemans et al. 2009, Annemans et al. 2008, Sicras et al. 2009, Spaeth 2009).

Current evidence-based treatments for FSDs lead to improvements in core symptoms and general functioning (Hauser et al. 2009, Malouff et al. 2008, NICE 2007, van Koulil et al. 2007). However, treatment has only limited benefit in a relatively large number of patients, particularly in those whose symptoms are most severe (Luyten et al. 2009, Van Houdenhove and Luyten 2007, Van Houdenhove and Luyten 2008). We consider that an attachment-based approach to the management and treatment of these patients may be most helpful as it offers a comprehensive approach that takes into account the biological, psychological and social/contextual factors that have been implicated in the development and course of these disorders.

A contemporary attachment-based approach to FSD

Introduction

There is now good evidence to suggest that FSDs are associated with often severe stress dysregulation as a result of complex interactions between genetic and environmental factors (Ablin et al. 2012, Heim et al. 2009, Tak and Rosmalen 2010). This leads to a state of

allostatic load (McEwen 2007), which disrupts the dynamic equilibrium that normally characterizes stress regulation systems and related neurobiological systems such as the immune and pain-regulating systems. This is expressed in dysfunctions of the hypothalamic–pituitary–adrenal (HPA) axis – the main stress regulation system – that are typically associated with FSDs (Heim et al. 2009, Powell et al. 2013, Tak and Rosmalen 2010, Van Houdenhove et al. 2013). Immune system dysfunctions are often apparent as abnormal inflammatory activity. Proinflammatory cytokines have been shown to play a role in feelings of lethargy, increased stress and pain sensitivity, mild fever and cognitive problems (e.g. loss of concentration) – the so-called "sickness response" that is typically observed in many FSD patients (Dantzer et al. 2008, Watkins and Maier 2005).

The disturbance of allostasis and accompanying biological and subjective responses represent a serious burden to the individual and his/her relationships, particularly as their complaints are often met with suspicion or disbelief by others, including health professionals. The individual's experience of the physical and psychological symptoms of FSD and the associated distress activate his/her attachment system; this is a biologically pre-wired system that has a key role in the regulation of stress and affect and the restoration of allostasis. Activation of the attachment system involves seeking proximity to attachment figures, which, when achieved successfully, typically leads to effective downregulation (see Figure 1). However, in the context of FSD, in which the complaint may be persistent and often lacking a clear explanation of cause of prospect of cure, the normal process of co-regulation of stress and arousal in attachment relationships easily spirals out of control. This breakdown is often further reinforced by the inability of health professionals to provide relief, particularly when these professionals respond insufficiently to the emotional needs and needs for validation in particular of patients with these complaints.

As a result, these patients have to resort to excessive use of so-called secondary attachment strategies, that is, stress or affect regulation strategies that are used when normative stress regulation fails. These strategies involve hyperactivation or deactivation of the attachment system (or a combination of both) in response to stress. As we will explain in more detail below, these strategies lead to further stress dysregulation because, as well as their high associated metabolic costs, they are associated with impairments in mentalizing – the capacity to interpret the self and others in terms of intentional mental states (i.e., feelings, wishes, desires, goals, etc.) – with consequent interpersonal costs, as these strategies give rise to (interpersonal) behaviors that perpetuate complaints.

The end result, particularly in patients whose symptoms have become chronic, is a severe state of stress dysregulation and allostatic load, high symptomatic distress, serious impairment in mentalizing capacities, and considerable interpersonal problems (see Figure 2). Repeated experiences of invalidation also lead to a state of epistemic distrust, characterized by an almost complete distrust of the medical profession, which may explain the "difficult to treat" character of many of these patients. As we will argue, however, these patients are not so much "difficult to treat" as "difficult to reach" because of their repeated experiences of invalidation. Hence, their distrust of health professionals reflects an understandable strategy, rather than a deficit or unwillingness to be treated or to be open to other perspectives.

Importantly, these patients' attachment and mentalizing problems were not necessarily present premorbidly, but may often be a result of persistent somatic complaints and continuing allostatic load. Of course, some patients with FSDs do have attachment and mentalizing problems before the onset of their FSD; for these patients, their symptoms and complaints and repeated experiences of invalidation further exacerbate these problems, often posing considerable challenges for management and intervention. In what follows, we

discuss issues regarding attachment, (embodied) mentalizing and epistemic distrust in relation to FSDs.

Attachment and FSD

Research in humans and animals has amply demonstrated the key role that secure attachment experiences play in the development and regulation of the stress system. The attachment system has direct effects on both the subjective and neurobiological stress response (Gunnar and Quevedo 2007). These findings are of central importance for FSDs because, as we describe above, stress dysregulation is a common feature of these disorders.

Attachment theory allows a deeper understanding of these patients' responses when faced with stress and affect dysregulation. Increasing distress may activate different strategies in the individual in attempt to deal with this dysregulation, depending on the individual's attachment history.

An individual with a *secure attachment strategy* typically seeks proximity to attachment figures (either real or internalized), which results in downregulation of stress. Stress regulation thus always involves the co-regulation of stress in relation to attachment figures (Diamond et al. 2003, Luyten et al. 2010, Sbarra and Hazan 2008). This process has a strong neurobiological basis, involving, for instance, the neuropeptide oxytocin, which is known to have a key role in fostering attachment and regulating stress (Fonagy and Luyten 2009, Neumann 2008). Activation of the attachment system leads to (a) activation of a mesocorticolimbic, dopaminergic "reward" system (Insel and Young 2001), (b) downregulation of neuroendocrine stress regulation systems (the HPA axis and sympathetic nervous system), and (c) activation of neural systems that have been found to be involved in mentalization (Fonagy and Luyten 2009, Lieberman 2007). These include the lateral and

medial prefrontal cortex, lateral parietal cortex, medial parietal cortex, medial temporal lobe, and rostral anterior cingulate cortex.

High mentalizing capacity, particularly when an individual is under high levels of stress, has been associated with resilience (Fonagy et al. 1994). This association seems to operate through so-called "broaden and build" (Fredrickson 2001) cycles of attachment security, in which feelings of secure attachment and agency, and effective stress and affect regulation ("build") "pull" the individual into more adaptive environments ("broaden"), further fostering feelings of agency, trust, and security (Hauser et al. 2006, Mikulincer and Shaver 2007). In summary, secure attachment experiences, through their (neurobiologically) rewarding nature, reinforce affiliative behavior and mentalizing, and so foster the ability to regulate stress.

However, when an individual is faced with ongoing distress – as is typical in patients with persistent somatic complaints – even secure attachment strategies will eventually tend to fail, leading to the excessive use of secondary attachment strategies in an attempt to downregulate stress and arousal. There is good evidence to suggest that at least a subgroup of patients with FSD has a history of insecure and often severely disrupted attachment (Afari et al. 2014, Borsini et al. 2014, Kempke et al. 2013, Luyten et al. 2006, Maunder and Hunter 2008, Waller and Scheidt 2006). Early adversity has been shown to be associated with greater vulnerability to stress-related symptoms in both animals (Champagne and Curley 2009, Neumann 2008) and humans (Bakermans-Kranenburg et al. 2008, Gunnar and Quevedo 2007). However, as noted earlier, not all patients with FSDs have a history of insecure attachment experiences or early adversity that might be responsible for premorbid mentalizing impairments. Rather, many patients' overreliance on secondary attachment strategies, and their impairments in mentalizing, may be a consequence of the disorder; for other patients, existing problems with attachment and mentalizing may be exacerbated by

the experience of FSD. This has important implications for the treatment of these individuals (Luyten et al. 2012b, Luyten and Van Houdenhove 2013).

Clinical experience and research findings suggest that, in an attempt to cope with their distress, some patients begin to rely excessively on *attachment deactivation* strategies. These patients will often completely deny any attachment needs and will assert their autonomy and attempt to demonstrate independence and strength (Cassidy and Kobak 1988, Mikulincer and Shaver 2007). However, while these individuals may appear to be independent and resilient, this is a cover for their vulnerability (Van Houdenhove and Luyten 2008). Studies suggest that the use of attachment deactivation strategies is often found in individuals who also show high levels of self-critical perfectionism and associated features such as persistence, overactivity, and so-called "all-or-nothing" behavior (Creed 2007, Luyten et al. 2011). These features reflect defensive attempts to affirm the self and soothe negative introjects. There is increasing evidence to suggest that these features are also related to FSD in a subset of patients (Luyten et al. 2011).

The tendency to use attachment deactivating strategies is associated with considerable interpersonal and metabolic costs in the long term. These strategies – in particular, those associated with high levels of self-critical perfectionism – have been shown to lead to increasing isolation and loneliness (Mikulincer and Shaver 2007), while suppression of distress is associated with increasing allostatic load, which eventually results hypoactivity of the HPA axis as a consequence of the "wear and tear" of chronic stress (Hill-Soderlund et al. 2008, Miller et al. 2007, Wirtz et al. 2008), and impaired immune system function (Gouin et al. 2009). In addition, under increasing stress, attachment deactivating strategies tend to progressively fail, resulting in heightened feelings of stress and insecurity (Mikulincer et al. 2004).

In some patients, particularly those with a history of serious early adversity and/or those who show features of dependent or borderline personality disorder comorbid with their FSD, *attachment hyperactivating strategies* are predominant. These strategies manifest as anxious efforts to find support and relief from an attachment figure, often through demanding, clinging, and claiming behavior (Waller and Scheidt 2006). As for deactivating strategies, attachment hyperactivating strategies are associated with high interpersonal and metabolic costs. Demanding behavior often leads to frustration and antipathy in others, which confirms the individual's worst fear of being misunderstood and rejected. This pattern is not restricted only to close attachment figures: the patient's relationships with (mental) health professionals tend to show a similar pattern. As a consequence, the "broaden and build cycles" that would promote resilience and feelings of security are inhibited. There is no effective downregulation of distress, and allostatic load increases (McEwen 2007). This leads to a vicious cycle, as these patients tend to respond to increased stress and anxiety with even greater reliance on attachment hyperactivating strategies in an attempt to find relief, support, and understanding from others (Maunder and Hunter 2008, Maunder et al. 2006).

Embodied mentalizing and FSD

Attachment issues provide only a partial explanation of the presenting symptoms and complaints of patients with FSDs.

The symptoms of the disorder, and the resulting excessive use of secondary attachment strategies, in patients with FSD also have a negative effect on patients' mentalizing abilities. This leads to the (re)-emergence of non-mentalizing modes (see Fonagy, 1998) that in turn lead to behaviours that further perpetuate symptoms and exacerbate problems in interpersonal relationships (see Figure 2). As we noted earlier in this

chapter, mentalizing impairments are often a consequence of FSD or are exacerbated by the distress and interpersonal problems associated with the disorder.

Indeed, FSD symptoms can be perceived as an "attack" from within on the individual's capacity to reflect, particularly on the individual's capacity to see the body as a "lived body" that he/she owns, a body that is the seat of his/her relationships with others. For instance, Driver (2005) described the "otherness of the illness" in patients with CFS, in whom this "otherness" led to regressive fears and fantasies. (Schattner et al. 2008) reported that it is common for patients with a chronic illness to treat the illness as an "internal object" that the patient perceives as a constant threat that needs to be negotiated with and soothed. As we described earlier, chronic somatic complaints increase stress, which further impairs and/or exacerbates impairments in (embodied) mentalizing. This is consistent with studies showing an inverse relationship between stress and mentalizing (Fonagy and Luyten 2009, Luyten et al. 2012a).

Earlier formulations focused on these patients' high levels of alexithymia (that is, problems with being aware of and describing emotions) (Pedrosa Gil et al. 2008a, Pedrosa Gil et al. 2008b, Subic-Wrana et al. 2010). However, evidence suggests that only a fairly small proportion of patients with FSD (15–22%) show clinically elevated levels of alexithymia and lack of emotional awareness (Pedrosa Gil et al. 2008a, Pedrosa Gil et al. 2008b, Waller and Scheidt 2006). Furthermore, these features are not specific to FSD, but appear to reflect the effects of trauma and emotional neglect experienced by these individuals in early life. Hence, although patients with these issues are often seen in tertiary care, their premorbid deficits in mentalizing cannot be generalized to the all patients with FSD. However, it is important not to underestimate the impact of FSD (and negative responses to the patient by their close relationships and health professionals) on mentalizing,

as many of these patients are caught up in vicious interpersonal cycles for many years, often compounded by issues such as loss of the ability to work.

The mentalization-based approach that we propose suggests that, rather than being generally "alexithymic", patients with FSDs often have impairments in (embodied) mentalizing that are much more specific – that is, they are related to specific experiences and symptoms. Furthermore, these impairments are related to (interpersonal) situations and symptoms that result in high arousal or stress (Luyten et al. 2012c).

Clinical experience and research have shown that many of these patients interchangeably exhibit excessive mentalizing (*hypermentalizing*), expressed in apparently highly sophisticated narratives that lack any grounding in subjective experience, as well as *hypomentalizing* – that is, almost complete denial of the importance of inner mental states. In addition, many of these patients are unable to link their own emotional states to their own body, rather than showing a general "global" impairment in emotional awareness (Oldershaw et al. 2011, Stonnington et al. 2013, Subic-Wrana et al. 2010). Studies have suggested that patients with FSDs are less likely to describe physical sensations in terms of negative emotional states (Dendy et al. 2001); they are also less interoceptively accurate, particularly in contexts related to physical symptoms (Bogaerts et al. 2008, Bogaerts et al. 2010). Patients with FSDs also tend to have negative beliefs about their own emotions, in particular, regarding the expression of emotions (Hambrook et al. 2011). Furthermore, they tend to show a strong need to control thoughts and feelings (Maher-Edwards et al. in press, Rimes and Chalder 2010) rather than exhibiting "deficits" in processing emotions.

Context-specific impairments in (embodied) mentalizing lead to the reemergence of three so-called non-mentalizing modes that perpetuate the patient's symptoms and interpersonal problems (see Box 1).

In the *psychic equivalence mode*, patients equate inner and outer reality. Because of this, what is thought or felt is experienced as completely real, and there is no possibility of an alternative interpretation. In patients with FSD, this mode is often accompanied by a lack of ability or desire to explore inner mental states. This is particularly the case in patients who primarily use attachment deactivating strategies, and this may also explain these patients' difficulties in accepting help and believing that health professionals are genuinely concerned about them. In psychic equivalence mode, psychological and physical pain, and emotional and physical exhaustion, are equated, so that, for example, psychological pain may be experienced as bodily pain. This may help to explain the high comorbidity that has been reported to exist between pain, fatigue, and depression (Hudson et al. 2004, Van Houdenhove and Luyten 2008). This mode also underlies patients' resistance toward acknowledging the role of psychological factors in their disorder ("I am exhausted, not depressed"). One consequence of this mode is helplessness, which often arises in combination with catastrophizing ("I think there is something terribly wrong with me, so there is something terribly wrong with me [psychic equivalence], but no one pays attention [feeling of invalidation], I must have a terrible, incurable disease [catastrophizing]"). Psychic equivalence also has a negative influence on relationships: to the patient, *thinking* that others do not care means that they *actually* do not care. Being rejected hurts (Eisenberger et al. 2003), but for patients in the psychic equivalence mode often only the physical pain they feel in association with rejection seems to be real.

Finally, and importantly, in psychic equivalence mode, the patient's body starts to feel like an "alien self-part". The body is no longer felt like "me", it is increasingly seen and felt as a dysfunctioning set of organs and systems. The patient feels under constant pressure to externalize these alien self-parts in a defensive attempt to remove painful feelings of helplessness and disintegration in an attempt to restore the coherence of the self. We are all

familiar with this tendency to evacuate self-states when we can no longer bear them (e.g., when we are ill) – by complaining to others, by becoming overcritical and hypersensitive to even minor noises, for instance. The consequence is that others are made to feel what we feel; yet, when extreme, this often has a destructive influence on the patient's relationships, including relationships with health professionals.

In a *teleological mode*, the patient recognizes that mental states drive behavior, but this understanding is limited to those mental states that have clearly observable causes (i.e., observable activities that reflect rational, goal-directed behaviors and/or material causes). Many patients with FSD believe that only rational, goal-directed behaviours and actions can be effective; this belief underlies their tendency to be excessively concerned with finding objective "proof" that their illness exists. When dealing with a patient in a teleological mode, health professionals may be drawn into endless discussions about the roles of biological versus psychosocial factors as the cause of the patient's FSD.

This tendency for patients to ruminate about the causes of their disorder often leads to hypermentalizing – or "mentalization on the loose" – in *an extreme pretend mode*. In this mode of experiencing subjectivity, the relationship between thoughts and feelings and reality is typically severed. Overly analytical, cognitive and repetitive narratives follow that lack any grounding in real affective experiences. The patient also typically is unable to switch perspectives, and attempts to switch his/her perspective are often met with fierce resistance ("I don't see why I should think about what he wants, I am the one who is ill!").

Epistemic distrust and FSD

Patients with FSD are often considered to be "difficult to treat" (Fischhoff and Wessely 2003). We believe that this label is neither accurate nor helpful. Many patients with FSD feel severely misunderstood and stigmatized, and for good reason. In the face of their own

continuing distress, for which they can find little or no relief, they are often met with disbelief and scepticism from others. Their feelings of stigma and not being understood are often reinforced by mental health professionals' use of unhelpful diagnostic labels, obsolete theories about the cause of FSDs that imply a mind–body dualism, and provision of a pessimistic prognosis (Rudich et al. 2010, Rudich et al. 2008). Furthermore, many health professionals underestimate these patients' need for validation that their problems are both distressing and real. This further fosters the feelings of invalidation and embitterment that have been demonstrated in patients with FSDs (Blom et al. 2012, Kool et al. 2009).

Not surprisingly, these patients frequently have turbulent relationships with the health professionals treating them. The patient may cling on to a medical specialist, whom they idealize and believe to be a "last resort" who will cure them. Often, of course, this rapidly leads to disappointment on the part of the patient and reproach. This, in turn, tends to induce feelings of contempt and rejection in the professionals treating the patient; even if these feelings are not communicated explicitly, they can be demonstrated non-verbally, for example, through facial expressions of affect (Rasting et al. 2005)! These negative interaction patterns are likely to reduce the patient's response to treatment, particularly if the dynamics between patient and health professional are not appropriately addressed.

We believe that many iatrogenic effects of treatment in these patients are due to the dynamics outlined above (Luyten and Abbass 2013). We therefore believe it is crucially important for the management and treatment of patients with FSDs to understand that these patients often suffer from severe problems with *epistemic trust*. These problems may have been premorbidly present, originating from disrupted attachment experiences, and/or may arise from or be reinforced by negative relational experiences, including experiences in relationships with health professionals (Luyten et al. in press).

"Epistemic trust" is, in essence, the capacity to trust others as a reliable source of knowledge about the world. This capacity first develops in young children in the context of their relationships with attachment figures. Individuals who experienced attachment disruptions in early life often have problems not just with trusting others on an emotional level, but also with epistemic trust. These dificulties with epistemic trust may, when severe, be expressed in cycles, from being overtrustful of others to complete epistemic distrust, expressed in *epistemic hypervigilance*. The individual is constantly on his/her guard: "Can I trust the advice or opinion of others?" Epistemic distrust is particularly prevalent among individuals with dismissive and disorganized attachment styles; these attachment styles are commonly found in patients with FSDs, as we have outlined above (Waller and Scheidt 2006). Epistemic distrust impairs patients' capacity to form a therapeutic alliance with health professionals, and to accept help from others more generally. It may also explain the attitude of some of these patients towards health professionals, which can verge on paranoia.

Another facet of this distrust is patients' tendency to ruminate on what they experience as others' unwillingness to believe that they are actually ill (Van Houdenhove and Luyten 2008). Studies have shown this tendency to be related to these patients' feelings of invalidation, loneliness and sometimes embitterment (Kool et al. 2009). Thinking in psychic equivalence mode, "I feel as if nobody cares about me and my illness, therefore nobody does care", only tends to reinforce these feelings, and this often escalates to distrust in the medical profession and even to beliefs that, as well as not wanting to help, medical professionals want to harm the patient. Restoring epistemic trust through validation and communicating understanding is therefore a prerequisite for any treatment of these patients.

Management and treatment

Management of patients with FSDs needs to take into account three core features of these patients from an attachment perspective: (a) their overreliance on secondary attachment strategies, (b) their mentalizing problems, and (c) their difficulties with epistemic trust. These three features, particularly when excessively present, may seriously impede the patient's ability to form a working relationship, and thus is likely to reduce the benefit of any treatment.

A clinical approach that validates these patients' suffering may counter their epistemic distrust and recover their capacity to mentalize. This will open up patients' capacity to consider alternative perspectives regarding their complaints and their own developmental history and future. These are necessary prerequisites for any treatment to be successful. This is often a slow process that requires considerable empathy and tolerance of negative affect on the part of the clinician.

It is particularly important for clinicians to be constantly aware of the potential for their interventions to be iatrogenic, given how common it is for these patients to use secondary attachment strategies/non-mentalizing modes either as a cause or a consequence of their symptoms. This frequently leads to high rates of drop-out and/or stormy transference and countertransference issues that are difficult to resolve even in long-term treatment (e.g., idealization-denigration cycles, regressive dependency, sadomasochistic transferences, etc.) (Luyten and Abbass 2013).

Interventions based on these and related assumptions have been shown to be effective in the treatment of these patients. A meta-analysis by Abbass et al. (2009) of 23 studies of short-term psychodynamic psychotherapy for people with FSDs (13 randomized controlled trials and 10 case series with pre–post outcome assessment) reported significant effects for physical symptoms, psychiatric symptoms, and social adjustment; these effects

were maintained at long-term follow-up. Brief dynamic treatment was found to be associated with a 54% greater treatment retention rate compared to control treatments; this suggests that this type of treatment can address many of the interpersonal issues that render these patients "difficult to reach" and treat successfully. Notably, even very brief treatments were associated with considerable improvement. Recent research evidence also suggests that psychodynamic treatments influence the neurobiological circuits involved in stress, affect regulation, and mentalizing (Abbass et al. in press), congruent with the views advanced earlier in this chapter.

For patients whose FSD is more severe, longer-term, multi-component interventions may be indicated. Recently, Koelen et al. (2014) published a meta-analysis of 10 randomized controlled trials and six non-randomized trials, with a total of 890 patients receiving psychotherapy and 548 patients receiving treatment as usual (TAU). They reported that multi-component treatment was more effective than TAU for physical symptoms (d = 0.80 vs. 0.31, $p < .05$) and functional impairment (d = 0.45 vs. 0.15, $p < .01$), but not for psychological symptoms (d = 0.75 vs. 0.51, $p = .21$). Importantly, these effects were maintained at long-term follow-up.

The formulations put forward in this chapter are in line with the core tenets of more interpersonally oriented psychodynamic treatments for patients with FSDs, such as brief interpersonal psychotherapy (Guthrie et al. 1999, Sattel et al. 2012, Thomas et al. 2009) and dynamic interpersonal therapy (Lemma et al. 2010). These treatments focus on the here-and-now, placing greater emphasis on *current* interpersonal issues and their relation to the patient's presenting symptoms rather than the patient's history, and focusing on the process of reflecting on the connections between interpersonal problems and symptoms. In DIT in particular, the focus is often more on the *process* of mentalizing than the *content*, as focusing on content (e.g., the connection between the patient's presenting symptoms and

interpersonal issues he/she has experienced, whether in the present or the past) often exceeds these patients' mentalizing abilities, particularly in the early stages of treatment and in patients with chronic or multiple FSDs.

Conclusions

This chapter presents a contemporary attachment-based approach to the conceptualization and management of patients with persistent somatic complaints. The central assumption of this chapter is that contemporary attachment approaches provide the clinician with a broad, evidence-based theoretical framework that helps to understand the connections between the patient's presenting problems, his/her subjective responses to these complaints, and his/her developmental history. These formulations also have clear implications for the management of these patients regardless of the specific treatment approach used – for instance, the importance of health professionals being keenly aware of the importance of distinguishing between premorbid vulnerability and the patient's response to his/her complaints, and the potential for iatrogenesis in treatment, given these patients' impairments in epistemic trust and mentalizing.

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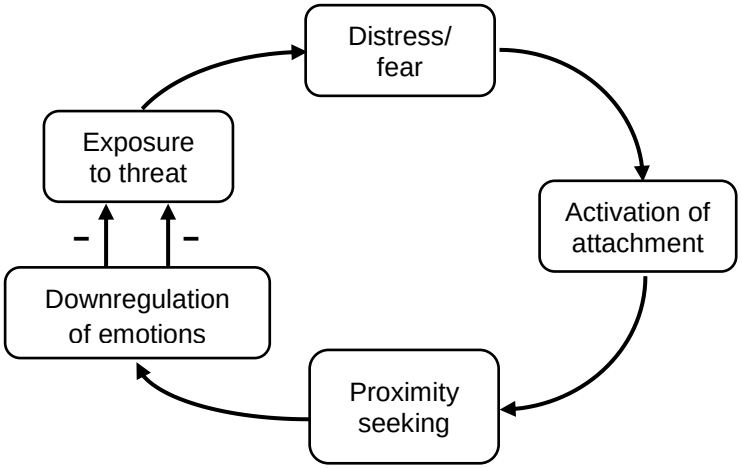
Figure 1. The relationship between the attachment and stress regulation systems

(a) Downregulation of distress via the normally functioning attachment system



(b) Hyperactivation of the attachment system in the context of FSD

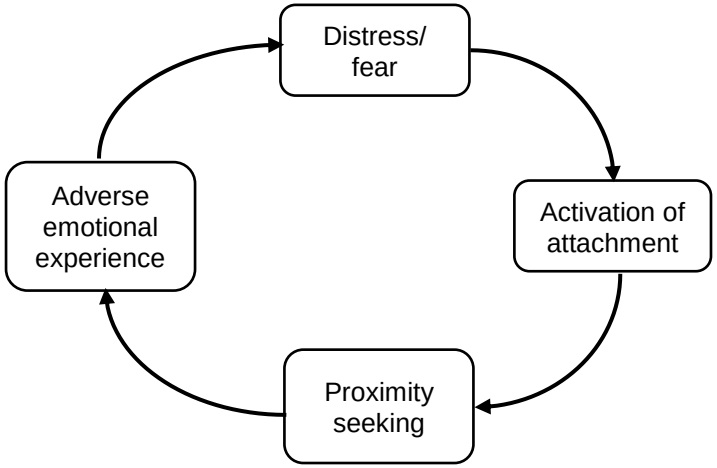
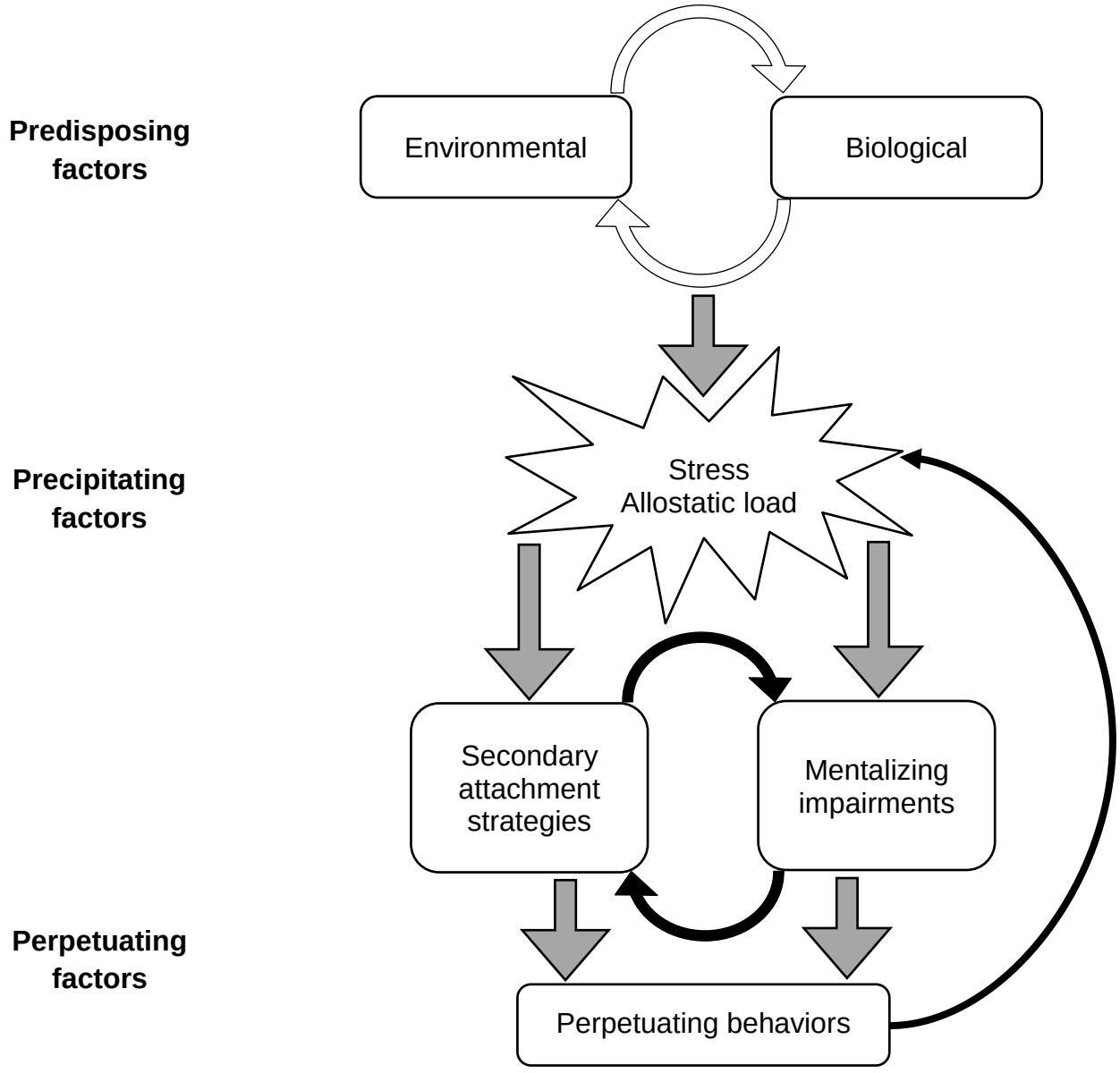


Figure 2. Putative roles of attachment problems and mentalizing impairments in individuals with functional somatic disorders



Box 1. Three non-mentalizing modes in patients with functional somatic disorders, and their management in therapy

Psychic equivalence mode

- Patients equate inner (mental) reality with outer reality ("mind–world isomorphism"). Because of this, the internal has the same power as the external
- Intolerance of alternative perspectives – leads to "concrete" understanding
- Managed in therapy by the therapist avoiding being drawn into non-mentalizing discourse: validate the patient's thoughts and feelings, but suggest alternative perspectives

Teleological mode

- Extreme exterior focus
- Patients cannot accept anything other than an obvious, observable change or action as a true indicator of the intentions of the other
- Managed in therapy by validation, then switch focus to how this makes the patient feel, and how these feelings are connected with current (interpersonal) problems

Pretend mode

- Ideas form no bridge between inner and outer reality; the patient's mental world (thoughts and feelings) is decoupled from external reality
- In extreme, may manifest as "dissociation" of thought (hypermentalizing or pseudomentalizing)
- Managed in therapy by interrupting non-mentalizing processes and moving back ("rewinding") to when the patient was mentalizing