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An Overview of Conceptualisations of ‘Somatisation’ with Reference to Merleau-Ponty’s Phenomenology of ‘Embodiment’.

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Abstract
This article explores key conceptualisations of ‘somatisation’, a term that refers to physiological symptoms without organic causes. A history dating back to Freud identifies philosophical underpinnings of a dualistic theorising of bodily symptoms and subsequent medicalisations of bodily illness, with recent elaborations on influencing psychological sources in somatic symptom presentations. Conceptualisations include: Freud’s trauma model, concepts of ‘faulty perception’, ‘emotional avoidance’, developmental perspectives including ‘affect dysregulation’, and ‘mentalandization’, ‘stress and physical illness’ and Schore’s neurobiological and psychobiological perspectives and the ‘genetic’ model of health and illness. Then Merleau-Ponty’s phenomenological theory of ‘embodiment’ is offered as an alternative way of conceptualising the body and bodily manifestations.


**Introduction**

The mind-body problem can be traced back to the Renaissance with ideas of a ‘wandering uterus’ responsible for hysteria which originated from the Greeks. The nineteenth century was the golden age of hysteria, where the female body was undeniably pathologised (Showalter, 1985). Hysteria had been used to describe a disorder or illness relating to the existence of unexplained physical symptoms. Ancient Greek physicians and the philosophers Hippocrates and Plato believed the womb (hystera) was a separate entity which when empty, roamed freely around a woman’s body and pressed on other organs causing physical symptoms (Veith, 1965; Decker, 1991). Hysteria was a convenient catch all diagnosis (Ussher, 1991) and a reclassification and re-labelling of what was previously described in medical texts as malingering.

Charcot (1825-1893) the French neurologist, was the first to equate hysterical illness with unresolved sexual conflict and Freud, eventually elaborated on his work to conclude that hysterical illness was the result of repressed emotional disturbance (In Shaw, 2003). By the late nineteenth century, Freud’s contributions to psychoanalysis connected physical symptoms with repressed emotional trauma. This early conceptualisation was coined as ‘somatisation’ by Stekel (1943), the Viennese psychoanalyst, to encapsulate somatic problems without organic causes. Stekel regarded hysteria as equivalent to the concept of conversion, which was introduced by Breuer and Freud (1895) to explain the development of motor sensory symptoms in hysteria (see Taylor et al, 1997: 116).

Since Freud’s interest in understanding the language of the body, through reducing symptoms to mental causes, less emphasis was placed on the bodily organs as having a separate life from the mind. However, despite his attempts to deal with the mind-
body split, Freud’s method of reducing bodily symptoms to neurotic causes could not escape from the Cartesian dualism.

Somatisation has now replaced the term hysteria. Kirmayer and Robbins (1991) refer to the Diagnostic and Statistical Manual of Mental Disorders (third edition (DSM-III) to show that the classical concept of hysteria was split to form a number of ‘somatoform disorders’. Broom (1997) made two distinctions: ‘the term ‘somatiser’ refers to persons who are somatic symptom presenters, and the term ‘somatization’ refers to persons with somatic symptom presentations’ (p.4). The diverse ways employed to define and measure the phenomenon led to more contrasting views on the phenomenon.

Recent theorising has been less concerned with mechanisms of unexplained illness, concentrating instead on the processes underlying normal somatic perception. Brown, (2004) suggests that illness, emotional arousal, or everyday physiological processes produce bodily sensations that capture attention and lead to interpreting sensations as indicative of disease that produces illness anxiety and adopting the ‘sick role’ (Brown, 2004). This perspective gives credence to the way individuals interpret or misinterpret physical sensations.

In contrast to the idea that somatic problems are a problem of perception, Broom (1997) believes they involve emotional avoidance. He argues that many patients who present with symptoms including allergies ‘are avoiding facing emotional truths, and therefore present as somatisers, and are looking for a practitioner who will collude with this way of managing the problem’ (p.39). This assertion assumes that patients are conscious of a psychological component to their symptoms, intentionally avoiding pain.

The idea of patients being aware of the emotional component to their physical symptoms is in direct conflict with developmental perspectives (Fonagy et al, 2002; Taylor et al, 1997). These show many patients presenting with somatic problems as both lacking in knowledge and understanding of their emotional world, having higher level defences or that cognitive capacities to regulate affect have not been adequately
developed (Taylor et al, 1997: 91). This model refers to difficulties in ‘mentalizing’, or reflecting. This group of patients display alexithymic characteristics (Taylor et al, 1997), including not being cognisant of their emotions and lacking the capacity for imaginative, reflective experiencing.

**Stress as influencing factor in somatisation**

The Second World War influenced the 1950’s view of bodily phenomena through the empirical observations of traumatised soldiers and civilians with increasing recognition that stress adversely affects the immune system. This led to ideas that traumatic experiences and associated stress gave rise to overwhelming emotions resulting in somatic illness. These observations provided the stimulus for further research. There is now evidence that persistent somatic symptoms with little or no identifiable disease are related to stress. For example, a study on dermatological conditions found that 69% of psoriatic patients experienced psychological stress that influenced both the course and the development of psoriasis with emotional stress found to be the most common trigger (Simonic, E. et al, 2000: 1). Studies on Rheumatoid Arthritis also found a correlation between the onset and progressive deterioration of the disease and emotionally conflictual life situations such as bereavement or marital conflict, and somatic problems (Rimon, R. and Laakso, R.L. 1985).

Several other studies reinforce the notion that stress is linked to physical conditions. Rimon (1969) and Rimon and Laakso (1985), whilst suggesting that there is a psychological heterogeneity among rheumatoid patients, identified a sub-type that was less connected with genetic factors and influenced more by emotionally stressful events (In Taylor et al, 1997: 237–239). Concurrent to stress, rheumatoid arthritis was also associated with alexithymia. Fernandez et al, (1989) conducted a study in India to assess alexithymia in a group of patients with rheumatoid arthritis and found that they scored significantly higher than healthy subjects on the alexithymic scale (27.5% compared with 7.5% in the healthy group). Findings from studies conducted by Baker, (1997) and Rimon (1969) are consistent with a high percentage of patients with rheumatoid arthritis reporting that they had experienced an emotionally stressful life
event prior to the onset of symptoms (In Taylor et al, 1997: 239). Similarly, Engel made the observation that stress associated with overwhelming affects could influence the course of diseases such as inflammatory bowel disease, ulcerative colitis and Crohn’s disease. The researcher observed that ‘the onset or exacerbation of ulcerative colitis was associated frequently with feelings of helplessness and hopelessness in response to disruption of an important attachment relationship’ (Engel, 1955, 1958, In Taylor et al, 1997: 239).

Neurobiological perspectives reinforced the link between stress and physical illness. Chrousos and Gold, (1992) took this idea further and proposed ‘that human disease states fundamentally involve a dysregulation of stress systems’ (In Schore, 1994: 432). How the dysregulation of stress systems relates to immunity was the subject of the Coe et al, (1985) study who postulated that: ‘a variety of psychological and environmental perturbations can affect the immune system and that psychosocial context is a powerful determinant of immune reactions’ (cited in Schore, 1994: 435).

Schore’s (1994) and Kirschbaum’s (1998) neurobiological studies showed the effects of cortisol on health, with increased cortisol production during stress impacting negatively on health. Kirschbaum, (1998) found that big cortisol responders had a general poor well-being, poor psychological well-being, cardiovascular problems, poor wound healing and somatic complaints. The impact of stress on psychological and physical health is also demonstrated by Pruessner et al, (1999), who found among normal subjects that increased cortisol response was associated with low self-esteem.

Research cited thus far shows strong evidence that the capacity to modulate affects can help protect people from somatic illness, help keep symptoms under control and minimise deterioration and flare-ups. These studies suggest that there is interplay between unmodulated affect and somatic conditions.

**Affect dysregulation and somatic problems**

The concept of affects is rooted in different philosophical traditions, from Descartes to
Aristotle and later Spinoza who departed from Descartes’ dualism, ‘in conceiving of humans as embodied minds’ (Fonagy et al, 2002: 68-69). Whilst Descartes portrayed ‘affects as sensations that are in the body and as mentalistic’, Aristotle advocated ‘an ideal for human agents of integrating reason and feeling’ (Fonagy et al, 2002: 68-69). Freud’s theory of affects was closely associated with his drive theory; that is, alongside Darwin’s evolutionary theory, he emphasised instincts as key to survival (ibid). This gave bodily processes a primary importance in human life and further perpetuated the dualistic split.

Recent conceptualisations attempted to deal with this dualism by regarding ‘affect regulation as a process involving reciprocal interactions between the neurophysiological, motor-expressive, and cognitive-experiential domains of emotion response systems’ (Taylor et al, 1997: 14). The result of this theory of spontaneous and simultaneous activation and alteration of all systems within the organism, which impact upon one another, is an attempt to develop a more integrated theory of affects. Bradley (2000) argues that ‘affect regulation occurs largely in the context of learning within the family and other important relationships’ (p.30). This study postulates that early care giving can help or hinder affect regulation.

Theories on affect regulation discuss two important caveats. First the role of the empathic, attuned care giver is crucial in enabling the child to develop a balanced emotional world. Trevarthen and Aitken (1994) postulate that the experience of sharing emotions and ideas with the care giver is critically important for the infant’s learning to share emotions (In Bradley, 2000: 109). Second the capacity to self-regulate corresponds with the development of mentalization, seen as the process by which we realize that having a mind mediates our experience of the world (Fonagy et al, 2002).

Affect regulation refers to the ability to process emotions. Current developmental perspectives suggest that attuned, responsive and empathic responses from primary caregivers help in the development of a psychologically healthy emotional life (Stern, 2004). Bradley (2000) cites Stroufe’s explication (1989) that ‘the process of developing
affect regulation is a developmental progression in which the caregiver initially does all
the regulating, through sensitive responsiveness to infant signals of distress and
interest, with gradual transition to the infant’s having the capacity to regulate his or her
emotions physically then gradually finds symbolic and psychological language to
express them. Research and clinical data confirm the idea that in infancy and beyond,
the regulation of affect is a central organizing principle of human development and
motivation.

In neuroscience Damasio and Panksepp’s view of the self is implied in a neural
for minimizing the importance of emotional feelings (In Fonagy et al, 2002: 76). In
contrast, Damasio (1999, 1998, 1994a,) placed emotions in the highest order of direct
expression of bio-regulation in complex organisms. He postulated that primordial
representations of body states are the building blocks and scaffolding of development.
From this perspective the regulation of emotions is essential to the adaptive function of
the brain. The aim of Damasio is to create a synthesis between affects, the self, and
the brain and, along Spinozistic lines to create a theory of an embodied mind (Fonagy

Tomkins (1962) suggested that affects constitute a primary innate biological motivating
system and Izard (1991), (In Taylor et al, 1997) added cognition as linked to affects in
early development. The cognitive skills used to effectively monitor and regulate
emotions are also discussed in Goleman’s (1995) construct of ‘emotional intelligence’.
These skills include the ability to accurately appraise our emotions, use them in
adaptive ways and comprehend the feelings of others with empathically appropriate
responses. Individuals, who experience difficulty in affect regulation, typically manifest
deficits in these cognitive skills.

Bowlby’s (1969) attachment theory has become one of the most influential conceptual
frameworks in understanding affect regulation in connection with bodily phenomena.
Bowlby put emphasis on the anxiety-buffering and physical protection functions of early key relationships, understood proximity as an alternative to the fight-flight responses and placed particular significance of interpersonal experiences as sources of individual differences in affect regulation over the life span. Schore (2000b) described attachment theory as an essentially regulatory theory. Research studies on attachment styles in infancy and childhood support the idea that a responsive early environment is a major determinant of the way a child learns to regulate distressing emotions (Bretherton, 1985; Goldberg et al, 1994).

By looking at early infancy and the development of the limbic system, Schore (2001) demonstrated that the caregiver’s psychobiological regulation of the infant’s maturing limbic system influences a secure attachment. Schore illustrates how the fast developing brain ascribed to the right hemisphere that specialises in the organisation of learning and the capacity to adapt to a rapidly changing environment, can mediate stress-coping capacities and stress-regulating events. The result of successful regulation through a secure attachment relationship is that the infant develops a ‘control system that integrates the psychological and biological spheres of mind and body and is known to play an essential role in the processing of interpersonal signals’ (2001: 36). In examining the impact of affect dysregulation on physical health he concludes that ‘a relationship characterized by extensive misattunement and regulatory failures engenders an incomplete structural maturation of a dual circuit orbitofrontal cortex. The developmental failure of this system is responsible for future vulnerabilities to psychosomatic disease’ (Schore, 1994: 442).

The literature illustrates that the concept of affect dysregulation has been associated with a variety of conditions including ulcerative colitis, peptic ulcer, thyrotoxicosis, hypertension, irritable colon, some skin disorders, asthma, anorexia, bulimia nervosa, drug and alcohol addictions (Sifneos, 1994: 194) and allergic skin disorders, bronchial asthma, hyperthermic states, hypertension, peptic ulcers and ulcerative colitis (McDouggall, 1974: 440). Other studies associate drug addiction, with an inability to deal with emotional arousal. According to these perspectives, taking the drug is an

Bradley, (2000) encapsulates the importance placed on affect regulation in the following assertion: ‘I regard the most important aspect of affect regulation related to the development of psychopathology as being how the individual deals with states of prolonged negative affect/arousal’ (p.29). These theories argue that a build-up of tension and anxiety in individuals unable to process emotions is channelled into compulsive behaviour such as binge-eating and substance abuse, understood as displaying a desire to discharge tension. As a result, unmodulated emotion is expressed somatically (Taylor et al, 1997: 31). The Fonagy et al, (2002) thesis of affect dysregulation has been developed further to suggest that a failure to regulate affects is failure in ‘mentalizing’ or reflecting.

**A Genetic challenge to psychosocial models**

Recent scholarship in genetics threatens to bring a return of reductionism and biological determinism with findings showing a correlation between heredity and genetic predispositions and behaviour. These ideas are a direct challenge to psychosocial perspectives, especially current developmental theories and concepts (see Fonagy et al, 2002) which emphasise environmental factors as key to human development. A recent article by Kennair (2003) highlights the geneticists’ paradigm shift. In what appears as a polemic directed at the environmental, attachment based theorising, Kennair (2003) argues that ‘The new empirical research, with at least part of its base in biological disciplines – such as behavioural genetics and evolutionary psychology, but also other disciplines such as cognitive neuroscience and psychopharmacology – is revolutionising our understanding of human nature, brain-mind processes and mental disorder’ (p.196). The author is convinced that there is no evidence of early childhood experience adversely affecting personality and resulting in psychopathology in adulthood.

Findings on heritability of somatoform disorders are contradictory. Kender et al (In Noyes et al, 2006) who found a 50% genetic contribution to somatically unexplained
symptoms, whereas ‘Torgersen failed to find significant heritability for somatoform disorders… the author concluded that somatoform disorders may be familial’ (ibid: 275). Other studies cited by the authors suggest that familial factors, particularly inter-generational transmission, play a major part. Evidence from these and other studies question the idea of genetic factors as the main determinants of somatisation.

With the new focus on biology as the main determinant of human behaviour are implications of reducing humans to biologically determined entities, erasing human agency from the idea of being human. In discussing the trend in modern theories of the brain, especially those developed since the 1990’s, Fonagy et al, (2002) raise the pressing question of the dangers of a return to a biologic, reductionist mode of theorising about what makes us human. They challenge Plomin (1994 and 1999), Plomin and Bergeman (1991) and O’Connor et al, (1998) (see Fonagy et al, 2002) on the little statistical significance they place in their theorising compared with heredity. The trend of creating meaning through genetic explanations of illness permeates current thought among geneticists with the implication of a return to an established mind - body dualism. For Fonagy et al, (2002) the implications of genetic arguments are obvious: ‘The reduction of models of pathology to a principally genetic mode of causation is undoubtedly a relatively comfortable solution for all of us - but like all comforts, it comes at a price’ (p.99).

According to Fonagy et al, (2002), a premise of much of the literature on genetic factors does not take into consideration how ‘early attachment experiences (which) may well be key moderators of the expression of individual genotype, and (b) the primary evolutionary function of attachment may indeed be the contribution it makes to the ontogenetic creation of a mental mechanism that could serve to moderate psychosocial experiences relevant for gene expression’ (pp. 107-8). This brings us to a fundamental question:

‘Is the body invariant across history and culture, or is it the product of social constitution?’ (Couzens Hoy, 1999: 3). Phenomenology, and in particular theories of
‘embodiment’ are attempts to shed light on this question.

**Merleau Ponty’s Embodied Subjectivity**

By placing emphasis on the unity of consciousness as a phenomenon inseparable from being in the world (a world consisting of subjects and objects), Merleau-Ponty (1962) tried to move away from the Cartesian dualism. His study of perception constructs the body as a unified entity inhabiting space and time. The concept of embodiment is relevant for the understanding of somatic experience and helps elucidate the phenomenon of somatisation as a lived experience. The term embodiment was developed by the French phenomenologist Merleau-Ponty (1962) in his philosophy of perception. From this perspective it is postulated that the world exists before we come to know it and the lived world is pre-reflective. This idea suggests that the world out there exists and is not known to us until we think about it and learn to represent it through language. Consciousness therefore comprises of the lived experience and as Merleau-Ponty explicates *‘man is in the world, and only in the world does he know himself’* (1962: xi). With ‘embodiment’ somatic phenomena were firmly placed in the lived world comprising of objects subject to our perception in the same way that our experience of our self, our body and our relationships are.

Embodiment is the central theme in European phenomenology, with its most extensive treatment in the works of Merleau-Ponty. Embodiment in Merleau-Ponty’s (1962) philosophy means experiencing and knowing the world reflectively and through the living body-subject. *This is captured in his postulation that: ‘Consciousness is being-towards-the-thing through the intermediary of the body’* (ibid: 138-39). His account of embodiment distinguishes between the objective body, which is the body regarded as a physiological entity, and the phenomenal body, which is not just some body, some particular physiological entity, but ‘my body as I experience it’. The distinction between the objective and phenomenal body *‘is central to understanding the phenomenological treatment of embodiment. Embodiment is not a concept that pertains to the body grasped as a physiological entity. Rather it pertains to the phenomenal body and to the role it plays in our object-directed experiences’* (The Cambridge Dictionary of
Philosophy, 1999). Merleau-Ponty’s ‘reversibility’ thesis (1968) implies that the objective and the phenomenal body are two sides of the same coin and that this abstract knowledge is subject to our perception. Thus the body senses and is being sensed.

The central feature of Merleau-Ponty’s phenomenology is his challenge to Cartesian and empirical ideas of knowledge. His critique is against notions of objective thinking. For Merleau-Ponty the reflective analysis required for objective thinking is not sufficient in understanding human subjectivity. True consciousness in the Cartesian tradition does not encapsulate the importance of the subjective experience of phenomena. Lived experience, he argues, is a totality of our external and internal perceptions which are products of a continuous dialectical interaction between the phenomenal body and the pre-objective world (Merleau-Ponty, 1962: xi). Implicit in this conceptualisation is the notion that human beings are social and cultural through our participation in the world. Subjects are made via engagement with others and their environment. Thus knowledge cannot be detached from culture, language and history; it is the product of participation and dialogical engagement with the world.

It is precisely in the orientation toward the world that existence is concretised as an intentional entity through the body. In Csordas’ (1994) argument: 'the term “body” is often used (my italics) without much sense of “bodiliness”… as if body were little more than a synonym for self or person. This tendency carries the dual dangers of dissipating the force of using the body as a methodological starting point, and of objectifying bodies as things devoid of intentionality and intersubjectivity (p.4). We learn about ourselves through being with others and through understanding our actions through our perceptions. It is in this context that we learn and adopt cultural behaviour. From this perspective, culture is a given, with a fluid substance and cannot be divorced from human subjectivity. The body is subject and object simultaneously and although conceptualizations organize the body in specific ways such as the biological, cultural, political or representational, the body in Merleau-Ponty’s phenomenology is indeterminate and irreducible. The body, in other words, consists of a dialectically fluid
relationship between the individual subject in relationship with the self and the lived world.

This notion of human subjectivity as indivisible from culture and engagement with others (inter-subjectivity) was the subject of extensive discussion at a lecture given by Colwyn Trevarthen (1996) on the ‘Psychobiology of Sympathy’. Trevarthen demonstrated with visual images that infants engage with others very early on and learn to distinguish adult signals and respond in ways that maximize belonging to the group. He argued that language knowledge among other learning, are constructions of collaborative inventions, mediated by culture. This perspective advocates that self and other are in dialectical relations, culturally influenced and shaped through sympathetic relations. Such relations involve sensitive and affective understanding of the other. This idea of sympathetic relation resembles the *corps proper*, a concept regarded as one of the pivotal achievements of Merleau-Ponty. The *corps proper* is the place where subject-object are not in opposition but in unity. It is a place where the intersection between the world and being occurs. In Van Wolputte’s (2004) words on the body: ‘*We all have and we all are a body*’ (p.251).

As early as 1890, William James presented a philosophy of embodiment. Shapiro (1996) introduces her work with the following quote from William James (1890, In Shapiro (1996):

> ‘What kind of an emotion of fear would be left if the feeling neither of quickened heartbeats, nor of shallow breathing, neither of trembling lips nor of weakened limbs, neither gooseflesh nor of visceral stirring, were present, it is quite impossible for me to think’ (William James, 1890).

The passage highlights the corresponding relationship between mind and body with no hierarchical importance between them but an embodied experience between the senses and the mind. From this point of view there is a prototype theory of embodiment in James’ work. Damasio (2003) traced James’ ideas of embodiment to Spinoza (1888) (see Byatt, A.S. 2003). As Byatt puts it ‘*the study of embodied*
consciousness is leading us to reconsider all kinds of aesthetic problems and proceedings’ (2003: 3). From this perspective, mind is essentially embodied. Spinoza’s notion of freedom as self-determination is pivotal to his view of the mind and the problem of understanding mind is one of reconciling the mental phenomena with the material world. Similar to Spinoza’s idea of mind as embodied, the body in Merleau-Ponty is a source of meaning (Van Wolputte, 2004). Recent ideas of mind (Fonagy et al, 2002) such as ‘objective subjectivity’ attempt to integrate Spinoza’s notion of embodiment where subjectivity arises out of a hierarchical order in the process of mental and reflective development leading to the optimal level of mentalized affectivity.

Along Spinozistic lines, Merleau-Ponty’s (1962) concept of ‘embodied intersubjective development ‘was a profound challenge to classical dualistic theories… (where he) argues that knowledge of ourselves, and others, is given through our interconnectedness’ (Langdridge, 2005: 87). In a paper titled ‘The Child’s Relations with Others’, Langdridge (2005) elaborates on Merleau-Ponty’s criticism of child development theories discussed in his Phenomenology of Perception, arguing that Merleau-Ponty’s theory of embodiment places the focus on the immediate lived experience. To this end it is a theory of understanding the body in terms of a total system and not as a separate group of sensations. The implications of the phenomenology of embodiment on our understanding of somatic phenomena are implicit in the notion of ‘lived experience’ and ‘lived body’. If in somatic presentations individuals focus purely on the bodily sensations, then this could be described as ‘dis-embodiment’, or as ‘dis-embodied consciousness’ preoccupied with the objective body and unable to reflect on the phenomenal body. Thus experience remains partially devoid of the affective component that comes from experiencing oneself in totality.

Embodiment in Merleau-Ponty was explored at two levels: the phenomenological and the cognitive unconscious. At the first level, individuals are conscious of their feelings and actions, while at the second level, sensorimotor and other bodily-oriented inference mechanisms inform their processes of abstract thought and reasoning. By employing the term ‘embodiment’ ‘Merleau-Ponty stresses the unity of the two
New research in cultural anthropology shows that the concept of embodiment is now widely recognised for its' value in understanding bodily phenomena. Csordas (1999), amongst others, situates culture at the heart of embodiment: ‘If embodiment is an existential condition in which the body is the subjective source or intersubjective ground of experience, then studies under the rubric of embodiment are not 'about' the body per se. Instead they are about culture and experience insofar as these can be understood from the standpoint of bodily being-in-the-world’ (p. 143). In his cultural phenomenology, he describes Heidegger’s idea that the human body is not the same as the animal body, as an exposure of the inadequacy of distinctions among mind/body/soul/person. He discusses physical illness as an existential crisis with cultural meaning and is opposed to the biologism of adding a mind or soul to the human body and the sociologism of treating the body as a blank slate upon which meaning is inscribed. He tries to resolve these problems by theorising of a body that is not objectified, in other words is not a resource, but is of itself an agent in the pre-objective bodily synthesis (Csordas, 1999: 287-288).

Conclusion
Freud’s early ideas linked symptoms without organic causes to repressed emotional or sexual trauma described as ‘hysteria’ and led to Stekel’s (1943) concept of conversion where emotional trauma was communicated in bodily illness. In the 1990’s the concept of somatisation was used to describe unexplained illness. While scholars in contemporary theorising have debated on the contributing factors, suggestions of somatisation as a problem of misguided interpretation and faulty perception of physiological sensations, as emotional avoidance, or caused by psychological stress, permeate current thinking. Developmental theorists influenced by attachment, neurobiological and neuropsychological perspectives associate somatisation with affect dysregulation, alexithymia and problems in mentalising or reflecting, leaving the sufferer no option but to express unmodulated emotion physically.
The phenomenological concept of embodiment provides a dialectical relation between body and mind with body and body consciousness intertwined with subjective experience of the lived world and being subject to our moods, perceptions and interpretations. More importantly embodiment looks at somatisation as a phenomenon not merely subject to a body separate from the world, but as part of a dialectical, fluid and irreducible relationship between the subject and the unity of his or her lived experience. Finally, Merleau-Ponty’s embodiment puts agency back onto the map of bodily phenomena with the body reclaiming its lived experience, where clients with unexplained bodily symptoms can exercise their agency to understand psychological components to their symptoms. The term also offers psychotherapy practitioners a new embodied framework for understanding unexplained somatic illness. Such a framework does not limit understandings on the intra-psychic world, but embraces the lived experience situated in the external world of the person.
References


