

Corso di Psicosomatica

Scheda n. 2

Teorie psicoanalitiche e sistemiche in psicosomatica

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Per gentile concessione del professor Silvio Merciai, docente al corso di Psicosomatica presso il corso di laurea in Psicologia dell'Università di Torino

Lo studente trova un excursus adeguato sulle teorie psicoanalitiche in psicosomatica sul libro di **Trombini-Baldoni**, nei capitoli II-VI alle pagg. 25-94, e su quello di **Solano**, alle pagg. 10-19. Analogamente, sulle teorie sistemiche rimando al cap. VIII, pagg. 111-137 del **Trombini-Baldoni**.

La psicoanalisi ha, in un certo senso, inventato (o riscoperto) la questione psicosomatica e ne ha offerto, nel corso del suo sviluppo, le spiegazioni più affascinanti e più avvincenti, contribuendo a raccogliere un'importante esperienza clinica nella gestione del disturbo somatico di (supposta) origine psichica. Ce lo ricorda **John C. Nemiah** nel primo dei contributi di cui faccio cenno in questa scheda. Dalle primitive formulazioni di Freud o di Alexander, si è via via passati ad analisi più raffinate soprattutto da parte di quegli autori, come **Donald W. Winnicott** ed **Eugenio e Renata Gaddini**, che si sono dedicati allo studio dello sviluppo infantile e delle prime fasi della formazione del sé. La loro indagine sulla mentalizzazione (di cui ripareremo più avanti nel corso) ha dato nuovo impulso al pensiero psicoanalitico in psicosomatica, assieme alle teorie dei grandi psicosomatisti della scuola francese ed agli autori che si sono occupati dell'alessitimia (a cui è dedicata una prossima scheda). È in questo contesto e sulla scia di questa tradizione che si è affermata l'opera della psicoanalista contemporanea più nota e più significativa in campo psicosomatico, **Joyce McDougall**.

Difficile dire che cosa rimane comunque valido oggi, per lo psicologo ed il clinico che voglia accostarsi al problema psicosomatico, e forte è il rischio che il predominio dell'approccio neuroscientifico finisca con lo sciupare l'esperienza che la psicoanalisi ha costruito sul problema. Ma, d'altra parte, il tentativo spesso ostinato del mondo psicoanalitico di offrire spiegazioni causali al problema psicosomatico e il suo inevitabile radicamento in un modello dualistico mente-corpo, insieme con la scarsamente dimostrata efficacia delle sue capacità terapeutiche in questo ambito e l'estrema varietà dei modelli proposti e delle indicazioni di trattamento che ne sono scaturite, hanno indotto sconforto e discredito in molti ambienti: incluso il mondo psicoanalitico stesso. Si veda come, per esempio, l'entusiasmo e il prestigio della McDougall stessa non riescano a persuadere l'estensore della relazione di un panel dell'IPA in argomento ...

Discuteremo assieme i termini del problema grazie ad un articolo assai illuminante:

O. Todarello e P. Porcelli, Osservazioni sul trattamento psicoanalitico di un caso di rettocolite ulcerosa, *Psicoterapia e Scienze Umane*, 30 (4): 67-86, 1996; il lavoro in questione è disponibile su Internet sul sito di Psychomedia all'indirizzo <http://www.psychomedia.it/PM/ANSWER/psychosoma/todpor1.htm>.

Per un approfondimento sul pensiero di Luis Chiozza, segnalo il suo sito a <http://www.chiozza.com/us/index.htm> e quello della Fundación Luis Chiozza a <http://www.funchiozza.com/us/index.htm>.

Psicoanalisi e Medicina Psicosomatica

Su Psychosomatic Medicine del 2000 (n. 62 pagg. 299-303) è comparso un bell'articolo di *John C. Nemiah* intitolato **A Psychodynamic View of Psychosomatic Medicine**, nel quale vengono lucidamente ripercorsi gli esordi ed il significato del contributo psicoanalitico alla psicodinamica (con particolare attenzione al pensiero di *Janet*, spesso trascurato):

... the too-exclusive pursuit of research along biological and phenomenological lines in recent years has not only resulted in a paucity of psychodynamic studies of psychosomatic processes but has also led to a striking amnesia for the findings and concepts that had evolved over the earlier years of psychosomatic research. It is my purpose here briefly to review the history of that development and to indicate the potential value of those earlier inquiries for future psychosomatic investigations.

*Although the origins of the psychodynamic view of the psychosomatic process stem from the psychological studies of Pierre Janet at the end of the 19th century, for more than 100 years before that there had been a lively interest in the possible role of the human imagination as both a cause and a cure of somatic illness. The renowned English psychiatrist Daniel Hack Tuke admirably summarized the extensive literature that had accumulated concerning mind-body relationships during the previous 100 years in what may properly be called the first textbook of psychosomatic medicine. Published in 1873 and entitled *Illustrations of the Influence of the Mind Upon the Body in Health and Disease Designed to Elucidate the Action of the Imagination*, it recounts*

scores of telling examples of the effect of mental processes on somatic functioning, a phenomenon that, as Bate has noted, Samuel Taylor Coleridge had already dubbed "psychosomatic" in the early years of that century. Tuke, for instance, cites from the French literature the following startling "experiment": "The rejection of the contents of the stomach from a purely mental state is well exemplified in an experiment made upon 100 patients in a hospital and reported by Dr. Durand (du Gros) in his able work, 'Essais de Physiologie Philosophique.' The house surgeon administered to them such inert draughts as sugared water; then, full of alarm, he pretended to have made a mistake in inadvertently giving the man emetic instead of syrup of jam. The result may easily be anticipated by those who can estimate the influence of the imagination. No fewer than 80—four-fifths—were unmistakably sick."

That brief clinical vignette provides a striking illustration of Tuke's basic view of the effect of the mind on the body. It serves also to epitomize his delineation of a focus of medical interest that had begun with Mesmer and when Tuke wrote was approaching a scientific dead end of sterile neurophysiological speculations, such as Carpenter's "unconscious cerebration."

It was Janet who found a way around that conceptual impasse with his recognition that suggestion and its effects on human subjects were psychological phenomena that could be described and understood only in psychological language. Within that frame of reference, Janet formulated his concepts of the psychological process of mental dissociation, the splitting of consciousness, and the transformation of subconscious ideation into hysterical symptoms. These basic conceptual guidelines are evident in Janet's description of the clinical evaluation and treatment of his famous patient, Marie, a young woman with a variety of disabling somatic symptoms. Prominent among these was a profound disturbance in her menstrual functions.

"As her menses approached," Janet wrote, "Marie's character would change, she would become gloomy and violent and would suffer from nervous twitchings in all her limbs. Despite this, everything would go smoothly during the first day, but scarcely 20 hours after its appearance her menstrual flow would suddenly cease, and her whole body would be seized by a shaking chill followed by an acute pain starting in her stomach and rising to her throat, after which she would begin to have major hysterical crises. These convulsions never manifested characteristic epileptiform movements and were followed by long and intense delirium. The episodes would end with copious vomiting of blood following which everything would return to normal.

Although in her normal waking state Marie could not connect her symptoms with any events in her life, under hypnosis she recalled, as Janet tells us.

...the exact memory of a scene she had never been aware of before except in the most incomplete fashion. At the age of 13 she had had her first period, but either as the result of some childish idea or of a conversation she had overheard and misunderstood, she got it into her head that there was something shameful about the process and tried to find a way of stopping the flow as quickly as possible. Approximately 20 hours after her period had started, she went out secretly and plunged herself into a tub of cold water. Her action was completely successful. Her period was suddenly arrested, and despite a severe shaking chill that followed she was able to return home. She was ill for sometime thereafter, and for several days was delirious. Everything quieted down, however, and her periods did not recur for 5 years. When they did return, they were accompanied by the difficulties I have described. Thus, if one compares the sudden arrest of her menses and the shivering and pain she now experiences in her waking state with the account she gives under hypnosis (which, moreover, was independently confirmed), one arrives at the following conclusion. Each month the scene of the cold bath is repeated, leading to the same arrest of menses and delirium. In her normal state of consciousness, however, she knows nothing about that and is quite unaware that her shivering is brought on by a hallucination of cold. It is possible, therefore, that the scene occurs below consciousness and brings on all the rest of her difficulties in its train.

Janet's formulation of mental dissociation and its central role in symptom formation was well known to Breuer and Freud as they pursued their early investigation of hysterical phenomena. With reference to Janet's findings, they commented, "The longer we have been occupied with these phenomena, the more we have become convinced that splitting of consciousness in the well known clinical cases under the form of 'double conscience' [dual consciousness] is present in a rudimentary degree in every hysteria, and that a tendency to such a dissociation and with it the emergence of abnormal states of consciousness is the basic phenomenon of this neurosis."

It should be noted, however, that although Freud agreed at this point with Janet that hysterical symptoms were the surface manifestations of unconscious dissociated traumatic memories, he disagreed with Janet's explanation of the origin of dissociation itself. In Janet's view, dissociation was the result of a deficiency of psychological energy ("la misère psychologique"). Normal persons, he proposed, have a sufficient quantity of such psychological energy to enable them to bind together all their mental functions into an organized unity under the control of the "ego," or self. In some individuals, however, either through heredity or as the result of emotionally exhausting traumatic stresses, the quantity of psychological energy is lowered below a critical point. As a consequence, the binding power of the ego is weakened, leading to the dissociation from consciousness of selected mental elements. The latter can now be represented in conscious awareness as automatisms taking the form of ego-alien symptoms. In Janet's model of the mind, normal persons cannot be hypnotized. It is only those with a pathologically weakened ego who respond to hypnotic suggestion with an artificially induced mental dissociation.

By the same token, hypnosis becomes an effective therapeutic agent when applied to patients with pathological dissociative automatisms. For example, when Janet turned to the treatment of Marie's menstrual disorder, he was able to remove that idea [the dissociated memory of her aborted menarche] by a curious measure. It was necessary to bring her back to the age of 13 by hypnotic suggestion, to revive that earlier state of delirium, and then to convince her that her period had lasted for three days and had not been interrupted by any untoward occurrence. Once that had been accomplished, her next period arrived exactly on schedule, lasted three days without being accompanied by any interruption, any convulsions, or any delirium. It is now more than five months since that experiment was made, and Marie no longer presents the least sign of hysteria.

(Janet, it may be noted, used the therapeutic technique of cognitive restructuring nearly a century before the

introduction of modern cognitive therapy.)

Freud's explanation of dissociative splitting was radically different from Janet's formulation. In *Studies on Hysteria* he introduced the concepts of repression and psychological defenses. In hysterical patients, he proposed, the ego protects itself from the painful recollection of traumatic events by repressing both the associated memories and emotions from conscious awareness and by converting the painful affects into somatic symptoms symbolically representing the precipitating trauma.

If one compares these two models of symptom formation, the differences are readily apparent. Whereas Janet conceived of an ego too weak to maintain its functional integrity, Freud viewed the ego as being strong enough to preserve its normal functions and its emotional equanimity by exercising an active control over the range and quality of the contents of conscious awareness. In that latter formulation were born the concepts of psychological conflict and psychological structure that remained thereafter the bedrock of the psychoanalytic understanding of mental functioning. It is not surprising, therefore, that when psychoanalytically trained physicians turned to a study of the possible role of psychological factors in the causation of medical diseases, they invoked the mechanism of conversion that had initially been formulated in connection with the somatic symptoms of hysterical patients. In the early 1920s, for example, Deutsch commented, "The concept of the conversion process is now gaining in importance because similar transformation processes from psychic into organic phenomena can be observed also in diseases which by no means appeared to be psychogenic ones. Thus Freud's concept of conversion may be carried beyond its original meaning. A considerable part of organic symptomatology will then be recognized as a result of the conversion process."

In the course of additional psychoanalytic investigations of patients suffering from what were increasingly referred to as psychosomatic illnesses, it became evident that generalizations such as that set forth by Deutsch were unsubstantiated. Psychological exploration of psychosomatic patients rarely disclosed conversion mechanisms underlying their symptoms. As Alexander commented in a summary of the extensive clinical observations that had accumulated during the decade or two after Deutsch's formulation,

It seems advisable to differentiate between hysterical conversion and vegetative neurosis (i.e., a psychosomatic condition). Their similarities are rather superficial: both conditions are psychogenic, that is to say, they are caused ultimately by a chronic repressed or at least unrelieved emotional tension. The mechanisms involved, however, are fundamentally different both psychodynamically and physiologically. The hysterical conversion symptom is an attempt to relieve an emotional tension in a symbolic way; it is a symbolic expression of a definite emotional content. This mechanism is restricted to the voluntary neuromuscular or sensory-perceptive systems whose function is to express and relieve emotions. A vegetative neurosis consists of a psychogenic dysfunction of a vegetative organ which is not under control of the voluntary neuromuscular system. The vegetative symptom is not an expression of the emotion, but its natural physiological concomitant.

Although Alexander made a sharp distinction between the specific psychodynamic mechanisms underlying the production of a conversion and a psychosomatic symptom, he attributed both to a repression of affects. In so doing, he adhered firmly to the basic psychoanalytic concept of psychological conflict. At the same time, however, he highlighted a striking aspect of the mental functioning of psychosomatic patients, who exhibit marked behavioral defects in their affective and cognitive functions. Those characteristics subsequently became the explicit focus of interest of several investigators of psychosomatic illness, such as Ruesch in the United States and Marty in France, whose description and analysis of their nature went far beyond Alexander's brief passing mention.

Introdotta il concetto di *alexithymia* e mantenendosi nell'ambito di una visione 'classica' del problema psicosomatico, *Nemiah* continua:

Whatever the ultimate explanation of *alexithymia* proves to be, it is clear from its behavioral manifestations that the mechanisms of somatic symptom formation in *alexithymic* patients are quite different from those found in the production of conversion symptoms. A conversion symptom is the end result of processes occurring in a complex structure of psychological mechanisms that transform stress-induced arousal into a somatic dysfunction symbolically representing the original stressful situation. In the *alexithymic* individual, on the other hand, stress-induced arousal undergoes no psychic elaboration and is directly transformed into a somatic dysfunction. Despite those differences, however, from a conceptual point of view, both models of symptom formation are psychological in nature. Both use a psychological model that conceives of symptoms as the end result of stress-induced internal psychic arousal into peripheral somatic manifestations. There are, in other words, two radically different psychological pathways leading to clinical symptoms, one associated with the mechanism of conversion, the other with *alexithymia*.

e così conclude:

Finally, it should be emphasized that the historical information presented here is of more than mere antiquarian interest. On the contrary, it reveals a large body of empirically derived psychodynamic fact and theory that, although largely disregarded in our current preoccupation with the biology of psychiatric disorders, constitutes a major element of what Engel has termed the "biopsychosocial" model of human illness. In sum, as history teaches us, psychodynamic psychiatry has made important contributions to the understanding of psychosomatic illness, and it has many more to add in the years ahead to an integrated concept of human illness that, as Weiner has cogently demonstrated, is unique to psychosomatic medicine.

Aspetti positivi e negativi della malattia psico-somatica

Con questo titolo (*Psycho-Somatic Illness in its Positive and Negative Aspects*: il lavoro è pubblicato sull'*International Journal of Psychoanalysis*, 1966, 47:510-516) Donald W. Winnicott fa il punto sulla sua visione della questione psicosomatica. Premette, a mo' di sinossi, che:

1. *The word psycho-somatic is needed because no simple word exists which is appropriate in description of certain clinical states.*
2. *The hyphen both joins and separates the two aspects of medical practice which are constantly under review in any discussion of this theme.*
3. *The word accurately describes something that is inherent in this work.*
4. *The psycho-somatist prides himself on his capacity to ride two horses, one foot on each of the two saddles, with both reins in his deft hands.*
5. *Some agent has to be found that tends to separate the two aspects of psycho-somatic disorder, to give the hyphen a place.*
6. *This agent is, in fact a dissociation in the patient.*
7. *The illness in psycho-somatic disorder is not the clinical state expressed in terms of somatic pathology or pathological functioning (colitis, asthma, chronic eczema). It is the persistence of a split in the patient's ego-organization, or of multiple dissociations, that constitutes the true illness.*
8. *This illness state in the patient is itself a defence organization with very powerful determinants, and for this reason it is very common for well-meaning and well-informed and even exceptionally well-equipped doctors to fail in their efforts to cure patients with psycho-somatic disorder.*
9. *If the reasons for this tendency to fail are not understood medical practitioners lose heart. Then the subject of psycho-somatics becomes a subject for non-clinical or theoretical survey, and this is relatively easy because the theoretician is detached, and is not cluttered up by responsibility for actual patients. The theoretician is the very one who is apt to lose touch with the dissociation, and he is able to see from both sides only too easily.*

e così illustra, dopo alcuni esempi clinici, la sua tesi:

A multiplication of clinical examples would not further the argument. There is no area of personality development that escapes being involved in a study of psycho-somatic disorder. A severe disintegration threat can be hidden in a cricked neck; an insignificant skin rash may hide a depersonalization; blushing may be all that shows of an infantile failure to establish a human relationship through the passing of water, perhaps because no-one would look and admire in the phase of micturition potency. Moreover suicide may be gathered into a hard patch on the inner maleolus, produced and maintained by constant kicking; delusions of persecution may be confined clinically to the wearing of dark glasses or by a screwing up of the eyes; an antisocial tendency belonging to a serious deprivation may show as simple bed-wetting; indifference to crippling or painful disease may be a relief from a sado-masochistic sexual organization; chronic hypertension may be the clinical equivalent of a psychoneurotic anxiety state or of a long-continued traumatic factor, such as a parent who is loved but who is a psychiatric casualty. And so one might go on, but all this is familiar ground.

My contention is that these things do not of themselves constitute psycho-somatic disorder, nor do they justify the use of a special term or the organization of a Psycho-Somatic Group within the general medical and surgical profession. What makes sense of this grouping is the need that some patients have to keep the doctors on two or more sides of a fence, because of an inner need; also that this inner need is part of a highly organized and powerfully maintained defensive system, the defences being against the dangers that arise out of integration and out of the achievement of a unified personality. These patients need us to be split up (yet essentially united in the far background that they cannot allow themselves to know about).

For a long time I have been puzzled by our failures to classify psycho-somatic disorders and our inability to state a theory, a unified theory of this illness group. When I found a way of saying to myself what psycho-somatic disorder really is I found myself with a ready-made classification which I will give (for what it is worth). But first let me re-state my main thesis, linking it with the theory of maturation in individual growth.

... Psycho-somatic illness is the negative of a positive; the positive being the tendency towards integration in several of its meanings and including what I have referred to (1963) as personalization. The positive is the inherited tendency of each individual to achieve a unity of the psyche and the soma, an experiential identity of the spirit or psyche and the totality of physical functioning. A tendency takes the infant and child towards a functioning body on which and out of which there develops a functioning personality, complete with defences against anxiety of all degrees and kinds. In other words, as Freud said many decades ago, the ego is based on a body ego. Freud might have gone on to say that in health the self retains this seeming identity with the body and its functioning. (The whole complex theory of introjection and projection, as well as conceptualization around the term 'internal object', is a development of this theme).

This stage in the integrating process is one that might be called the 'I AM' stage (Winnicott, 1965). I like this name because it reminds me of the evolution of the idea of monotheism and of the designation of God as the 'Great I AM'. In terms of childhood play this stage is celebrated (though at a later age than I have in mind now) by the game: 'I'm the King of the Castle—You're the Dirty Rascal'. It is the meaning of 'I' and 'I am' that is altered by the psycho-somatic dissociation.

The splitting of the psyche from the soma is a retrogressive phenomenon employing archaic residues in the setting up of a defence organization. By contrast the tendency towards psycho-somatic integration is a part of

forward movement in the developmental process. 'Splitting' is here the representative of 'repression' that is the appropriate term in a more sophisticated organization.

... If this be true then it should be possible to classify psycho-somatic illness according to the theory of the maturational processes, including two main ideas:

1. A primary unintegrated state, with a tendency towards integration. Result dependent on Mother's ego reinforcement, based on her adapting capacity, giving the infant's ego a reality in dependence. Maternal failure which leaves the infant without the essentials for the operation of the maturational processes.

2. Psycho-somatic integration or the achievement of the 'indwelling' of the psyche in the soma, and this to be followed by the enjoyment of a psycho-somatic unity in experience.

In the process of integration the infant (in healthy development) gains a foothold in the 'I AM' or the 'King of the Castle' position in emotional development, and then not only does the enjoyment of body functioning reinforce ego development, but also ego development reinforces body functioning (influences muscle tone, coordination, adaptation to temperature change, etc., etc.). Developmental failure in these respects results in uncertainty of 'indwelling', or leads to depersonalization in so far as indwelling has become a feature that can be lost. The term indwelling is used here to describe the dwelling of the psyche in the personal soma, or vice versa.

At the 'I AM', or 'King of the Castle' position the individual may or may not for internal or for external reasons (and the infant is still highly dependent) be able to cope with the rivalry that this engenders ('You're the Dirty Rascal'). In health rivalry becomes an added stimulus to growth and to the zest for living.

Hence, psycho-somatic disorder relates to Weak ego (dependent largely on not good-enough mothering) with a feeble establishment of indwelling in personal development; and/or Retreat from I AM and from the world made hostile by the individual's repudiation of the NOT-ME, to a special form of splitting which is in the mind but which is along psycho-somatic lines.

(Here an actual persecuting environmental detail may determine the individual's retreat to some form of splitting.)

In this way, psycho-somatic illness implies a split in the individual's personality, with weakness of the linkage between psyche and soma, or a split organized in the mind in defence against generalized persecution from the repudiated world. There remains in the individual ill person, however, a tendency not altogether to lose the psycho-somatic linkage.

Here, then, is the positive value of somatic involvement. The individual values the potential psycho-somatic linkage. To understand this one must remember that defence is organized not only in terms of splitting, which protects against annihilation, but also in terms of protection of the psyche-soma from a flight into an intellectualized or a spiritual existence, or into compulsive sexual exploits which would ignore the claims of a psyche that is built and maintained on a basis of somatic functioning.

One more complication. Naturally, when the personality is dissociated, dissociations in the environment are exploited by the individual. An example would be the use made of a tendency in the mother towards disintegration or depersonalization, of parental discord, or of the break-up of the family unit, or of antagonism (especially unconscious antagonism) between family and school. In the same way, use is made of the splits (to which I have referred) in the matter of medical provision.

Here there can be a return to my main idea, which is that the existence of a 'psycho-somatic' or (psychosomatic) group of doctors depends on the patients' need for us to split up for practical purposes, but to remain theoretically united by a common discipline and profession.

Our difficult job is to take a unified view of the patient and of the illness without seeming to do so in a way that goes ahead of the patient's ability to achieve integration to a unit. Often, very often, we must be contented to let the patient have it, and to manipulate the symptomatology, in a box-and-cox relation to our opposite numbers, without attempting to cure the real illness, the real illness being the patient's personality split which is organized out of ego weakness and maintained as a defence against the threat of annihilation at the moment of integration.

Psycho-somatic illness, like the antisocial tendency, has this hopeful aspect, that the patient is in touch with the possibility of psycho-somatic unity (or personalization), and dependence, even though his or her clinical condition actively illustrates the opposite of this through splitting, through various dissociations, through a persistent attempt to split the medical provision, and through omnipotent self caretaking.

II pensiero di Eugenio e Renata Gaddini

Eugenio e Renata Gaddini sono certamente gli autori italiani che più hanno contribuito allo sviluppo psicoanalitico della problematica psicosomatica.

In un suo lavoro del 1977 (ma letto l'anno precedente) **The Pathology of the Self as a Basis of Psychosomatic Disorders** (*Psychotherapy and Psychosomatics*, 28:260-271), Renata Gaddini così si esprime sulla questione:

... the psychosomatic symptom takes place when the mother has failed her interactional task during the child's infancy, a time when the child has not yet developed the necessary mental apparatus to endow an object, once associated with the mother, as a symbol for the mother. ...

The young child lives his physical experience, while growing, with disintegration anxieties and fears. Mental activity comes just at a point when the child can use it (he is in need of it) to master them. In the child's mind fantasy takes place, to save him from disintegration. Reality belongs to the body, in early life. It is all in the self when a child is a few months old, there is no external reality. But fantasy is lived through the body, it is materialized through the body, it turns to reality only through bodily experiences. This is the puzzling leap from

the mental to the physical that Freud referred to. We can solve it only by studying carefully the process of development. Let's take the example of rumination. In rumination the infant makes the fantasy of being the nursing mother (i.e. he lives again the experience which once he has lived in omnipotent fusion with his mother). This fantasy is lived in a way which is inextricably connected with his own previous bodily experiences and gets materialized through his own body. ... The fantasy which underlies rumination is a pathological fantasy on the part of the infant; ... No evaluation takes place in the process: it is an end to itself, and the child does not mature. This psychosomatic syndrome is a time-marking condition, insofar as it indicates a pathology which can only take place at a particular level of development, and which is dependent on maternal and infant factors. ... What is basic to self-creativity, seen as the capacity for contributing to the outside world with one's inner world, is the existence in the individual of a total separate self ... On clinical grounds, we can say that we rarely find self-creativity in the young psychosomatic patient. ... The conclusion of my presentation implies that it is the defenses of the self which have to be strengthened, if we want to contribute within the psychosomatic approach to individual susceptibility to disease. This can be best done in terms of prevention, which is, for me, support without interference in the natural processes that characterize a young child's relationship with his mother.

In un successivo lavoro del 1979 (ma letto nel 1977) **Early Psychosomatic Pathology** (*Psychotherapy and Psychosomatics*, 31:121-127), *Renata Gaddini* fa di nuovo il punto sui suoi studi:

Deviancy in relating to the object is now generally accepted to be the basis of psychosomatic pathology; my point here is that conflict relationships are potentially at the basis of every somatic illness, particularly in developmental age. On the basis of our observations we may also state that early environmental failure - as early as the first days of life - is a likely basis for psychosomatic pathology, and may be looked upon as a general predisposing factor to the development of psychosomatic disorders at a later date. We now have an indication on a substantial basis that early life organization is based on early interaction, and that difficulties in these early interactions correlate with a poor mental organization and with early psychosomatic pathology. One of these indications comes by the significant higher incidence of perinatal complications in asthmatic children in respect with their controls. ... In economical terms atopic dermatitis is an uncoordinated response in its connections between body and mind. From the itching-scratching we go to the atopic dermatitis, which implies a defense organization and therefore some sort of psychic activity, though a rudimental one. This sort of rudimental activity is a defense against a threat of separation, and is based on a pathological model. In fact, the child's mode of demarcating his or her own body limits is pathological. ... Perinatal and neonatal difficulties are present in a number of atopic dermatitis children, and these are often connected with a low birth weight. Overfeeding and force feeding appear to be typically present in atopic dermatitis in early life. This is probably the direct repercussion on the child of the mother's anxious feelings about her infant's vulnerability, as is usually the case in our culture. Skin eruption, of the type we are used to diagnosing as food allergy, follows this relative overfeeding. The toxic skin irritation, with the consequent itching and scratching, may be seen as the somatic triggers of atopic dermatitis. The mother's concern for her infant's fragility, the way it has been described among the reactions to the threatened loss of a child, ... is a powerful psychic trigger. Itching and scratching go with continuously aggravating cutaneous lesions requiring ointment treatment. Mother's pain-relieving interventions, with her touching and massaging, has the vicarious function of mother-infant bonding, after separation at birth.

In un successivo lavoro del 1986 (del quale non dispongo della corretta referenza bibliografica), *Eugenio Gaddini* e *Renata Gaddini De Benedetti* offrono un quadro complessivo della loro teorizzazione in ambito psicosomatico.

... la psicoanalisi considera l'attività mentale come la più differenziata delle funzioni corporee, tanto differenziata da richiedere un proprio metodo di ricerca, tali da studiarne i fenomeni così come essi occorrono, indipendentemente dai presupposti biologici che loro soggiacciono. E' anche vero, però, che la psicoanalisi considera il tutto corpo-mente come un continuum funzionale, il cui elemento-chiave è ancora un processo che si svolge nel corso della differenziazione della funzione mentale, la cui direzione si svolge dal corpo verso la mente, ma che la psicoanalisi studia dalla mente verso il corpo. ... Freud riteneva che la sola psicologia scientifica che si doveva costruire era una psicologia che implicasse l'idea della mente come una funzione corporea differenziata insieme con un complesso funzionamento mente-corpo. ... in primo luogo l'io è un io corporeo. ... a livelli molto precoci, l'io non fa rappresentazioni delle esperienze emozionali, ma le costruisce come stati corporei. ... Ciò che distingue i fenomeni psicosomatici da altri fenomeni che coinvolgono sensazioni corporee, quali i sintomi di conversione, l'ipocondria e i deliri di ordine somatico, è che l'origine dei fenomeni psicosomatici ha luogo in processi che sono al di fuori della formazione del simbolo. La teoria che considera la patologia psicosomatica come un difetto maturativo ha, d'altra parte, risvolti tecnici e prognostici. Per poterli trattare in chiave terapeutica, si deve cercare di scoprire le sensazioni fisiche (o gli eventi a queste connessi) che all'origine sono stati sopraffacenti, per via dei sentimenti che vi ci aveva attaccato la madre o che erano stati vissuti come tali impedendo in questo modo che si potessero sviluppare in attività mentale. La patologia psicosomatica riguarda quindi i processi maturativi precoci, assai più precoci di quanto lo siano la psicosi e le condizioni borderline, in termini di psicopatologia. Esso implica un difetto della possibilità di mentalizzare il disagio, investendo il corpo in modo tale da rivivere la minaccia come simbolica piuttosto che come esistenzialmente presente. ... il paziente psicosomatico si può considerare come una persona che agisce all'interno di sé (acting in), in contrasto con l'acting-out, che è un agire fuori, all'esterno di sé. Il termine acting-in è stato impropriamente usato per indicare l'agire nella seduta psicoanalitica. Il vero acting-in è invece l'agire nel corpo, organizzando in

questo modo una risposta somatica oppure il sintomo somatico. Lo scopo economico è di scaricare nel corpo tensioni che la mente non è in grado di sostenere. L'acting-in produce alterazioni dell'equilibrio psico-fisico che danno luogo a sintomi somatici. L'acting-out, al contrario, dà luogo ad alterazioni del comportamento.

Psicoanalisi e psicosomatica

La *Revue Française de Psychoanalyse* ha dedicato, nel 1998, un numero speciale al problema della psicosomatica ed alcuni dei contributi più rilevanti sono stati poi riprodotti, in traduzione italiana, su *Ricerca Psicoanalitica* (2000, XI, 1). Ne traggio, qui di seguito, qualche spunto interessante:

Nel suo articolo introduttivo - **Psicosomatica e psicoanalisi (Après coup**, nell'edizione originale), *Claude Smadja* scrive tra l'altro:

La medicina, da sempre e a diritto, ha occupato il territorio della psicosomatica. Cosa normale se si pensa che la sofferenza di questi malati si esprime principalmente sul versante somatico. ... l'unità del pensiero medico poggia sulla componente biologica della malattia, alla quale gli altri fattori vengono subordinati. ... Non è difficile cogliere le conseguenze dell'oggettivazione scientifica della malattia: il malato si vede proibita la parola, quella della sofferenza sottratta al lavoro psichico. Ricordiamo l'osservazione piena di verità di G. Canguilhem: "Il malato è una persona che ha bisogno di parlare a qualcuno". ... Per questo la dimensione soggettiva del malato non può in alcun modo essere eliminata dalla relazione con il medico.

Ma può la psicoanalisi occuparsi dei malati somatici sui tre versanti della pratica, della clinica e della teoria?

*Questa domanda rimanda alla storia della stessa psicoanalisi. Le nevrosi attuali, studiate da Freud fin dall'inizio, rappresentavano una categoria di malati che interessava più la medicina che la psicoanalisi. Eppure rimangono per la psicoanalisi un riferimento permanente. Conosciamo la posizione ferma di Freud: "Le nevrosi attuali non interessano la psicoanalisi". Questa dichiarazione, carica di conseguenze, ha certamente inciso sull'esclusione, per più decenni, di una parte della clinica psicoanalitica, almeno fino a quando gli autori di *L'investigation psychosomatique* (1963) non hanno reintrodotto in seno a quella stessa clinica la psicosomatica. ...*

Il secondo ostacolo all'integrazione del fatto psicosomatico nell'ambito della psicoanalisi è rappresentato dalla malattia somatica quale dato eterogeneo al campo psicoanalitico. Per superare questo ostacolo dovremmo avere strumenti concettuali capaci di fondare un vero monismo soma-psiche. ...

Questa premessa mirava a precisare una posizione teorica generale: la psicosomatica è uno degli ambiti di intervento dello psicoanalista. ...

Gli psicoanalisti dell'École de Paris, riuniti intorno a Pierre Marty, hanno operato un profondo cambiamento nella storia della psicosomatica. Hanno trasformato lo statuto della psicosomatica passando dal regime di applicazione della psicoanalisi a quello della pratica della psicoanalisi. Il pensiero operatorio è nato da questa nuova interpretazione del fatto psicosomatico. Il dato clinico della vita operatoria, così come Pierre Marty l'ha formulato nei suoi scritti e nel suo insegnamento orale, è così ricco, acuto e completo da farne il riferimento e la base di ogni intervento analitico.

L'autore si dedica poi ad esplicitare una sua rilettura del funzionamento operatorio nella linea della seconda topica freudiana accostando le condizioni psicosomatiche agli stati borderline, che ha per la presente scheda minore interesse.

A Claude Smadja rispondono *Jaqueline Amati-Mehler* e *Simona Argentieri Bondi* con il lavoro **Un altro modello per la psicosomatica** (nella versione originale. **Un autre modèle pour la psychosomatique**):

... pensiamo sia più utile offrire una diversa prospettiva ... Un gruppo di psicoanalisti italiani che seguono il pensiero di Eugenio Gaddini ... ritiene che i livelli precoci implicati nella malattie psicosomatiche rimandino ad un'area pre-strutturale nella quale nessuno degli elementi delle due topiche si è ancora chiaramente differenziato. Un'area dove ancora non esiste la possibilità di integrare psichicamente sensazioni, percezioni e affetti in rappresentazioni comunicabili a se stessi e agli altri. Dove non abbiamo che elementi affettivi confusi, angosce primitive non traducibili in acquisizioni di senso. Non c'è pensiero simbolico e le pulsioni non possono essere ancora mentalizzate in rappresentazioni e dirette verso un oggetto riconosciuto come tale. ...

Nel 1981, al congresso della Federazione Europea, sia Betty Joseph che Eugenio Gaddini hanno sostenuto che le fantasie sono, dall'inizio, intimamente legate alla formazione delle difese precoci che hanno origine nelle esperienze istintive corporee. Ma, mentre Betty Joseph propone di datare le fantasie e le difese in base allo sviluppo pulsionale e al loro rapporto con gli oggetti interni e le loro angosce, Gaddini propone un modello di comprensione delle origini delle fantasie basato sulle esperienze mentali primitive del corpo proprie di un determinato funzionamento fisico, per esempio, all'inizio, l'alimentazione.

... Gaddini ... ritiene che bisogna ricercare l'origine della mentalizzazione ancor prima dell'immagine visiva allucinatoria, a un livello più vicino al biologico e al corporeo. Piuttosto che di oggetto e di pensiero, ritiene che all'inizio sia più corretto parlare di attività di rievocazione nel corpo di sensazioni connesse con funzionamenti precedentemente sperimentati e che hanno lasciato una traccia mnestica. ... L'esperienza mentale primitiva è in questa fantasia corporea: per esempio, lo stimolo della fame porta il neonato a succhiare 'a vuoto', come per riattivare il funzionamento corporeo e de sensazioni di cui ha fatto esperienza nell'allattamento. "Questa risposta psicofisica-fantasia del corpo" che Gaddini ha chiamato profantasia "funziona come difesa autarchica della mancanza di soddisfacimento reale del bisogno" per contenere la minaccia aggressiva della pulsione di morte ...

ed è diversa dalle fantasie sul corpo che hanno bisogno di una mentalizzazione più evoluta.

... Siamo convinte, con Eugenio Gaddini, che l'angoscia 'catastrofica' che minaccia il fragile nucleo primitivo del sé si esprima in due modi: l'angoscia di non-integrazione e l'angoscia di integrazione, due tendenze difensive opposte. Clinicamente, la prima corrisponde al panico di annientamento, alla paura di perdersi nello spazio infinito e esprime lo sforzo di integrazione e di maturazione per tenere assieme i frammenti non ancora integrati del sé. L'altra invece tende a mantenere un'organizzazione fluida frammentaria e indefinita che vive ogni progresso o cambiamento come una minaccia di morte. Le protofantasie e le sindromi psicofisiche sarebbero legate a una difesa d'integrazione più che ad una spinta, nella direzione opposta, alla disintegrazione, dovuta ai processi regressivi.

L'articolo successivo, di Jean Guillaumin, **L'operatività e il corpo nel 'monismo' freudiano (L'operativité et le corps dans le 'monisme' freudien)**, ripercorre il pensiero di Freud alla luce della dicotomia corpo-mente pervenendo in conclusione a questa affermazione:

... non si tratta di ridurre l'esperienza del corpo a qualcosa d'altro, ma di ammettere, lo ripeto, che non possiamo capire psicoanaliticamente la relazione che i nostri pazienti hanno con il loro corpo se non attraverso quello che loro sentono o non sentono, si rappresentano o non si rappresentano e che questa conoscenza non può avvenire per loro e pervenire a noi se non nel gioco del transfert e del controtransfert. Il corpo non esiste psicoanaliticamente se non attraverso la traduzione che se ne dà il pensiero: quello del paziente, ripreso da quello dell'analista nell'ambito del legame vivo che unisce l'uno all'altro.

L'articolo conclusivo è di Steven Wainrib, **Interpretazione e problematiche psicosomatiche (Interprétation et problematiques psychosomatiques)**:

... il funzionamento operatorio del paziente è una difesa. Si tratta di una difesa contro la disintegrazione, completamente differente dai comuni meccanismi di difesa utilizzati contro le pulsioni di un Io ben organizzato topicamente. ...

Siamo in presenza di un paziente che distrugge ogni sensazione di esistere per eliminare il dolore di esistere, il dolore legato al sentimento di essere, quando non c'è più la speranza di farsi riconoscere dall'altro nel proprio essere corpo.

È la difesa: 'Sono come mi volete'. Difesa difficile da reggere per l'analista perché non elimina solo l'esistenza del paziente, ma anche quella del suo interlocutore che perde la sensazione di essere un referente dai contorni definiti. ...

Paradossalmente più questi pazienti sono blindati contro la disorganizzazione, murati nel loro essere incollati al fattuale, incapaci di articolare la loro vita pulsionale nella continuità dell'essere, più sono fragili somaticamente. In effetti, l'eccitazione, che dovrebbe dar luogo alla pulsione, cioè all'esigenza del lavoro psichico legato al corporeo, viene vissuta come disturbo somatico. Privato della continuità dei processi di soggettualizzazione, premessa indispensabile dell'articolazione soma-psiche, il corpo si ritrova in balia di brusche spinte di perturbazione identitaria nel suo sistema immunitario o di folli tempeste neurovegetative.

Questa realtà non comporta l'astenersi dall'interpretare, ma un interpretare in modo diverso dagli abituali termini di conflitto di desiderio o di meccanismi di difesa dell'Io. In effetti, non siamo tanto in presenza di un conflitto strutturato, quanto di un conflitto che fa esplodere, che oltrepassa le capacità psichiche di contenimento, che mette di fronte alle angosce più arcaiche di annientamento. ...

Mi premeva ... fare cogliere come, partendo dalla somatizzazione, l'interpretazione possa avere una funzione di creazione di legami, veicolo di significati e sostegno alla soggettualizzazione, proprio là dove viene scoperta una spaccatura dell'esistenza.

Joyce McDougall

Di questa Autrice, una delle più significative nel panorama contemporaneo, consiglio la lettura del volume **Teatri del corpo**, pregevole anche per la descrizione viva ed appassionata di una serie di casi clinici (alcuni dei quali discuteremo assieme durante il corso). Austin Silber, rivedendo il libro in una sua recensione pubblicata nel 1991 sull'*International Journal of Psychoanalysis* (72: 367-370), scrive tra l'altro:

McDougall makes demands upon herself to be able to perceive what may be unspoken or even unspeakable but which needs to be intimated from her constantly expanded awareness of her patient's life. Making use of construction and reconstruction, of verbal and preverbal clues, she tries to lay bare all that can fortify her patients with increased knowledge of their functioning body and mind.

She seems convinced that expanded psychoanalytic knowledge, jointly used and properly applied, can destroy the dragons of illness, psychosomatic as well as psychic. Her clinical discussions are most persuasive. She has learned much and can teach all who are open to learning.

... The analyst's conviction as to what is possible in a congenial analytic setting is a factor that must be considered as part of every ongoing effort to understand how an analytic treatment responds to the special process that is set up by the two participants. In this book we are most fortunate since McDougall openly and clearly describes what she senses, what she infers and what she understands from the patient within the

analytic setting. She also makes very explicit what she says, so that the reader becomes a participant in the consulting room drama.

Maintaining a balanced perspective in regard to understanding, she notes, 'It also commonly happens that certain psychosomatic phenomena, as well as recurrent tendencies to fall ill physically, disappear as an unanticipated side-effect of psychoanalytic treatment, sometimes without specific exploration of the underlying significance of such illnesses in the psychic economy' (p. 3). The observation that psychosomatic symptomatology can fall away, unexplored, as a product of the psychoanalytic enterprise indicates that any number of factors might be involved, or different factors with different patients. The therapeutic setting itself, the way it is structured, the nature and attitude of the participants, its security in regard to freely sharing verbal exchange with another person, may help provide the requisite environment for bodily change to take place. At the same time it reflects a respectful, necessary caution that it is the psychoanalytic insight itself, however elegantly phrased, which is completely responsible for the observed bodily changes.

... McDougall began to realize that the roots of psychosomatic phenomena were to be found in early infancy. Her adult patients at certain times functioned psychically as though they were infants. They responded to emotional pain psychosomatically rather than with words. The infants' earliest psychic structures are built around non-verbal 'signifiers' in which the body's functions and the erogenous zones play a predominant role. Psychosomatic illness reflects an 'archaic form of mental functioning that does not use language' (p. 9); a psychosomatic symptom is a non-verbal communication.

The meaning of a psychosomatic symptom is of a presymbolic order that circumvents the use of words. In addition, McDougall noted, 'The thought processes of the psychosomatic sufferer frequently appear to have drained language of its emotional significance' (p. 18). The absence of experienced affect, which can modify expressed thinking, receives the author's closest scrutiny. Also 'In psychosomatic states the body appears to be behaving in a "delusional" fashion, often overfunctioning excessively to a degree that appears physiologically senseless'.

It seems a reasonable assumption for the reader to make that this bodily 'overfunctioning' may reflect the discharge of unassimilated affect—affect that the patient cannot connect with words—it is as though a more archaic pathway for discharge has taken over. In a therapeutic sense it seems likely that the analyst's words supply what was muted in the parents, and this added verbal element can now shift the affect in the somatizing patient from the somatic to the verbal, ideational realm. This seems implicit in what McDougall presents in her clinical examples. Her ability to conceptualize verbally for her patients the gradually derived verbal meanings of their somatic symptomatology is based on her sensitive knowledge of each patient's development with its reconstructed, unconscious, often preverbal, history. McDougall is especially skilful in using events in the transference to make cogent and accessible her patient's unaware somatic use of the past as it repeats in the analysis. Implied in this formulation is that reconstruction of the past as it emerges in the transference permits an undoing of a somatic mode of discharge. The use of words, first by the analyst, then made meaningful for the patient, opens a different pathway for the patient, discharge is no longer automatically experienced in the soma. The author, in reviewing the work of psychosomatic specialists, adds operatory thinking (pragmatic and affectless way of relating to oneself and to other people) and alexithymia (certain people have no words to describe their emotional state), as 'frequently used defensive measures [by psychosomatic patients] against inexpressible pain and fears of a psychotic nature, such as the danger of losing one's sense of identity, of becoming mentally fragmented, perhaps of going mad' (p. 25). She adds to the operatory thinking and alexithymia, as noted in somatizing patients, her discovery of early psychic trauma of a disturbing nature. This trauma, related to the interactive disharmony between mother and child, can lead to affectless modes of functioning as a way of combating psychological pain, early frustration and panic. An additional clinical observation is that reports of very early autonomy (walking and talking at an unusually early age) fill out the picture. The author feels that this precocious autonomy often reflects a deficiency in the mother child relationship and leads to prematurely seeing parents as separate people—before proper or adequate development of the child's own psychic apparatus.

McDougall states that somatizing patients 'maintain a camouflage of "pseudonormality" in order not to think or feel too deeply about inner pain and conflict that might otherwise be experienced as overwhelming and mentally disorganizing' (p. 26). A point which holds great importance theoretically for the author focuses upon the connexion between somatic manifestations and psychologically disturbing events in the life of the patient (p. 27). 'These perceptions were not denied or repressed and thus unconsciously registered, as occurs in neurotic psychic organizations. Instead all memory of the troubling perceptions was expelled or totally destroyed' (p. 27). This is what Freud referred to as foreclosure or repudiation from the psyche (Verwerfung). As McDougall notes, 'Freud considered the capacity of the psyche to completely eject an experience from consciousness (rather than keeping it in the form of repression) to be a typically psychotic manifestation' (p. 102). McDougall continues, 'Based on my clinical experience, I would suggest that this capacity to foreclose certain perceptions, thoughts, fantasies, or other psychological events (frequently mobilized by current events in the external world) is operative in the adult's regression to psychosomatic rather than psychological responses to conflict and psychic pain. There is a dissociation between word-presentations and thing-presentations, so that the bodily signals of anxiety (that is, the somatic pole of affect) become equivalent to a thing-presentation, severed from the word-presentation that would give meaning to the experience ... Exploration of the historic reasons for this body-mind or thing-word split opens the way for many conjectural hypotheses concerning the earliest transactions between mother and infant'.

McDougall is posing questions about the formation and structure of the infant's mind as well as the mind of the patient who regresses to the use of psychosomatic symptomatology. The similarity and differences in regard to these 'minds', and the propriety of fruitfully comparing them, as McDougall does, merits a great deal of further thought and reflection. This is a comparison that troubles me because it presumes that the infant's mind remains available, in situ, to be recathected, unaffected by its further developmental experience. This is too static a theoretical concept for me. However, I have no question as to its clinical usefulness as a background hypothesis that can take on considerable conviction and therapeutic usefulness for both patient and analyst.

There is also an implication that the mind of the neurotic and the mind of the psychosomatic patient function differently. It thus seems that the mind of earliest infancy, as it or aspects of it get recathected in a regression related to a psychosomatic illness, can resort to a mechanism of repudiation that is typically associated with psychosis. At the same time the vulnerable psychosomatic mind, with its thing-word and body-mind splits, brings into question how stable any mind is, since, as McDougall correctly points out, everyone at one time or another is capable of developing psychosomatic symptoms. We also know from the kind of screening that McDougall employs, that certain unmotivated somatizers may be more traumatized by having analysis attempted with them. So efforts to undo the thing-word or body-mind split can lead to further danger rather than repair. Psychosomatically ill patients as well as addicted patients do not seem to be able to regress in the service of the ego. As they regress they seem to take the ego, its functions and structures, along with them during regression. In this way they do seem different from the neurotic patient and this does almost suggest a qualitatively different kind of mind.

What is striking and rewarding in reading the author's psychoanalytic approach to psychosomatic illness is the ready grasp she has of developmental theory, which becomes manifest in her uncanny ability to cull the infant and child out of her psychoanalytic encounter with each of her adult patients.

... It is clear that for analytic treatment to be successful, the analyst's attitude towards patient and illness assumes the utmost significance. It is McDougall's attitude of hope, in the face of formidable pathology, that comes through in reading this book. Her hope is backed by her considerable knowledge and scholarly interest in psychosomatic illness as well as her life of productive immersion in clinical analytic work. It is clear that she is constantly prepared for and open to whatever analytic journey is dictated by her patients' needs. Her flexible, imaginative approach is bound to bring out what is latently accessible in her patients. It is also her conviction that change is possible which may supply the needed spark to breathe life into the joint analytic endeavour. McDougall's significant caution in accepting her somatically ill analysands needs emphasis. Her criteria for acceptance are stringent, as they need be, because of the depth and likely early onset of her patient's 'preverbal' vulnerability. It is only those with whom she can make the proper connexion, which makes possible both the needed intimacy and the optimal distance with which to conduct the analysis.

*As McDougall's experience expands we are fortunate that she invites us along to share in her learning. She presents her findings and her thinking in a candid, modest, and lucid manner. It is a pleasure to join her audience in *Theaters of the Body*.*

La teoria di base sul disturbo psicosomatico di **Joyce McDougall**, quale espressa nel libro, ha a che vedere con il concetto di *désaffectation*, che così definisce:

Per quanto riguarda le affezioni psicosomatiche, sembra probabile che certi modi di funzionamento mentale acquisiti nei primi mesi di vita possano predisporre a risposte di ordine psicosomatico piuttosto che a soluzioni nevrotiche, psicotiche o perverse. Ho postulato l'esistenza di una sessualità molto primitiva, caratterizzata da tratti sadici e fusionali, che sarebbe all'origine di regressioni psicosomatiche passibili di essere considerate come difese contro vissuti mortiferi (isteria arcaica). In questo universo arcaico, in cui la distinzione tra sé e l'altro sfuma sino a venir meno, si ha un solo corpo per due. L'isteria nevrotica si costruisce a partire da legami verbali mentre l'isteria arcaica cerca di preservare non il sesso o la sessualità del soggetto bensì l'insieme del suo corpo, la sua vita, costituendosi a partire da legami somatopsichici preverbal. ...

*Le osservazioni degli psicosomatologi sul pensiero operatorio e sull'alessitimia mi parevano giuste, ma avevo constatato che questi fenomeni svolgevano soprattutto una funzione difensiva. Alcuni pazienti rifiutavano di riconoscere il loro dolore psichico e facevano mostra di una capacità non comune di escludere dal loro discorso in analisi certe esperienze cariche di affetto, le quali di conseguenza trovavano espressione fuori dell'analisi e, in un certo senso, fuori della psiche. Queste esperienze che si scaricavano nell'azione o sull'ambiente esterno divenivano accessibili alla parola solo per il tramite di una preoccupazione controtransferale. Mi resi conto che era solo in condizioni di stress che essi si rivelavano alessitimici o operatori e ciò mi indusse a pensare che quelle reazioni equivalenti a misure draconiane per contrastare dolori mentali non elaborabili o angosce psicotiche. Questi pazienti respingevano fuori dalla psiche certi traumi, in una forma che si distingueva nettamente dal funzionamento mentale dei nevrotici: non rimaneva traccia di quei segnali d'angoscia che consentono alla psiche di prepararsi a far fronte alla situazione traumatica, il che equivale a dire che quelle fonti potenziali di angoscia non erano divenute simbolizzabili. Questo tipo di funzionamento si ripercuoteva sul discorso associativo, conferendogli una tonalità *désaffectée*, tale da suscitare reazioni controtransferali (come una canzone di cui non si riescono ad afferrare le parole). ...*

*Per certi pazienti la fantasia fondamentale vuole che l'amore porti alla morte e che solo l'assenza di ogni libido garantisca la sopravvivenza psichica; il soggetto quindi cerca, attraverso un lavoro di *désaffectation* di proteggere la propria sopravvivenza mentale, giacché teme non soltanto la perdita delle barriere psichiche contro l'implosione provocata dagli altri, ma anche la perdita dei propri limiti corporei. Diviene allora necessario mantenere una barriera devitalizzata davanti all'investimento narcisistico del proprio corpo e della propria psiche. Tutto ciò a sua volta può accrescere la vulnerabilità psicosomatica in maniera allarmante e divenire così una minaccia contro la vita stessa. ...*

*Il termine significa due cose: una persona si disaffeziona (*désaffectation*) di qualcuno o di qualcosa quando se ne distacca o ritira il suo affetto da essa; ma in francese il termine *désaffectation* rimanda anche ad un oggetto che ha perduto la sua destinazione originaria (una chiesa, un tempio, una sala da pranzo, ...). Il termine racchiude spesso un'idea di sconsecrazione, di estraneità. Un luogo *désaffecté*, adibito ad altro uso o sconsecrato, che non ha più la sua utilità originaria, conserva tuttavia qualcosa dell'uso che ne è stato fatto in precedenza.*

Ma il termine allude a due altri sensi ancora: il prefisso latino 'dis' (che contiene un'idea di separazione o di perdita) può suggerire metaforicamente che certi individui sono psichicamente separati dalle loro emozioni e

possono aver perduto la capacità di restare in contatto con le loro realtà psichiche; il prefisso greco 'dys', per parte sua, evoca l'idea di malattia ...

A cosa rimanda in analisi la *désaffectation*? Innanzi tutto a un discorso che definirò di parola *déaffectée*, un discorso i cui termini non hanno più la destinazione originaria, ossia, detto altrimenti, la loro funzione di legame pulsionale; essi esistono solo come strutture irrigidite, svuotate di sostanza e di significato. Un simile discorso può essere intelligibile, e persino altamente intellettualizzato, ma è totalmente privo di affetti. ...

Preferendo il termine *désaffectation* ad altri, correnti oggi nella ricerca psicologica ('pensiero operatorio', 'alesitimia', 'nevrosi di comportamento'), vorrei segnalare che questi soggetti hanno fatto precocemente l'esperienza di emozioni intense che minacciano il loro sentimento di integrità e di identità, e che è stato loro necessario, per sopravvivere psichicamente, innalzare un sistema molto solido per prevenire il ritorno del loro vissuto traumatico, portatore di una minaccia di annientamento.

Il contesto in cui questa teoria si sviluppa è ben illustrato da un importante lavoro pubblicato nel 1974 sull'*International Review of Psychoanalysis* dal titolo **The Psychosoma and the Psychoanalytic Process**, dal quale traggio le citazioni che seguono.

The inherent difficulty facing the infant in his task of becoming an individual is of a more global, more 'psychosomatic' nature than the problems encountered in coming to terms with sexual realities. Failure to sort oneself out from the 'not-me' environment and so to create a sense of personal identity produces more catastrophic results than does a similar failure in the acquisition of sexual identity and the rights which belong to it. Yet such catastrophic failure does not necessarily result in a startling psychosis. It may go unnoticed while its insidious effects continue, silently, like the Freudian death instinct. When this occurs, body and mind have somehow lost their connecting links.

In the earliest attempt to deal with physical pain, frustration and absence psychically we have the first 'mysterious leap' from body to mind. We know very little about it. Considerably more knowledge has been garnered by psychoanalysis about that still more mysterious leap in the other direction, the leap from mind to body which underlies hysterical conversion and the various inhibitions of bodily functioning. Long before such complicated psychic creations are absorbed the baby must first have been seduced to life by his mother, for herein lies the initial movement which stirs the first glimmerings of psychic life. This much we know: the structuring of the psyche is a creative process destined to give each individual his unique identity. It provides a bulwark against psychic loss in traumatic circumstances and in the long run in man's psychic creativity may well lie an essential element of protection against his biological destruction.

This brings me to the first point of my paper: the importance of man's innate capacity for symbolic activity and psychical creation, and in particular, the heterogeneous character of these creations. In the attempt to maintain some form of psychic equilibrium under all circumstances, every human being is capable of creating a neurosis, a psychosis, a pathological character pattern, a sexual perversion, a work of art, a dream, or a psychosomatic malady. In spite of our human tendency to maintain a relatively stable psychic economy and thus guarantee a more-or-less enduring personality pattern, we are liable to produce any or all of these diverse creations at different periods in our lives. Although the results of our psychic productions do not have the same psychological, nor indeed the same social value, they all have something in common in that they are the product of man's mind and their form is determined by the way his psyche has been structured. They all have inherent meaning in relation to his wish to live and to get along as best he can with what life has dealt out to him. From this point of view it is evident that the psychosomatic creations appear the most mysterious since they are the least appropriate to the over-all desire to live. If their psychological function is conspicuous by its absence, their biological meaning also eludes us. In many respects they are the antithesis of neurotic or psychotic manifestations. Indeed it is frequently when the latter cease to function that psychosomatic (as opposed to psychological) illness declares itself. My reflections on this particular phenomenon have been much enriched by the extensive research into psychosomatic illness carried out by my colleagues in the Paris Psychoanalytical Society. I refer in particular to the works of Marty, Fain, David and de M'Uzan. My personal interest in psychosomatic symptoms and their relation to symbolic processes has come from a different direction which I hope will become clear.

My second point is that man's irrepensible psychic fertility of whatever order is coexistent with life itself. If we admit that something like psychic death may occur then it is possible that when psychic creation falters or comes to a halt man may be threatened with biological death. The psychic processes that create and maintain psychic health as well as those responsible for maintaining psychic ill-health are nevertheless on the side of life. When we, for any reason, fail to create some form of mental management to deal with psychic pain, psychosomatic process may take over.

This brings me to my final point. The psychoanalytic process is itself a creative one in that it re-establishes separated links and also forges new ones. Like our psychological creations, these links too are of a heterogeneous nature: liaisons between past and present, conscious, preconscious and unconscious, affect and representation, thought and action, primary and secondary processes, body and mind. I would suggest that psychoanalytic processes are the antithesis of psychosomatic processes. Psychosomatic transformations pose special problems in the course of an analysis and it may be that they demand a different approach from that required to understand the neurotic parts of the personality. I do not wish to suggest that there are special 'techniques' for dealing with man's different psychical manifestations but simply, that further insight into the processes at work may alter our way of listening to our patients. Itten, in his remarkable book on colour and painting (1961), writes of artists in words which might equally apply to the intuitively creative aspects of the analyst's task: 'Doctrines and theories are best for weaker moments. In moments of strength problems are solved intuitively, as if of themselves.' So is it with analytic work. Itten goes on to say. 'If you, unknowing, are able to create masterpieces in colour, then un-knowledge is your way. But if you are unable to create

masterpieces out of your un-knowledge, then you ought to look for knowledge.'

... The fact of the matter is that the analyst is rarely given the choice. Not only will he find himself constantly confronted with psychosomatic behaviour of a general kind in all his analysands, he will also discover that a considerable proportion of his patients, whether he wishes it or not, suffer from authentic psychosomatic disorders. These may range from allergic skin disorders, bronchial asthma, hyperthermic states and hypertension to peptic ulcers and ulcerative colitis. This frequency is in no way due to a preponderance of psychosomatic pathology among psychoanalytical patients. Psychosomatic manifestations affect analysts as well and indeed must be regarded as a common phenomenon in the population at large. If we include in our considerations the psychosomatic aspect of increased sensitivity to infectious diseases and the psychological problems of the accident prone, we shall be obliged to recognize that most of our patients, as well as our friends and colleagues, suffer at one time or another from psychosomatic manifestations. In my own analytic practice, although no patient has ever come to me specifically for his psychosomatic troubles, I have had, over the years, seven analysands who at some time in their adult lives had contracted pulmonary tuberculosis, in circumstances which left little doubt as to the important part played by psychological factors. I have had many patients with gastric dysfunctions of varying severity, including two with a history of serious peptic ulcers. Bronchial asthma has been the lot of several others and I have had the usual run of patients suffering chronically or intermittently from urticaria, hay fever, eczema and the like. The psychological problems raised by the somatic symptoms of these patients have given me much food for thought, particularly when I felt I had uncovered certain features in common among them. The analyst cannot but feel that psychosomatic man is a challenge to his understanding of the psychological determinants of their physiological symptoms.

In addition to the ubiquitous nature of psychosomatic symptoms it should be added that they are often resistant to cure, whether approached from the physiological or the psychological direction. Yet, psychosomatic patients suffering from grave symptoms do get better, and frequently as a result of psychoanalytic help when all else has failed. Let us add in passing the common clinical observation that people who have had several years of analysis find their susceptibility to colds, influenza, headaches, stomach aches and such like, dramatically reduced as the analytic work progresses. Why this should be so, and whether it is our theories that cure them, is another matter!

... The uses and abuses of man's body by his mind are so varied and so extensive that it is well to define what we mean by the term psychosomatic, and to delineate in particular the distinction between psychosomatic disorders and hysterical or other somatic manifestations. We might recall that Freud designated two types of somatization: conversion hysteria and actual neurosis. In a sense one was the antithesis of the other. Whereas in hysterical conversion we witness the 'mysterious leap' from mind to body, in the concept of the actual neuroses there is a leap in the opposite direction, from the somatic to the psychic sphere. In either case an invisible barrier is crossed. The problems raised by this transition have, to this day, lost little of their mystery. Although 'actual neurosis' as a nosographical entity is little used nowadays it is pertinent to our enquiry to note, as Laplanche and Pontalis (1967) have pointed out, that in Freud's conception the 'actual' symptoms (neurasthenia and anxiety neurosis) were principally somatic ones. Being of a physiological order they were considered by Freud to be devoid of symbolic meaning and therefore not truly within the scope of psychoanalytic treatment. Freud's belief that the actual neuroses are brought about as a reaction to actual everyday tension, and in particular to the blockage of libidinal satisfactions, is closely related to certain modern conceptions of psychosomatic reactions, though today the notion of psychic 'pressure' would lay equal emphasis on the blockage of aggressive impulses and on all that might be subsumed under the term of environmental stress. Freud considered that conversion hysteria and actual neurosis both arose from sexual sources but whereas the latter was related to present day sexual problems, the former stemmed from the sexual conflicts of early childhood and the physical symptoms retained their symbolic significance, i.e. they appeared in the place of instinctual satisfaction and were in essence a symbolic solution to an unconscious conflict and not a reaction to frustration. It is evident that the 'somatic' symptoms of conversion hysteria are symbolic in that they refer to a fantastic body in the literal sense of the word, a body functioning as a small child might imagine or a fantasy body such as might be contrived by primary process thinking.

After the construction of his topographical model Freud also came to consider hysterical conversion and hysterical identification as ego defences. In this way were added to the well-known list of hysterical symptoms those which use the body to translate inhibitions of id impulses as a reaction to the repressive forces of ego and superego. Thus inhibitions of bodily functioning such as constipation, impotence, frigidity, psychogenic sterility, anorexia, insomnia and so on have come to be considered as closely allied to classical conversion symptoms. In every case the symptom tells a story. Once decoded, the story always reveals the hero to be a guilty victim of forbidden wishes who has met setbacks on the pathways of desire. His symptoms might be said to result from the combined effects of his unconscious fantasy life and the structure of his ego defences. These symptoms, of indubitable psychogenic origin, do not form part of what is denoted by the term psychosomatic. We might say that in hysteria the body lends itself and its functions to the mind to use as the mind wills, whereas in psychosomatic illness the body does its own 'thinking.' The drama which is being expressed is a more archaic one and its elements have been stored differently. The symptoms are signs, not symbols, and follow somatic rather than psychic laws. Unlike the hysterical dramatizations, the thinking of the soma is carried out with, sometimes literally, deadly precision. The recurring character of science fiction, the mechanized robot who takes over, without a shred of emotion or identification with human wishes and conflicts, is a pristine image of the workings of the psychosomatic symptom. The soma is no longer concerned to translate the wishes of the psyche as in neurotic illness. If we attempt to define the area covered in today's terminology by the word psychosomatic we might say that this term is reserved for organic disorders of demonstrable physiological dysfunction. Although they have no apparent symbolic significance, they appear nevertheless to be linked with the patient's personality structure, life circumstances and history, i.e. they declare themselves in connection with situations of stress arising either from within the individual or from his immediate environment. The psychosomatic sufferer, however, is rarely aware of any such connections and is frequently unaware of being under any particular stress. This definition, though extremely vague, serves to distinguish such disorders from hysterical manifestations in

which there is neither physiological lesion nor infection, and also from organic illness in which no links with the personality or to the environmental stress are apparent.

At this point we come back to the fact that the mental and the physical are indissolubly linked yet at the same time essentially different. The psyche-soma functions as an entity. There is little doubt that every psychological event has its effect upon the physiological body just as every somatic event has repercussions on the mind, even if these are not consciously registered. Industrial research has produced convincing statistics to demonstrate that people are more apt to fall ill, need operations, or have accidents when they are feeling depressed or anxious than when they feel fulfilled or optimistic about their lives. Indeed one does not have to be a psychoanalyst to recognize that there is a relationship of contiguity between the psychological and the biological events in any given individual's life. This type of intuitive knowledge is within the scope of the porter's wife or somebody's grandmother. 'No wonder he had that car accident after all the trouble they've had with the family. And naturally she went down with the Hong Kong 'flu straight away after the accident,' is a typical comment from my concierge upon the trials of his neighbours.

Freud's position in respect of the psyche-soma should be recalled. He grounded the psychoanalytic theory of mind on firm biological territory and constantly emphasized the tendency of the human organism to function as a whole. Nevertheless, he chose to concern himself solely with the psychological aspects of the psyche-soma and showed a distinct disinclination to cross the frontier between the psychological and the physiological, even in areas where he recognized organic illness as being of psychosomatic origin. At the same time he was constantly preoccupied with the relations between body and mind and the fact that psychic processes grow out of organic ones. His theory of the instincts and of libidinal development, and the importance he accorded to erogenous zones all witness to this interest. With the expansion of psychoanalytic knowledge and the ever increasing accumulation of clinical experience and research it was inevitable that analysts would concern themselves with psychosomatic symptoms arising in their analysands and would try to decode their meaning. It was equally inevitable that they would at first try to reconstruct the underlying fantasy formations which the somatic symptoms might be thought to symbolize, following the well-known pattern of the hysterics. But this did not turn out to be so easy. Freud had already made the discovery that such symptoms, unlike hysterical symptoms, yielded no answers under hypnosis. As time went on, other analysts were to discover that with psychosomatic patients presenting few neurotic symptoms, the analytical process did not by any means reveal the clear oedipal and preoedipal structures, with their contingent of fantasy, sexual symbolism and object-relation patterns, which were the fruit of analytical work with patients suffering from hysterical and obsessional neuroses and from sexual perversions. In fact, many of the patients whose reactions to anxiety were almost exclusively psychosomatic, revealed themselves to be quite refractory to analytical therapy. Others plunged into the analytic adventure whole-heartedly, analysed many of their neurotic symptoms and terminated analysis with their psychosomatic disorders intact. Others again found their symptoms modified or even lost them completely. The theoretical reasons adduced to explain the effects of psychoanalysis on psychosomatic symptoms did not meet any great measure of agreement among analysts.

We are, today, far from the epic period of Flanders Dunbar, Margolin, Alexander and other pioneers in this field. Re-reading their inspired texts I feel the magic has gone out of the high hopes held at that time for the future of psychosomatic medicine and the role that psychoanalysis might be expected to play therein. Nevertheless, many correlations were found between specific emotional conflicts and specific personality traits on the one hand, and specific psychosomatic afflictions on the other. These were studied by psychiatrists using both physiological and psychological techniques (as in the well-known studies of Wolf & Wolff, and Mirsky & Margolin, on the relation of repressed psychological impulses to gastric secretions). At the same time, analysts, using only their therapeutic skills and intuitions drawn from classical psychoanalysis, attempted to reconstruct the unconscious fantasies which might be thought to underlie somatic symptoms. Perhaps the best known of these are the dramatic hypotheses contained in the published papers by Garma. Speaking of patients with gastric ulcers, he would describe the ulcer as a vengeful 'bite' which the patient was obliged to give himself as a punishment for his babyhood wishes to bite his mother's breast. Thus, out of unconscious guilt, the future ulcer patient might select food harmful to himself, and procure for himself an introjected bite simultaneously into his stomach and psyche. In addition the ulcers were ultimately found to carry miscellaneous symbolic meanings related to the castration complex.

I should mention at this point that I personally see no objection to correlating environmental stress with gastric functions. Nor do I take umbrage at fantasy constructions of the kind created by Garma. But I do not feel they give us much insight into causes. The fact that stress situations cause gastric hyperfunctioning in certain individuals does not tell us why this should occur nor why most people are not affected in this way. The fact that an ulcer patient may get better during analysis, while it can without doubt be attributed to the therapeutic skill of the analyst and the effects of the analytic process, does not in any way indicate that repressed fantasies of the kind described above were the cause of the ulcer. We are faced here with a methodological error of some dimension which begs reflection. First, in so far as spontaneous fantasy productions in analysis are concerned, it should be noted that any somatic event will tend to attach to itself ideas dealing with different aspects of the castration complex as well as fantasies concerning the early mother-child relationship. ... There is a further methodological error to be indicated at this point. Since the interaction of psyche and soma are so intricate and so inevitable, we may easily lose sight of their fundamental difference. A cartesian metaphor like 'body is white and mind is black' might yield the idea that psychosomatic manifestations could be considered as an infinite series of greys. But this simplified graphic model would overlook the essential difference between psychic and somatic functions. We might do better to compare the psyche-soma to a fusional substance like sea-water. In spite of its unity our sea-water can be transformed on the one hand into a heap of dried salts and on the other, a cloud of watery vapour. Let us say that the somatic elements are the salts and the psychic dimension the watery cloud. This allows us to conceive the two components as different in substance and subject to different laws. The fact that they combine should not allow us to obliterate their dissimilarity. Following the analogy a little further one might also emphasise that neither substance quite adds up to a piece of living ocean. So we can readily sympathize with those who find that the somatic approach to the problem resembles a pile of dried dust,

drained of its psychic fluid. And we can equally well understand that the somaticians and the psychobiological experimenters, when faced with the archaic fantasy constructions and hypotheses which the less rigid psychological approach allows, feel they are called upon to take arms against a sea of suppositions: a cloud of watery vapour with no solid matter left. In fact neither tells us much of what is going on in the stormy ocean, an image which is more evocative of man's psychosomatic dramas. Nevertheless, theoretical confusion will result if we overlook the fact that somatic processes and psychic processes are governed by different laws of functioning. We cannot apply the laws which structure psychological functions to those which govern physiological functioning. There is not a causal but an analogical relationship between the two orders. Konrad Lorenz's brilliant observations and reflections clarify this fact and lead him to say that the movement from soma to psyche will remain forever mysterious. From our psychoanalytical observation post we are constantly made aware of the intricate and ineluctable interdependence of psyche and soma, and yet, are confronted with their ineradicable difference.

I may be told at this juncture that this is so much theoretical hair-splitting, that, if patients are able to modify their psychosomatic symptoms as a result of psychoanalytic therapy, then it matters little what causes what, or what is or is not, authentically symbolic. I cannot agree with this approach. Our theories do affect our practice, not only in our way of listening to and understanding our patients' communications but also the form and timing of our interventions and interpretations. The fact that psychosomatic patients often show little spontaneous fantasy, whether attached to their somatic afflictions or to other aspects of their lives, is an important note for the attuned ear of the analyst. One may become aware as it were of listening to a song in which the words are present but the melody is missing. I personally feel that such analysts should be helped to an awareness of this lack and to analysing the reasons underlying the phenomenon.

The objection is sometimes made that somatic illness is not within the domain of psychoanalysis. This is perhaps due to the fact that analysts feel lost without their symbols. We might say that psychosomatic transformations are signs rather than symbols when compared with neurotic symptoms. In this way they resemble psychotic objects which also are signs. Freud's example drawn from the case of the Wolf-Man expresses this clearly. The Wolf-Man referred to the dints in his skin as vaginas—which, as Freud points out, is not symbolic usage and can in no way be regarded as a hysterical representation. Signs represent the body or bring messages from it; they do not symbolize it. The body only becomes symbolic when, taking the place of something repressed, it enters into relationships of meaning with other psychic representations. Faced with the elusive psychic dimension of psychosomatic maladies, there is a risk that the analyst may feel his patient's inexplicable soma to be a narcissistic affront to his interpretative powers (Fain & Marty, 1965). Thus there is a countertransference dimension which may lead many an analyst to a lack of interest in his patient's psyche-soma when it behaves in ways which put it beyond the reach of the analyst's sphere of influence, or at least make it appear intractable to methods which succeed so well with the neurotic parts of the personality. As analysts we will always be primarily interested in man's body as a mental representation held through the network of language. Yet, we might well question by what mysterious means is the psyche able to make a breach in the body's immunological shield, and might well concern ourselves with the equally elusive biological purposes of disorders such as bronchial asthma or gastric hyperfunctioning, when such events occur within the analytic situation. We possess a theoretical structure capable of apprehending these questions. Concerned as we are with symbolization and psychic significance, we are particularly well placed to observe the point at which symbolic functioning breaks down or has perhaps never been fully operative. Those who are interested analytically in psychotic states well know to what extent the mind, which leads an existence detached from the reality of the body which contains it, suffers immeasurable damage. The links which have been destroyed (not repressed as with neurotic formations) between psychic and corporeal reality may have to be recovered through delusional constructions, as Freud demonstrated in the Schreber case. But there are other alternatives to those used in psychotic creations. The ego, instead of detaching itself from external reality may create another sort of splitting, in which the instinctual body is not hallucinated but denied existence through psychic impoverishment. Instead of some form of psychic management of disturbing affect or unwelcome knowledge or fantasies, the ego may achieve complete destruction of the representations or feelings concerned, so that these are not registered. The result then may be a super-adaptation to external reality, a robot-like adjustment to inner and outer pressure which short-circuits the world of the imaginary. This 'pseudo-normality' is in fact a widespread character trait (McDougall, 1972b) and may well be a danger sign pointing to the eventuality of psychosomatic symptoms. The creations of the psychotic ego may often serve to protect the body from destruction and death. A factor of alternation between psychotic and psychosomatic incidents has been clinically observed by certain analysts (Sperling, 1955). I would add that the loss of other well-established psychic patterns such as organized sexual perversions or dominant character patterns, as well as exposure to events sufficiently traumatic to overthrow well-functioning neurotic defences, may also expose the individual to psychosomatic attack. ...

This brings me to the theoretical model of the Paris psychosomaticians, which comprises an economic theory of psychosomatic transformation and the concept of a psychosomatic personality structure (as opposed to neurotic, psychotic, perverse, etc., structures). The economic concept is closely allied to the early theory of the actual neurosis, emphasis being laid upon urgent instinctual discharge which escapes psychic elaboration because of deficient representation and diminished affective response: in short, an impoverishment of the capacity to symbolize instinctual demands and their conflict with reality, and to elaborate fantasy. Instinctual energy, bypassing the psyche, thus affects the soma directly, with catastrophic results. This particular theoretical approach to psychosomatic formations is in complete opposition to the theory of hysterical formation: the latter being the result of repressed fantasy elaborations while the former would result precisely from the lack of such psychic activity. The failure to represent instinctual conflict symbolically leads to a specific mode of mental functioning and this may in turn determine a 'psychosomatic character pattern' (Marty, M'Uzan & David, 1963). In each case the authors have delineated certain characteristics observed in seriously ill psychosomatic patients, based upon several years of research (interviews and psychotherapy). Their findings include the following:

1. Unusual object relationships, notably lacking in libidinal affect. This is also manifest in the interviews in that these patients, compared with others, show little interest in the investigation and practically none in the

investigator.

2. An impoverished use of language marked in particular by what the authors call operational thinking ('la pensée opératoire'). This refers to thoughts that are pragmatic in the extreme. E.g. 'What kind of woman is your mother?' Reply: 'Well, she's tall and blonde.' 'What was your reaction when you learned of the death of your fiancé?' 'Well, I thought I'd have to pull myself together.' 'Were you upset when you ran over this woman with the baby?' 'Oh, I was insured against third party accident.' In the three cases cited, each patient was being questioned about circumstances which appeared to be closely connected with the onset of serious psychosomatic illness. Listening to recordings of such interviews one is struck by the flattened affect and an impression of unusual detachment. These have a psychotic resonance, yet there is no resemblance to a psychotic ego functioning in other aspects of these patients' lives, nor to any form of psychotic thought disorders. Indeed, 'operational thinking' may be highly intellectual and abstract. De M'Uzan has pointed out that the outstanding feature of such thinking is its detachment 'from any truly alive internal object representations'.

3. A marked lack of neurotic symptoms and neurotic character adaptations.

4. Facial movements, bodily gestures, sensorio-motor manifestations and physical pain will appear where one might expect neurotic manifestations.

5. Preliminary interviews are characterized by a type of inertia which threatens to bring discussion to an end, unless the investigator makes vigorous efforts to stimulate associative material concerning the patient's relationships, life experience and illness. Dramatic or painful events are recounted with little emotional overtone or are omitted if not directly solicited.

A paper by Fain & David (1963), deals with the cardinal importance of dreaming and of unconscious fantasy in the maintenance of psychic equilibrium. The work of Despert, Lewin and French is reviewed and linked to their own research. In their conclusions the authors state that the psychosomatic patient reveals a damaged capacity for creating fantasy to deal with infantile and present day anxieties. Comparisons are drawn with psychotic patients who, in circumstances similar to those which precipitate psychosomatic illness, will suffer hallucinatory episodes. Unlike the psychotic, the psychosomatic patient remains closely attached to facts and things in external reality. The ego may show impoverishment but there is no distortion. However, in both cases pathological problems arise in proportion to the inability to use regression or dream functioning. The comparison calls to mind the clinical findings of Spiering (1955). Although she adduces quite different theoretical conclusions, she noted alternations between psychotic states and psychosomatic illness in the same individuals. I come now to the important contribution of Fain (1971), concerning the earliest beginnings of fantasy life and their role in the predisposition to psychosomatic illness. This includes findings from earlier research (Fain & Kreisler, 1970) on babies suffering from serious psychosomatic disturbances in the first months of life. One important group is comprised of infants who are only able to sleep if rocked continually in their mothers' arms and otherwise suffer from almost total insomnia. Fain's studies suggest that these mothers have failed in their function as a protective shield against exciting stimuli, precisely through over-indulging the exercise of this function. Instead of the development of a primitive form of psychic activity akin to dreaming which permits most babies to sleep peacefully after feeding, these babies require the mother herself to be the guardian of sleep. The author links this breakdown of the capacity to recreate symbolically a good internal state of being, to an allied failure to develop autoerotic activity. Fain's observations lead him to the conclusion that these babies do not have a *mère satisfaisante* ('satisfying mother') but a *mère calmante* ('tranquillizing mother'). The latter, because of her own problems, cannot permit her baby to create a primary identification which will enable him to sleep without continual contact with her. Cases of infantile asthma show a similarly disturbed mother-nursling relationship. Analogous observations have been made concerning the mothers of allergic children. These mothers appear to allow no satisfactions which are not obtained in direct contact with themselves. Autoerotic activity and the capacity for psychic development is blocked in these children. 'We have postulated that these mothers unconsciously wish to bring their children back to foetal bliss inside their own bodies', writes Fain. In other words, we find here a pathological exaggeration of what is fundamentally a normal instinctual attitude on the mother's part, namely, to create a sheltering womb-like world for her new-born babe until he is able to provide this for himself. But, because of her own unconscious needs, she does not create conditions in which the baby can take over this function. If her libidinal interest in the other aspects of her life, particularly her love-life, does not lead her to disinvest her baby sufficiently (e.g. wishing it to go peacefully off to sleep leaving her free for other preoccupations) she may overdo her protective role, thus keeping her baby tied to her bodily presence. Fain describes three types of baby sleep-patterns related to early psychic functioning: the first infant makes small sucking movements while sleeping, the second sleeps with his thumb firmly planted in his mouth; the third sucks frenetically and does not sleep. We have here three modes of autoerotism which manifest qualitative differences in the balance between motricity and the capacity for psychic representation. This in turn implies a difference in the distribution of narcissistic libido and that part of the libido which remains attached to the object. The first baby reinforces his capacity to maintain sleep through some form of hallucinatory discharge of excitation, the second requires a real object for a much longer period of time; babies of the third category are thrown into a perilous cycle of endless discharge. The author concludes from his observation of the mothers that the continual investment of the baby by the mother impedes the development of primary autoerotism and this automatically leads to a most dangerous vicissitude—the exclusion of libidinal activity from the symbolic chain. ... This type of maternal failure is frequently accompanied by a corresponding failure in the father's role as a figure of authority.

... From a historic-genetic viewpoint, Fain's research suggests that there are two predominant trends in disturbed baby-mother relationships which are apt to create a predisposition to psychosomatic pathology. The first is unusually severe prohibition of every attempt on the baby's part to create autoerotic substitutes for the maternal relationship, thus vitiating the nodal point for the creation of inner object representations and the nascent elements of fantasy life. The second trend is the antithesis of this, namely, a continual offering of herself on the mother's part as the only object of satisfaction and psychic viability. The work of Spitz on mother-child relationships and the importance of these in creating or hindering the development of autoerotism coincides in many ways with Fain's observational research (Spitz, 1962). One might say that it is a question of

leaving the baby too much or too little psychic space in which to be mentally creative on his own. My own clinical experience, derived mainly from analytic work with adults, has shown that patients with predominantly psychosomatic reactions to anxiety situations tend to reveal parental imagos showing both these tendencies. ... Absence and difference, the two great reality experiences around which identity is constructed, must become significant and also infused with libidinal meaning and value if the individual is to create a viable psychic model of existence and of his own place in the order of human relationships. On the foundation of this early model of Otherness will be constructed the oedipal model, a blueprint to make sense of, and symbolize, sexual and social relationships. Here the significance of the father's role, already communicated in an important way through the mother's psychic economy, comes into full play. This factor may then be decisive for determining which psychological 'solutions' will dominate in adult life. But this takes us far beyond the scope of this paper, centred on the earliest psychosomatic experiences and the first blocks to symbolic functioning. If psychosomatic personalities may be said to be 'antineurotics' due to their inability to create neurotic defences, from another standpoint they may also be considered as 'antipsychotics', in that they are 'over-adapted' to reality and the difficulties of existence. ...

The desperate search for facts and things in the external world and the tendency to treat people as things in an attempt 'to grasp at some fragment of experiencing' (Rochlin, quoted by Yahalom) recalls de M'Uzan's description of the desperate clinging of the classical psychosomatic patients to what he calls 'the factuality of existence'. The attempt to cling to facts, things and persons unconnected in themselves makes itself felt in the analytic discourse of certain patients, and the analyst frequently feels at loss to understand why his patient is telling him the facts of his daily existence without a trace of affect or interest in the significance that the facts may have for him. ... It seems to me that we are faced here with a lack of symbolic structures to give meaning to the representations and their allied affects, so that sensations and experiences impinging from without and within the individual are not readily integrated into an elaborated psychic system. In default of a sound psychic model of one's existence as an individual in relation to other individuals, there will of course be a dangerously deficient feeling of inner 'safety'. If the model does not contain such symbolic and fantasy construction to order, process and contain all that is experienced, the individual will experience existence as an overwhelming phenomenon fraught with the danger of being submerged and losing his identity. 'Safety' must then be sought in the external world. The acquisition of language and other symbolic capabilities should normally enable the child to develop an ever increasing network of internal representations and permit him in this way to free himself from helpless dependence upon the environment and his important objects. He may then be in a position to deal with frustrations and excitements through symbolic mediation.

In trying to come to terms with the substructure of all 'action disorders' including psychosomatic 'acts', we are in the area of transitional phenomena and are witnesses to the attempt to make substitute objects in the external world do duty for symbolic ones which are absent or damaged in the inner psychic world. Such attempts are ineluctably doomed to failure and the victim of this kind of lack is equally doomed to endless repetition and addictive attachment to the outer world and external objects. To come back then to the striking differences between psychosomatic and psychotic creations we might say that whereas the psychotic child clutches at a delusional 'monster' to palliate the lack of the internal object brutally projected outwards, the psychosomatic sufferer has precociously laid his monsters to rest. He has lost them. I would suggest that there are deeply buried archaic fantasy elements encapsulated somewhere in the unconscious, but that these are unarticulated linguistically and thus have no access to preconscious, or conscious thought. Stored at a presymbolic level they do not find expression even in dreams. (I would suggest further that we all contain such still-born monsters.) With a psychic substratum in which the 'monsters' have been neither allowed to grow up nor projected in hallucinatory fashion but simply neglected through lack of psychic nourishment, what is missing is something much more subtle. Perhaps a concept such as negative hallucination might be invoked here. Bion (1962) Green (1973) and Fain (1971) have each explored in different ways the contours of such a concept. Such a mode of mental functioning would lead to an arrest in ego development which would be markedly different from that found in psychosis. The split, the schisms is drawn in differently. In psychotic states the ego is overwhelmed by the imaginary world once it slips out of its traces and is then no longer able to perform its initial function of inhibiting hallucinatory fulfillments (Freud, 1915). The psychosomatic ego has choked the archaic elements of fantasy in their very beginnings and thus becomes split off from its instinctual roots, leaving few elements available for the creation of psychotic delusions. These may in fact come into being under the impact of the psychoanalytic process. My own clinical experience with analysands suffering from psychosomatic disorders of a serious kind has taught me that they may have to recreate their psychotic monsters, and live with them even in projected form for a while, until such time as they can be contained and integrated. This kind of psychic growth allows patients to feel alive in new ways, even though they bring with them a measure of mental suffering. Not only neurotic pain but also many perverse and 'crazy' creations come to life. Although there are finer creations of the spirit than perversion and psychosis, in the long run it is better to be mad than dead.

... There is a marked difference between psychosomatic patients and patients who talk about their bodies in neurotic terms: whether this be the bizarre and imaginative discourse of the hysteric who, all the while talking of his symptoms is drawing our attention to something else, a sexualized element which has been displaced, or the elaborated fears and fantasies of patients suffering from what one might call 'castration-hypochondria', fears of cancer, tuberculosis, syphilis, which take on the characteristics of compulsive ideas and are often linked to an obsessional structure. We are dealing here principally with repressed fantasies concerning the oedipal drama and with infantile sexual wishes which have undergone regression to pregenital fixation points.

... Allied to the physiological 'hardiness' of many a psychosomatic patient is a character trait which has already been alluded to as a frequent manifestation in psychosomatic personalities: the refusal to give in to psychic pain, anguish or depression. This gives an impression of superhuman emotional control and is allied I think with a pathological ego ideal which refuses need and dependency. 'I always had to cope alone and I always shall. No one ever helped me to become myself.' 'I was forced to fly before I had any feathers. Now I must just keep going. Whatever happens I must not stop nor look down.' 'I never had what they call a "transitional object". Mother wouldn't have allowed it. I learned early that I could rely on no one but myself.' These three patients, all

with marked psychosomatic problems and personalities, might well be adult incarnations of the mercycist babies who had to 'cope alone' without the psychic capital to do so. This splendid isolation gives the impression that such people are untouchable and invincible and contributes to the observations made by the Paris psychosomaticians of the operational mode of object relations and the unshakeable barrier of 'operational thinking'. The individuals concerned show little libidinal investment in their external objects and appear drastically cut off from their inner ones. In many cases it might be true to say that they are dimly aware of a need, so total and so abject, that to recognize it would destroy the relational mode upon which their ego identity is built. To let disappointment, anger, despair, or any incapacity or failure reveal itself would be tantamount to an insupportable narcissistic wound. The lines of a modern folk-song by Simon and Garfunkel epitomize this character trait:

I touch no one

And no one touches me.

I am a rock.

I am an island.

And a rock feels no pain

And an island never cries.

The baby who cannot internalize the breast, who cannot create within himself his mother's image to deal with his pain is a lonely island. One way out is to turn oneself into a rock. Thus many psychosomatic patients continue on their unwavering tight-rope, ignoring the body's signs and the mind's distress signals. This invincibility invades the analytic situation. The stifling of feeling, the breaking of associative chains, the attack upon the analyst's attempts to make symbolic links may give the analyst the feeling that his patient is unanalysable. And it may be so. The upsurge of emotion is often felt like a 'crazy' intrusion into the mind and words may acquire the hypercathetic charge of psychotic objects if they become infused with fantasy. Much of the success or failure of the analysis of the psychosomatic dimensions of the personality depend on the extent to which the transference is able to bear the coming alive of archaic instinctual impulses, and consequent ego perturbation. Perhaps the limits of the analytic process in these cases are the limits of the analyst. One does not always 'survive' as an inner object for one's patients and then the mother-nursling failure is repeated once more and the psychosomatic defences hold firm. On the other hand the analytic process can produce overwhelming change even though to do this it may lead the rock to feel great pain and the island to cry for many years to come.

Dieci anni più tardi, in un lavoro pubblicato su *Contemporary Psychoanalysis* (16:417-459), in un lavoro dal titolo **A Child Is Being Eaten**, Joyce McDougall fa di nuovo il punto sull'argomento ulteriormente affinando le sue tesi:

Certain patients reveal in analysis that they have at their disposal few psychic defenses against mental pain other than total foreclosure from the psyche of incompatible ideas, frightening fantasies and perceptions, conflicting instinctual impulses and painful emotional states. The lack of neurotic symptoms in such analysands frequently creates the impression of a stable and markedly "normal" personality structure. While it is true that everybody possesses a certain "psychosomatic potentiality" which readily reveals itself under conditions of psychic stress, these patients are more exposed to serious psychosomatic disorganization than those who have constructed neurotic barriers—or even psychotic ones—against psychic conflict and stressful circumstances. ... It is my hope that this psychoanalytic vignette has given some insight into the nature of the psychic economy that lies behind psychosomatic disorders and of the back and forth movement in analysis between somatization and massive anxiety states, and between these and the formation of hysterophobic symptoms. This clinical fragment also highlights the archaic sexual significance and primitive oedipal organization that may be presumed to underlie psychosomatic regression and other forms of acting-out disorders. When such symptoms are the principal ways in which stress and mental conflict are met, we are witnessing the result of defenses of a primitive kind that have been erected to deal with psychotic anxiety concerning body limits, ego identity and self-object confusions. It would appear that these have never been elaborated mentally and thus have not been able to be integrated at the phallic-oedipal level of organization; instead they have remained split off from the rest of the personality, but continue to exert their effect on mental functioning, with the result that many perceptions, larval thoughts and affective states fail to achieve psychic representation.

To characterize the psychosomatic phenomena that may result I have coined the term "archaic hysteria" to indicate that the conflicts concern early somatic libido or primitive sexual and sadistic exchange in which certain bodily zones and functions are confused with the mother's body or felt to be under her control. The capacity to represent psychically wishes and fears concerning primitive impulses depends on the earliest transactions between mother and infant. These will inevitably be profoundly affected by the unconscious of both parents, and more specifically by the place of the father in the mother's libidinal and narcissistic economy, and the role that her baby is called upon to fulfill for her.

... Finally I would reiterate that the so-called normal-neurotics (which we would suppose includes the majority of psychoanalysts) with today's longer analyses invariably come to reveal the sectors of their personality structure where there too, somatic symptoms, narcissistic problems, addictive behaviour, second-hand ideas and discharge in action have taken the place of psychic work—of thinking and of feeling. Thinking is a burden and facing one's feelings is frequently painful and humiliating. So we are not surprised to discover that we all have shadowy areas in our mental economy where we no longer take time to question ourselves and our motives nor seek to be in closer contact with our psychic reality.

... the man who drinks to drown a passing sorrow; who smokes or overeats to weather life's daily frustrations; who takes a pill when anxious or afraid he may not sleep; who steals insignificant objects compulsively, or destroys valuable ones "by accident", when under the sway of certain erotic or aggressive tensions; or, who uses people addictively in similar circumstances. All are relatively commonplace occurrences among individuals

who in most respects are not considered as psychologically ill. This is to say that everyone tends at times to get rid of tension and psychic pain through inappropriate action in situations where thought and emotional containment would be better indicated and even required if one wished to achieve an adequate and more durable solution. From the point of view of the psychic economy, the specificity of such "act-symptoms" is that they involve minimal psychic elaboration and indeed often take the place of it altogether.

In certain analyses we may observe that such functioning is the predominant method of maintaining psychic homeostasis whenever the libidinal economy (in either its object oriented or its narcissistic aspects) is threatened. We see this clearly in a number of clinical categories such as organized perversions, addictive behaviour or certain forms of character pathology and in all situations in which psychic stress precipitates somatic dysfunction or facilitates physiological disease. Psychosomatic symptoms of this kind would come at the very end of the "act-symptom" series I am proposing here, in that psychic elaboration in this sector would be at a minimum or totally absent. The roots of such patterns of mental functioning are to be found in the dawning of psychic life. Evidence of their disturbing effect may be clearly observed in small infants where the pathological manifestation—since the baby cannot psychically work through situations of a stressful and mentally painful kind—is invariably of a psychosomatic nature such as infant insomnia, merycism, cyclic vomiting and spasmic reactions of various types. Such observations present psychoanalysis with challenging research problems in both the theoretical and the clinical fields.

... Insofar as psychosomatic phenomena are concerned this would mean that mental conflict is disavowed and thrown out of the psyche to be discharged through the body and its somatic functioning instead. It might be emphasized that at the beginning of psychic life the body is experienced as an object belonging to the external world. This state of perception continues to exist in dream-life and in certain psychotic states—that is the body itself, or certain of its zones and functions, are treated as independent entities and sometimes as belonging to and hence under the domination of Another. (This allows an individual, for example, in psychotic states in which severe self-mutilations are inflicted, to be totally unaware of any immediate sensations of pain.) The important question for our present enquiry concerns the possibility that in psychosomatic states certain body parts and functions might still be regarded unconsciously in this fashion, that is they may be considered as not being the subject's own property but belonging to someone else—the Mother of early infancy. This would then be in marked contrast to the psychic structure underlying hysterical conversion, in which primary process thinking gives to certain zones and functions a symbolic significance of an instinctual kind. Neurotic and psychotic symptoms are primarily attempts at self-cure through some form of psychic activity which leads to the creation of the symptom as a "solution" to the mental conflict in question. Psychosomatic symptoms on the other hand, while they may acquire secondary symbolic significance (sometimes of the "secondary benefit" kind), are primarily the result of avoidance mechanisms uncompensated by the creation of psychological symptoms. This tends to give to individuals who use such escape mechanisms to a predominant degree an appearance of "normality" in that they are symptom-free and often appear, owing to the stifling of affect, to be able to cope in all circumstances. It is precisely this latter aspect of acting-out phenomena and more particularly when these take a psychosomatic form that renders such manifestations so tantalizing in psychoanalytic practice. The analyst finds himself listening to an associative discourse which while being eminently coherent seems to lead nowhere. At such moments we are observing something that is lacking, a missing dimension, often of an affective order—rather like hearing the words of a song without the music. This is very different from the type of analytic discourse in which repressed thoughts, fantasies and denied feelings although unconscious to the analysand seek by numerous means to give clues as to their existence—not only through the symptoms themselves but also through dreams, sudden associations, parapraxes and so on. When the communication is not of this order but reduced to actions and reactions, such as occurs in all of us from time to time, then we know that the inner theater is being externalized to be put on the world's stage rather than being elaborated internally even in the form of neurotic or psychotic symptomatology.

The shift from mentalization to discharge-in-action is particularly liable to arise when we are subjected to sudden narcissistic wounds or to unexpected object-loss. Such events frequently produce unusual behaviour or precipitate mild or severe psychosomatic manifestations. I am using the term "psychosomatic" here in a broad general sense, stemming from a uniquely psychoanalytic view-point. In other words I am concerned with the body and the somatic self as it is revealed in the course of the analytical experience. Thus I am referring not only to well-recognized psychosomatic maladies such as gastric ulcers, bronchial asthma, ulcerative colitis, etc. but also to ill-defined anxiety and depressive states which are invariably accompanied by physical symptoms such as fatigue, sweating, trembling, listlessness and so on. To this array of psychosomatic phenomena must be added accident-proneness and increased susceptibility to infection in times of stress. The psychoanalyst has many opportunities for observing such phenomena and is in a position to formulate different hypotheses from those made by psychosomaticians who, while they see many more patients, are less likely to be able to follow them through the intense experience of a psychoanalysis or psychoanalytical psychotherapy of a continuing kind.

Although we all possess what I would call a psychosomatic potentiality my clinical observations have led me to postulate that this is notably increased following any perturbation in our narcissistic economy. The more fragile our narcissistic balance the more likely we are to deal with tension derived from instinctual sources or due to outer events, through some form of "acting-out" behaviour or the act-symptom of somatization. In the latter case the individual concerned usually remains unaware of his mental conflict and psychological pain. It is perhaps a rare individual in any case who thinks of his physiological ills as being at the same time psychological ones. ... It appears to me that in such situations the body is defending itself as though threatened by biological illness and is therefore engaged in marshalling survival techniques in a mistaken situation. It is perhaps this very quality of unawareness of painful affect or mental conflict that contributes to the by now classical description of a "psychosomatic" or "operational" personality structure; catastrophic events which to most people would cause considerable psychic pain are sometimes met with apparent calm and lack of affect which strikes the observer as astonishing. It is my contention based on many years of work with analytic patients that analysis will often reveal that the traumatic events which so frequently precede the outbreak of grave

psychosomatic affections, such as loss of security or love objects or sudden loss of narcissistic self-esteem, have caused pain or perturbation that lies too deep for the subject to bear, or stirs up anxiety of psychotic dimensions. The concomitant fear of being overwhelmed by uncontrollable affect and pushed to mad action or the panic of "falling to pieces", of losing one's ego identity or the capacity to function will sometimes come to the fore in analysis. The unwelcome ideas and painful affects have, until then, been eliminated so rapidly that the individual retains no knowledge of their even having existed. It might be added that when tension of any kind is reacted to as a narcissistic threat at the level of one's baby narcissism (in which the body is as yet little differentiated from the mother-body) then the psychosomatic response to instinctual tension and environmental stress is an accusation against that part of one's bodily self which is felt to belong to the mother or to be her. ... It seems to me that many people have created a psychic armour-plating which requires that they neither think nor feel too deeply in certain circumstances. These circumstances may be comprised as suggested above, of catastrophic external events, but they might also be daily occurrences such as sexual or work situations which contain a hidden traumatic potential unsuspected by the individual

There is however that group of psychological ills of a psychosomatic order in which strong affect, though diffuse and unattached to clearly defined mental representations (in contrast to neurotic symptomatology) is clearly felt—that is in the manifestations of what Freud called the actual neuroses and to which I should like briefly to turn my attention. These early Freudian texts in a sense are the first psychoanalytical papers dealing with psychosomatic phenomena. The old-fashioned term "actual neurosis" comprised two categories: neurasthenia and anxiety neurosis (to which Freud later added the category of hypochondria). The signs of "neurasthenia" included physical fatigue of "nervous" origin, headaches, digestive troubles, constipation, diminished sexual activity, etc. "Anxiety neurosis" (such as my patient Isaac presented) was characterised by sweating, trembling, palpitations and breathing difficulties. Many of today's analysts describe such symptoms just as vividly as they did in Freud's time. Indeed with today's much longer analyses we frequently find that after the disappearance of the neurotic symptoms which bring patients to analysis, these and other "discharge" patterns become another "rock" upon which many an analysis may founder. The symptoms are gone, there are many inner psychic changes but the analysand still feels tired, frequently anxious, unhappy and unfulfilled. And the analyst too!

Freud of course attributed the origin of the actual neuroses to the blocking of libidinal affect due to lack of sexual satisfaction or to masturbation. This explanation would seem somewhat inadequate in the current of today's psychoanalytic thought—and perhaps this dubious aetiology did much to discredit the concept. I should like to extend Freud's causal hypotheses in several directions. Whereas I do consider, following Freud, that depressive, listless states and anxiety neuroses are indeed mobilized and set off by "actual" or everyday tensions I would attribute this activation to a specific form of mental functioning, as described above. This way of functioning through discharge in action is closely linked to the nature of the primitive fantasies which lie in a larval state behind the urgent need to act rather than to reflect and to stifle emotion rather than to contain it; its origins however are to be found in the early physical and emotional transactions between mother and nursling. My analytic experience leads me to postulate that in severe psychosomatic and anxiety states we tend to find a primitive oedipal organization in which the mother, while not repudiating the father nevertheless is felt to have lived her relation to her child as a sexual complement or a narcissistic extension of her own self. This is frequently linked with an image of the oedipal couple as taking second place to the important mother-child unit. Also this situation seems to require a somewhat complaisant father who, in accordance with his unconscious problems, permits the incestuous relationship to continue and seeks to maintain his exclusion from this magic and over-gratifying circle. The child runs the risk of then feeling over-seduced, in danger of invasion and a prey to archaic sexual longings and terrors. His image of the primal scene tends to be condensed and sadistic. I would therefore suggest that while psychosomatic manifestations are frequently able to be traced to unrecognized libidinal tensions these are only set in motion by present day libidinal blockage to the extent that this derives from very early sensual and emotional tensions and traumata. If Freud's theory of the pathogenic effects of sexual frustration or of masturbation may receive any credence today this could only be linked to perturbing elements built into the child's psychosexual structure by the parents' unconscious sexual conflicts and dissatisfactions, thereby making the child's body and self an object of undue and terrifying investment, and the conflict one in which archaic sexual wishes and fears predominate over phallic-oedipal ones.

In addition to the indubitable factor of libidinal conflict analysts would also emphasize today the importance of aggressive tensions and their contribution to psychosomatic phenomena, as well as the role of primitive sadism that has failed to be integrated within the idealized mother-baby relationship. This might well be the after-effect of the child's projected greed and envy but it may also include unacknowledged ambivalence and envy of her child on the part of the mother. In this respect it might be noted that Freud did not leave much space for the idea that things might go badly between mother and nursling. He tended in fact to envisage this period as the nostalgic basis for the belief in Paradise. In a somewhat phallic way he maintained that man's object of desire was woman but that woman's object of desire was a male infant of her own. (It will be seen that my patient Isaac was in total agreement with Freud on this point!) My contention is that an exclusive mother-baby relationship of this order in which the child, male or female, was felt to replace the father as the object of desire and libidinal longing would be, even at the nursing stage, a potentially pathological one. In such an eventuality the child would appear to represent for the mother an object of vital need rather than a child born of mutual adult love and for whom the parents wish that he too should become a loving and desiring adult and parent. The "need-object" child frequently reflects the parents' unresolved sadistic and archaic sexual conflicts as well as unsatisfactory adult sexual lives.

Such mothers are often excessively "maternal", not "good-enough" in Winnicott's sense, but "over-good"; they over-care for, over-love, over-worry about, over-feed their children as often as not. However, in the child's mind this is apt to be experienced as psychic abandonment, as being cared for by a mother who appears totally indifferent to her infant's psychological needs and various affective states. Many such mothers are remembered at a later stage as having been uninterested in the child's mental pain, but quickly aroused and involved with any bodily pain or symptoms he might produce. The apparently gratifying situation also runs the risk of creating

in the child's mind the impression that he is indeed the mother's sexual and narcissistic complement and that nothing he can ever do will repair her or satisfy her. She is the abyss awaiting fulfillment. His needs and desires do not count. At the same time he cannot leave her without psychic distress for he is the cork-child required to keep her together. One might at this point wonder why such children have not become psychotic, or perverse? I have only a tentative explanation to offer, drawn from my clinical experience with patients whose main reaction to psychic stress was somatization, and who in other respects were not notably neurotic or perverse, nor ostensibly psychotic.

A proposito di Joyce McDougall, ricordo ancora che:

- una sua intervista, dal titolo **L'avenir de la Psychanalyse**, è reperibile a <http://www.carmed.org/interview.htm#TELÉ>;
- un suo breve profilo biografico e teorico è reperibile a <http://www.microtec.net/desgros/auteurs/galerif2.html>;
- una sua bibliografia è all'indirizzo <http://www.psychematters.com/bibliographies/mcdougall.htm> sul sito di **Psyche Matters**.

Affetto, Somatizzazione e Simbolizzazione

Un panel con questo titolo (**Affect, Somatization and Symbolization**) si è tenuto nell'ambito del 41o congresso dell'*International Psychoanalytical Association*, a Santiago del Cile il 27 luglio 1999, con l'intervento di *Dieter Bürgin* (Basel), *Charles Hanly* (Toronto), *Plinio Montagna* (São Paulo) e sotto la presidenza di *Joyce McDougall*; un resoconto, a cura di *Stanley C. Cohen*, è riportato sul'*International Journal of Psychoanalysis* (Volume 81 Part 1 February 2000, pag. 159). Ne riporto alcuni stralci significativi:

Joyce McDougall conveyed the optimistic attitude that the unfolding of transference during analysis helps to dissolve psychosomatic symptoms, replacing them with transference affects, once the patient becomes able to bear her feelings. The clinical presentations did indeed convey this optimistic potential that analytic engagement usually succeeds in overcoming the previous affect intolerance of many psychosomatic patients. That intense analytic engagement generates new, strong feelings in psychosomatic analysands seemed much clearer at the end of this panel than did our usage of the terms 'somatisation' and 'desomatisation'. Distance between analytic material and theoretical assumptions tended to hinder understanding, at least for this reporter, of why some of these patients needed their somatic symptoms and of how these symptoms functioned psychologically. In a nutshell, our presenting analysts were highly effective at treating patients' somatic concerns, far more effective than at being able to explain why and how the body was being used to defend against and to express conflict.

...

Bürgin suggested that symbol formation allows for somatisation, although he did not otherwise discuss somatisation. So, of course, he could not consider the opposite possibility, as McDougall (1980, 1989) has proposed and as the other panellists noted, that what is expressed bodily includes some of what has not yet been encoded symbolically. What has not yet been encoded symbolically may include the effects of early trauma. Then, traumatic affects that cannot be encoded in words, so that they cannot be expressed verbally, will be otherwise registered within the body's memory and thus become available for expression in bodily action. During analysis the analytic couple will need to translate such traumatic affects into words from various clues and expressions in action, bodily action and transference action (enactment).

...

Plinio Montagna presented the fascinating clinical vignette of C, a man who sought analysis for help with accepting a corneal transplant to restore his vision; he had already rejected two previous corneal transplants. ... It was not clear whether reducing this man's terror and guilt about taking in from others, so that he could tolerate his dependent longings more comfortably, was the primary factor allowing for the success of his transplant, or whether, as Montagna preferred, the patient needed to become able to symbolise his conflict in words. Montagna cogently proposed that 'the phenomenon of rejection' organised much of the patient's internal world within the analytic process. He acknowledged that he did not know how the patient's new-found tolerance for accepting what he needed from the analyst led to his body's acceptance of the corneal transplant. It is less clear whether this 'phenomenon of rejection' occurred, as Montagna contended, because 'in psychosomatic pathology, there are no words for emotions and no symbols for somatic states'. That is, as Hanly was soon to note, the meanings we attribute to somatic phenomena, and interpret analytically to our patients, do not necessarily establish such meanings as causal.

...

Each patient's somatic concerns melted away as transference affects intensified, justifying McDougall's optimistic perspective on the analytic treatment of psychosomatic symptoms. Each patient shifted her concerns from bodily discomfort to wishes and feelings, as she became able to tolerate and express her wishes and feelings. Indeed, it was impressive how successful our presenting analysts were in alleviating their patients' somatic concerns. We certainly do seem to be effective with our 'somatising' patients, even if we are unclear about what we mean by processes of somatisation and desomatisation. Unfortunately, this panel did not have sufficient time to consider in detail the presenters' conceptualisations of somatisation and desomatisation. Perhaps we persist with our earlier attempts to measure shifts in psychic energetic forces between too concretely

reified structures of the mind when we attempt to describe how repressed affects are shunted into, and subsequently released from, portions of the body. Rather than conceiving of most somatic symptoms as themselves expressing conflicted wishes, it seems more appropriate to consider patients' affect intolerance and need for hypochondriacal elaboration within regressive, pathological modes of relatedness (Coen, 1992). Perhaps we do better to eschew causal mechanisms, as this panel's clinical material would seem to indicate, instead to examine a given patient's need to defend against and express conflict through an intense focus on bodily experience.

Lo stato attuale della questione psicosomatica in psicoanalisi è ben documentato dal panel recentemente tenutosi al convegno internazionale dell'IPA di Nizza (2001) del quale riporto qui di seguito un resoconto, tratto dall'*Int. J. Psychoanal.* (2002) 83, 931.

A Critical Enquiry Into The Psychoanalytic Theories And Approaches To Psychosomatic Conditions

Moderated by: BETTY DENZLER, Gorgier

Reported by: NICHOLAS TEMPLE, London

This panel consisted of three contributions from Marilia Aisenstein, Elsa Rappoport de Aisemberg and Philip Muskin with the discussion by Gustavo Delgado-Aparicio. The Chair, Betty Denzler, and the audience had a challenging task to integrate the complex presentations and the discussion to create a balanced view of modern psychoanalytic approaches to psychosomatic conditions that could be the basis of a critical enquiry.

Dr Aisenstein discussed her theoretical position and illustrated her views by reference to two clinical cases, the second read by her colleague Marina Papageorgiou. Both of these clinical vignettes focused on the patients' dreams, which threw some light on symbolic aspects of the patients' psychosomatic symptoms. Dr Aisenstein's view is that psychosomatic medicine cannot be regarded as a rather distant branch of psychoanalysis but is an integral part of it. She bases this on Freud's definition of the instinctual drives as the psychic expression of somatic excitation. Although Freud laid the foundations for the psychosomatic approach, he did not explicitly deal with psychosomatic medicine as a psychoanalytic approach to somatic diseases.

She referred to Freud's idea that thought first emerged at the sight of a dead body, both loved and hated. In the discussion Dr Delgado-Aparicio linked this to Bion's words, 'Where there is no breast a thought can emerge and a creation starts', emphasizing that loss is the beginning of thought and the capacity to differentiate the self and the object. For a patient with psychosomatic symptoms, the problem is that the thought has been split off to appear as the bodily symptom, which Dr Rappoport concludes is a defensive regression to cope with psychic pain, the individual returning to the somatic code of infancy. Dr Aisenstein pointed out the difficulty of patients suffering from physical illness who show very little or no psychic elaboration with an apparent absence of conflict, although this is not entirely true of her clinical examples where the patients' dreams give rise to a sequence of thoughts that begin to give symbolic meaning to the physical symptoms. She related these ideas to Andre ´ Green's view that a psychosomatic illness occurs when excitation from inside the body does not reach the psychic area. He describes this failure as being due to a destructive drive acting to prevent the translation of excitation into thought and feeling.

This is a form of psychic blindness leading to the state of la pensée opératoire, which Green ascribed to the inability to create a representation of the absent object for which he also uses the term 'a blank thought'. In her first case she described a man suffering from Crohn's disease, a bleeding disease of the bowel, who remembered an old dream about a woman dying in Africa of a bleeding wound in her abdomen, which came to mind after eight months of psychotherapy.

He said that he had had the dreams six months before he became ill, when he had previously maintained that there was no connection between anything in his mind and the beginning of his illness. In his associations he recalled the name of an African city Ouagadougou. He remembered the dream after he had heard of the death of a woman he had loved who died of a wound in her abdomen. Her second case illustrated how the loss of representation in the psychosomatic patient acts on the countertransference and the analyst's ability to think with these patients. This is an important point and may be one explanation for the relative neglect of psychosomatic work by psychoanalysts. The patient had had a mastectomy for breast cancer but seemed to feel no psychic pain or emotion in relation to this and had the effect of making the analyst feel useless and angry. The patient had a dream following her realisation that the analyst could be interested in her painting. In her dream she was in the garden of her family home and although she was ill she was happy to stay at home and paint, having joyful memories about painting and mixing colours. She was not able to find a special red colour and could only paint the picture in black and white. In the end the picture became dusty white and foggy. The analyst has associations to the red colour as blood, to the black and white as related to the patient's African husband and to the dusty white as something connected with white mourning, which the patient had linked to

her mother's depression.

This led to the patient's associations about her mother's miscarriage a year before the patient's birth and her mother's disappointment in the patient and her sister. Dr Aisenstein completed her contribution with a discussion of Freud's instinctual theory, making the point that he did not maintain exclusive definitions of the terms 'psyche' and 'soma' and he made no clear distinction between them. Freud regarded the opposition between the instincts leading to conflict as the source of psychic life. She pointed out that the Paris Psychosomatic School regards the conflict of instincts as the organiser of the individual psychosomatic economy. Since Freud, psychosomatic research, based on mental economy and mental functioning integrating mind and body, puts the psychosoma problem into new historical perspective. This fits with the work of neurologists such as Damasio, who emphasise the integration of mind with body and challenge the traditional Cartesian mind/body split. Psychosomatic patients employ a mind/body split in locating mental content in a physical symptom to block psychic expression. Both of her patients illustrated the way in which dreams can begin to recover thoughts that have been split off into physical symptoms.

In her contribution, Dr Rappoport reviewed authors and ideas that have helped her to think about psychosomatic disorder and formulated some of her own hypotheses. She pointed out how psychosomatic conditions demand technical creativity on the part of the analyst to sustain the psychoanalytic process. In her view the approach to psychosomatic phenomena is a clinical extension of the psychoanalytic method, but it may give rise to theoretical formulations that can be at odds with the basic psychoanalytic metapsychology. This is true of Pierre Marty's formulations, while Joyce McDougall has succeeded in producing a satisfactory clinical and theoretical approach within a psychoanalytic frame.

Like Dr Aisenstein, Dr Rappoport believes that psychosomatic conditions belong firmly to the psychoanalytic field. She made the point that states such as *pensée opératoire*, which are widely agreed to be associated with psychosomatic conditions, may be chronic or sporadic in nature. She agreed with many authors, including Dr Aisenstein, who report that we come across patients with such operatory states with an absence of somatic disorders, while others who suffer from psychosomatic conditions do not display significant operatory thinking. Perhaps this observation can be better understood if *pensée opératoire* is thought of as a defensive structure that can operate chronically or can be deployed at times of psychic stress, for example following separation and loss. The high incidence of somatic illness following bereavement tends to indicate that this defence is a common one. Dr Rappoport referred to Smadja who described the four basic dimensions of psychosomatic pathology: first, the relationship to narcissistic pathology; second, the importance of Freud's concept of the actual neurosis; third, the frequency of trauma in the psychogenesis of psychosomatic symptoms; and fourth, the importance of the death drive in psychosomatic conditions.

She referred to Green's description of psychic suppressive deafness leaving the individual prey to destructiveness located in the body. Joyce McDougall wrote of the repudiation of painful or unbearable representations with primitive defences against anxiety that render psychic survival possible at the price of somatic symptoms. Dr Rappoport outlined some of her own hypotheses. She had noted patients with somatic disorders in whom psychoneurotic functioning is present or emerges during the treatment, so that neurotic and narcissistic functioning exist alongside each other. She made the point that the capacity to translate somatic excitation into psychic language is an internal path that developmentally originates in the mother-infant relationship. Narcissistic disturbance in this relationship will result in a disturbance of body image, leaving a tendency towards psychosomatic symptoms. This may be further intensified by difficulties in the mental representation of the body brought about by trauma and/or maternal *de. cit.* In her view, the adult capacity for psychic representation may be damaged by early experiences leading to the persistence of the normal alexithymia of infants and children. She described the difficulties in mourning in psychosomatic patients and regards the psychosomatic conditions as a form of defensive regression when confronted with psychic pain or overwhelming anxiety.

In his paper Dr Muskin described the clinical situation of a patient who requests euthanasia. The patient does not have a psychosomatic illness but the preoccupation with death is clearly allied to it. The patient asks, 'Doctor, would you kill me?' Dr Muskin described how the patient has a split experience. The demand for death is that the bad, medically sick part of the self should be killed, leaving the healthy self to survive. When death is demanded the conflict is reduced and actually the ill self begins to win. He described how these patients feel rage at themselves, rage at their doctors, rage at the world and rage at God for their illness and suffering. This rage is at all those who should care for them and is fundamentally rage at the mother in whom is located all their hate. The analyst becomes the focus of this hatred and revenge in the transference relationship. He believes that the patient's state of helplessness, sense of being out of control and terror of the unknown leads him to seek revenge by demanding death. In this way, the patient not only seeks revenge but also achieves mastery over the state of extreme vulnerability. Dr Muskin believes that these patients are seeking revenge by murdering what is an unconscious image of the mother who is simultaneously loved and hated. Dr Muskin believes that these patients who seek death are like psychosomatic patients who wish to be sick or die. In his view, the patients are the victims of parents who were not able to accept anything inadequate or sick in the child. For them being ill meant rejection, abandonment and psychic death.

The three contrasting papers in this panel raised some significant common themes about the theoretical nature of psychosomatic disorders and their psychogenesis. The contributors referred briefly to the difficulties in

treating these patients in psychoanalysis, but did not comment on this in detail. The contributors agreed that psychosomatic states are related to splitting defences against psychic pain in which there is regression. They are developmental disorders in which the early mother–child relationship has been crucial in interfering with the capacity for psychic representation, so that the psychosomatic state of pensée opératoire can be compared to that of an infant who, as Dr Rappoport suggested, might normally be regarded as alexithymic. All the contributors agreed on the significance of the effects of the death drive in psychosomatic patients, which were so strongly represented in Dr Muskin's case. There was also agreement in relating this to experiences of narcissistic problems in early object relationships, where there has been the lack of a capacity to accept all aspects of the infant, and an attack on the qualities of the infant that are at odds with the narcissistic requirements of the parents. A common feature is the presence of psychic trauma and a lack of a capacity to mourn, which is closely related to the difficulties that may have occurred in infancy.

The panel members agreed that psychosomatic medicine is an integral part of psychoanalysis, but recognised how difficult the countertransference work can be, with the requirement for the analyst to be able to be flexible and innovative to cope with the countertransference and the resistance to associative work in these patients. There was a lively discussion from the floor taking up Dr Muskin's presentation of the patient who requested euthanasia. A connection was made between this patient's preoccupation with death and the presence of the death drive in the other clinical cases that were discussed. The point was made that the death drive split off into the psychosomatic symptom. In both of the cases presented by Dr Aisenstein the dreams contained symbolic representation of the split-off preoccupation with death, which was a conscious wish in Dr Muskin's patient.

This was a stimulating panel with a theme that could be developed in future congresses.