

Psychoanalytic psychosomatics¹

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Introduction

Psychosomatics, or the treatment of psychosomatic illness, offers a new approach to the ill person, and for that reason belongs to the history of medicine. Right from the beginning, there have been several conceptual currents contributing to the growth of medicine, among which the life of the mind has had a more or less significant place. The term 'psychosomatic' first appeared in the second half of the 19th century. Its originator is said to be a German psychiatrist called Heinroth. The aim of the new current of medicine designated by the term was to introduce factors of a psychic nature into the organicistic and experimental current of 19th century medicine, in order to account for the causality and aetiopathogenesis of certain illnesses. This new and global approach to the ill person still has a place in medical practice, and constitutes one of its currents. However, its deployment has come up against the development of the biological notions and discoveries which continue to organize, more than ever, the foundations of Western medicine.

Freud's invention of psychoanalysis opened up a new avenue of approach to those with somatic illnesses, and several psychoanalysts have used it in their clinical observations and their psychoanalytic treatments. Thus a new current has developed in psychosomatics, psychoanalytic in origin, in contrast to the strictly medical current. The latter begins with the idea of illness and proceeds to look for all the aetiological factors, both biological factors and those of psychic origin. Psychoanalytic psychosomatics, on the other hand, starts with the ill person and his or her psychic functioning, in order to understand the conditions in which a somatic illness came to develop.

I. The history of psychoanalytic psychosomatics

A. The Freudian basis of psychosomatics

In the whole Freudian corpus, there is no piece of research specifically associated with psychosomatics. However, a number of studies and conceptual tools, developed by Freud in other areas of psychopathology, will be used as a basis for future elaboration by psychoanalysts interested in patients with somatic illnesses.

Although Freud was not interested in psychosomatics in the sense in which we understand it today, he did on the other hand frequently study the different states of the body. The theoretical preoccupations concerning the economy of the drives are informed by all the work relating to symptoms expressed in physical form. When we go through the work of Freud, we can thus identify four types of somatic symptom: the symptoms of hysterical conversion, the somatic symptoms of actual neurosis, hypochondriacal symptoms and constitutional organic illnesses.

(a) The symptoms of hysterical conversion According to the Freudian view, these are mnesic symbols converted into the body, supporting a group of unconscious phantasies in

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which the subject's bisexuality is involved. From the clinical point of view, one should emphasize that as a rule there is no anxiety accompanying these physical symptoms. From the metapsychological point of view, a certain number of psychic conditions are required for the formation of hysterical symptoms: the existence of a post-oedipal superego along with a relatively complete oedipal organization in which there is a dynamic unconscious in charge of symbolization and a permanent and effective mechanism of repression.

(b) The somatic symptoms of actual neurosis Clinically, these symptoms correspond to the category of functional disturbance in classical medicine, that is, to a hyper- or hypo-functioning of certain somatic functions. In general, they have no symbolic significance, unlike the disturbances of hysterical conversion, and they are usually accompanied by anxiety. At the metapsychological level, they are the result of a disturbance of psychosexuality or psychic sexuality. At the core of this disturbance can be found an inadequate mechanism of repression for which other, more economically costly mechanisms, such as suppression, have been substituted. Thus the subject's libido, instead of being worked over in the mind, withdraws to the organs which it overcathexes. Thus, according to the Freudian view of the actual neuroses, somatic symptoms in this context result from an erotic over-cathexis of the somatic function concerned. We must remember that one of the hypotheses of Freud's libido theory is the idea that each organ or somatic function has a dual instinctual allegiance. An organ is as much cathected by the self-preservative instincts, that is, by those which ensure its physiological functioning, as it is by the sexual instincts. For Freud then, and this is a hypothesis which is necessary to his instinct theory, there is an erotism of the organs which is manifested in the subjective feeling that the organs are functioning well. However, if there is an imbalance between the two kinds of instinctual cathexis in the organ or in the somatic function, the organ's self-preservative function, that is, the physiological function, will be disturbed. That is the economic situation created by the erotic over-cathexis of the organ.

(c) The symptoms of hypochondria Clinically these are somatic complaints characterized by a sense of grievance or even paranoia, which have no underlying organic lesion. From the metapsychological point of view, according to Freud, they come from a damming-up of narcissistic libido which has not been worked over in the mind. The projection of this narcissistic libido on to the body aims in this way to disavow the lack at the level of the organic auto-erotisms.

(d) Organic illnesses Clinically these are the objects specific to psychosomatics. Freud approached the study of organic illness from a psychoanalytic point of view, according to two different levels. The first is that of a narcissistic regression setting in after the illness has taken up residence in the body. Freud was interested in the links between the modifications of the subject's libidinal economy and the presence of a somatic event. For Freud, the redirection of erotic object cathexes towards the affected organ constitutes a regular mechanism in subjects with a somatic illness. It should be emphasized that this idea is a revival of the hypothesis put forward by Ferenczi in his work on neurotic illnesses. The second level considers organic illness from the point of view of its genesis in the light of instinct theory. Freud is here drawing on the second version of his instinct theory, developed from 1920 onwards, and based on the opposition between the life instincts and the destructive or death instincts. He emphasizes that in the course of a long-standing state of instinctual defusion, without the possibility of re-fusion, one of the consequences for the subject is that his somatic functions are deeply affected, giving rise to organic illness.

In addition, in the course of several observations, Freud emphasized certain paradoxical and enigmatic relationships between pathological states of the body and pathological states of mind, for example, in cases where there is a clinical and economic incompatibility between a state of traumatic neurosis and an attack of physical illness; similarly, a somatic illness may lead to the disappearance of a neurotic state. These seesaw movements

between psychic states and somatic states, and the paradoxical connections between them, seem to involve the quality of the subject's masochistic organization.

B. Post-Freudian currents in psychosomatics

Following Freud, several psychoanalysts have taken an interest in the psychoanalysis of patients with somatic illnesses.

(a) Pre-war theoretical currents Ferenczi devoted part of his work to the psychoanalysis of organic illnesses. His notion of neurotic illness sought to account for those neurotic, and by extension psychotic or narcissistic, modifications which can occur in the wake of an organic illness. He envisaged that masochism would have a place in these developments. Groddeck developed a psychoanalytic doctrine of organic illness according to which the all-powerful id was able to produce not only a neurotic symptom or a character trait but also a somatic illness. This view attributes symbolic value to all somatic illness, which thus becomes amenable to psychoanalytic treatment. The absence of any kind of discrimination or differentiation between the different psychic levels and the biological and physiological levels is one of the weakest points of Groddeck's theory.

F. Alexander, a pupil and colleague of Ferenczi, developed a current of psychosomatics called psychosomatic medicine. Most of this work was carried out in the United States, within the Chicago School, which he founded. He has a dualist approach to somatic illness, linking a psycho-analytic point of view with that of physiopathology. Psychosomatic medicine is built on two bodies of theory. The theory of organic neurosis derives from the Freudian notion of actual neurosis and postulates that emotions at the psychic level which are repressed over a lengthy period of time are transferred via the autonomic nervous system to the organs whose function they modify, leading in the first instance to functional disturbance, and then in the second instance to organic illness. The theory of specificity postulates that to each emotion corresponds a specific physiopathological syndrome. The work of Alexander and his colleagues of the Chicago School, along with other North-American authors, led to the creation of personality profiles linked to certain somatic illnesses, said to be psychosomatic. Although the ideas of psychosomatic medicine can be criticized from the psychoanalytic point of view, its observations and studies relative to certain complaints, such as bronchial asthma, gastro-duodenal ulcers or arterial hypertension, continue to be of great historical interest, and have opened the way for the later work of the psychosomaticians, in particular, in France after World War II.

(b) Post-war theoretical currents It was at the beginning of the 1950s that certain French psychoanalysts began to take an interest in somatic illness. When the work of the North-American psychosomaticians was disseminated in Europe and their theoretical positions became subject to critique, this led to new psychoanalytic ideas concerning psychosomatic conditions. Psychoanalytic practice with somatic patients refocused on the relationship and the transference, allowing the different authors to elaborate a new approach to psychosomatic conditions, which was psychoanalytic in nature. The theoretical debates which then developed among different schools centred primarily around the question of the meaning of the somatic symptom. For some, the somatic symptom was a vector of meaning; for others it was the result of a psychic structure whose principal effect was deterioration at different levels of meaning.

(i) J.P. Valabrega (1964): Generalized conversion

J.P. Valabrega's conception depends on the notion that all individuals harbour a kernel of conversion. In this view, the body is conceived as a preconscious bearing meaningful memory. Thus, all somatic symptoms contain a meaning which the work of psychoanalytic

treatment aims to discover and elaborate. We note that this conception leaves undetermined the issue of whether the meaning belongs to the patient or to the interpreting analyst. In addition, it does not distinguish the meaning which belongs to the genesis of the somatic symptom from that which belongs to a second stage, that of the modifications occurring later during the work of psychoanalysis in a patient with a somatic illness.

(ii) The Psychosomatic School of Paris

The Psychosomatic School of Paris came into being around the end of the 1940s. It included a number of psychoanalysts from the Paris Psychoanalytic Society [la Société Psychanalytique de Paris]: P. Marty, M. Fain, M. de M'Uzan and C. David, who were joined by other psychoanalysts. The first studies, led by P. Marty, either singly or in collaboration with M. Fain, concerned patients with cephalalgia (headache), rachialgia (spinal pain) or allergies, and date from the 1950s. They stressed the inadequacy of neurotic defence mechanisms and attributed to the somatic symptoms a value as substitute-formations, but lacking the symbolic dimension that one finds in the symptoms of conversion hysteria.

The notion of somatic regression originated at this time by analogy with the notion of libidinal psychic regression. At the beginning of the 1960s, a vast clinical–theoretical synthesis was elaborated, taking the form of a collective work entitled *Psychosomatic Investigations* and edited by P. Marty, M. de M'Uzan and C. David (1963). This work can be considered as the birth certificate of psychosomatics as a psychoanalytic discipline. New clinical concepts appear, such as depression without an object, operatory thinking and the mechanism of projective reduplication, and a new point of view now comes to govern the psychosomatic investigation of patients with serious somatic complaints, namely the economic point of view. From this new point of view, all human productions are viewed in the light of their transformations from one to another. This applies not only to psychic productions, neurotic symptoms, character traits, perversions, or sublimations, but also to behaviours and somatizations.

Following *Psychosomatic Investigations*, and within the School of Paris, different theoretical sensibilities will develop. P. Marty develops an evolutionist doctrine of the psychosomatic economy. The latter depends on the coexistence and alternation of two types of individual movements. The first, known as movements of life, are movements of hierarchical organization. The second, known as movements of death, are movements of disorganization. Thus in each individual case development leads to the construction of systems of fixation–regression more or less resistant to the current of disorganization. Generally speaking, serious somatizations are the more or less permanent result of the failure of these defensive systems while minor somatizations provide evidence of their presence.

In his studies, M. Fain emphasizes that, in the infant who will go on to somatize, there is an incomplete oedipal structure linked to the predominance of traumatic circumstances in the early relation to the mother and father. As a result, hallucinatory wish-fulfillment is more or less permanently blocked and the formation of the ego takes place prematurely in autonomous mode. The state of instinctual defusion thus forms the basis of somatizations which can then be interpreted as the singular fate of the instinct.

M. de M'Uzan distinguishes psycho-functional disturbances from organic illness. He believes the first are linked to a process of regression while the second are the result of a specific modality of mental functioning. In fact this modality, which he initially described as

a psychosomatic structure, belongs, in his view, to the normal range of psychic functions in any individual. It combines a lack of phantasy life, operatory thinking and the mechanism of projective reduplication, and results from the deactivation of psychic energy.

II. Clinical and theoretical approaches to psychosomatics

Unlike the medical approach to psychosomatics, which views the patient from the starting point of his or her illness, the psychoanalytic approach starts by locating a process of somatization in the patient's psychic functioning. So clinical approaches to psychosomatic patients can only emerge through the filter of the relationship which the psychoanalyst establishes with the patient who is ill. A process of somatization is a chain of psychic events which lend themselves to the development of a somatic complaint. A distinction is usually made between two modalities of the process of somatization: the process of somatization via regression and the process of somatization via instinctual defusion. What opposes these two movements is the quality of mentalization from which they develop.

Mentalization

We are speaking of a standard notion used by psychoanalytic psychosomaticians which encompasses the whole field of psychic working-over. Mentalization, then, refers principally to a person's activity of representing and phantasizing. To the extent that the work of linking representations goes on in the preconscious system, the evaluation of the quality of mentalization and that of the quality of the preconscious are virtually equivalent. For P. Marty, mentalization can be assessed according to three axes, each representing one of the dimensions of the activity of representation: its depth, its fluidity and its permanence. Depth refers to the number of layers of representations accumulated and stratified in the course of a person's history. Fluidity refers to the quality of representations and their circulation across different historical periods. Permanence refers to the availability at any moment of the whole network of representations, both from a quantitative and also from a qualitative point of view. To these three criteria, one should add a fourth: whether the activity of representation is governed by the pleasure–unpleasure principle or by automatic repetition. So one should distinguish the free activity of representation from the representational overactivity linked to a compelling necessity to repeat.

A. The process of somatization via regression This is a process which leads as a rule to minor and reversible somatic episodes. These would include asthma attacks, headaches or back pain, attacks of ulcerative colitis or high blood pressure. Such somatizations often recur in the same form in the same person. These somatizations generally occur in subjects whose psychic functioning is organized according to a normal–neurotic mode. Their mentalization is usually satisfactory or only slightly affected. In such cases, somatizations occur when the fluctuations of psychic functioning that P. Marty described as 'irregularity of mental functioning' are at a low ebb.

Irregularity of mental functioning

This is a term used to describe episodic changes, both habitual and reversible, in the system of mental functioning, which momentarily transform the psychosomatic economy. These variations give way to perverse or sublimatory activities, character or behavioural traits, or minor somatizations.

Because of an overload in the ego's work of linking in the preconscious, the libido comes to regress towards its somatic origins. The resulting hyper-erogenization of the organic

function generates a somatic disturbance in the form of a hyper-functioning or a hypo-functioning. This process of regression gives momentary relief to the work of the psyche, which can then after a certain interval, regain its usual efficiency.

B. The process of somatization via instinctual defusion This is a psychic process which usually results in serious and progressive illnesses that can lead to death. These include particularly auto-immune diseases and cancers. This process generally develops either in subjects presenting a non-neurotic ego organization, or in subjects who have suffered psychic traumas which have reactivated deep and early narcissistic wounds. In every case, the dimension of narcissistic loss is present and forms the basis of a momentary or lasting disturbance of mentalization. This dimension of narcissistic loss generates a state of instinctual defusion which modifies the whole psychosomatic equilibrium of the subject. As the process progresses, one sees firstly the development of psychopathological modifications, then secondly the physiopathological modifications indicated above. At the psychic level, one can observe a certain number of symptoms grouped under the heading of operatory life: a certain quality of depression, essential depression, and a certain quality of thought, operatory thinking.

Essential depression

This is a modality of depression characterized by the absence of symptomatic expression. It was described by P. Marty in 1966 and is defined by a general lowering of tonic vitality without an economic counterpart. In fact one does not find any evidence in the experience of essential depression either of feelings of guilt or of melancholic self-reproach. Thus essential depression is revealed through the absence of symptoms and through a strong countertransference impression evoked in the psychoanalyst. From the metapsychological point of view, it testifies to a libidinal loss both narcissistic and objectal, and represents in negative form the trace of the self-destructive current of the death instinct.

Operatory thinking

This is a mode of thinking which is in the present, factual and without links to a phantasizing or symbolizing activity. It accompanies the facts rather than representing them. In reality, it is a non-thought to the extent that it has lost its connection with its instinctual origin. It should be distinguished from obsessional thought. From the metapsychological point of view, the over-investment of the perceptual, on which it depends, aims to defend the subject against the failure of hallucinatory wish-fulfilment and from the consequential traumatic distress generated in the psychic apparatus. Operatory thinking for the subject, then, has a self-soothing function. Operatory life may become a chronic condition or take the form of a momentary and reversible crisis. It usually represents a fragile and unstable modality of psychosomatic equilibrium. In severe cases of operatory life one can often observe a deterioration in the quality of the superego and its replacement by a powerful system of idealization which P. Marty describes as an ideal ego.

The ideal ego

The ideal ego, narcissistically all-powerful, according to P. Marty's definition, is a behavioural trait defined by its excess. It derives from inexhaustible demands made by the subject both vis-à-vis himself and also vis-à-vis others. The point of locating an ideal ego in a patient is mainly that it implies the absence of regressive capacities and of psychic passivity, in both cases constituting a risk of psychic as well as somatic collapse.

Once in place, operatory life depends on the favourable quality of the environment which surrounds the patient, and particularly on the presence of a suitably appropriate psychoanalytic framework of treatment. Given the reduced mental capacity available for integration of the traumatic events which must lie behind it, it always represents a major risk of somatic disorganization. For that reason it may progress in the direction of a serious somatic complaint.

III The practice of psychoanalytic psychosomatics

In the view of the psychoanalysts from the Paris Institute of Psychosomatics [Institut de psychosomatique], set up by P. Marty in 1972, psychotherapeutic treatment of patients with somatic illness should be carried out by psychoanalysts with a theoretical and clinical psychoanalytic training, who have also received an in-depth training in the field of psychosomatics. This treatment is seen as complementary to the traditional medical and surgical treatments, and aims to allow the ill patient to find or rediscover his or her optimal level of psychic functioning. The place where psychosomatic psychotherapy takes place should be different from that where the medical treatment is carried out. The separateness of the place should allow the patient to invest his or her psychic functioning within the context of a new therapeutic relationship of a different kind. Thus psychosomatic treatment may take place either in an institute of psychoanalytic psychosomatics, like the Pierre-Marty Hospital of the Paris Institute of Psychosomatics, or else in the consulting room of a psychoanalytic psychosomatician.

The choice of framework assumes great importance because of the usually fragile psychic as well as somatic functioning of the patients. When we are dealing with patients who present with minor and potentially reversible somatic crises, and whose psychic functioning is close to normal–neurotic functioning, the choice of the couch may be suitable in a classical psychoanalytic treatment setting of three sessions per week. On the other hand, when we are dealing with patients who present with a serious and progressive somatic illness, whose psychic functioning is governed by narcissistic inadequacy and greater or lesser areas of operatory life, the choice of sitting face to face is indicated, with a frequency of one to three sessions per week. This frequency must be assessed in function of the patient's capacity to tolerate the source of excitation represented by the presence of the psychoanalyst sitting opposite. The rule of 'neither too much nor too little' should guide the choice of the psychoanalyst here. In all cases, the live presence of the psychoanalyst, as the sessions unfold, represents an invaluable narcissistic prop for the patient without which no psychic reorganization is possible or lasting.

The psychoanalyst's interpretative activity should be continually modified and adapted to the different levels of the patient's psychic functioning, and at the same time should take the utmost account of the economic weight of the illness and its characteristic progress. P. Marty has spelt out a guideline which acts as a framework indicating the gamut of possibilities in the field of interpretative activity: 'from the maternal function to psychoanalysis'. This guideline spells out two poles; one is the maternal function of the therapist, the other the interpretative function of classical psychoanalysis. The maternal function of the therapist is an attitude rooted in the psychoanalyst's capacities for narcissistic and primary identification with the patient, which accompanies all the patient's psychic movements. It aims to establish or re-establish a protective shield against excitation when this is lacking in the patient, or else, on the other hand, to introduce new sources of excitation when this is missing, particularly in cases of major essential depression. When the latter begins to dissipate, and once psychic reorganization is under way, the psychoanalyst can reduce his or her activity and take a more classical psychoanalytic position.

In all cases, the thing is to keep alive the psychotherapeutic relationship which ensures the narcissistic and masochistic reorganization in the patient. The work of the psychoanalytic psychosomatician assumes that he or she does not become bored with the patient, particularly when the latter is still embroiled in operatory moments. Here, the 'art of conversation' should be handled with tact while the analytic stance is maintained. The psychoanalyst might equally choose interpretations of a psychodramatic and playful kind in order to short-circuit the closed discourses of the operatory and rationalizing mode. These different linguistic activities on the part of the psychoanalyst should be adapted to the variations in the patient's mental functioning.

The termination of the treatment often raises tricky problems in the case of somatic patients. For some of them, it is possible to think in terms of a regular decrease in the frequency of sessions before ending with a separation between psychoanalyst and patient. For other patients, on the contrary, we have to resign ourselves to continuing the treatment indefinitely.

In fact, even though the psychic and somatic state of the patient appears to have stabilized, it is not uncommon for an interruption in treatment to regenerate a progressive illness with a potentially fatal outcome. Be that as it may, there is no systematic framework which holds for the whole group of patients, and it is up to the psychoanalytic psychosomatician to use the whole range of his or her personal and psychoanalytic capacities to assist the patient towards a life under the best possible conditions.

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