The difficulties of being human oblige us to create an infinity of psychic structures to bind or in some way cope with the inevitable physical and mental pain we are going to encounter. We have to start doing this shortly after birth and are only able to do it because of a unique phylogenetic heritage: the capacity for symbolic functioning. Most of our psychic pain is occasioned on the path to acquiring individual status and personal identity followed by the acquisition of our sexual identity. Freud was the first to emphasize the essentially traumatic nature of human sexuality while Klein and her disciples have thrown light upon the earlier traumata inherent in the process of separating one's image from that of the primordial Other in order to become a person. We must find answers early on to the conflicting claims of instinctual life and reality demands which these processes bring in their wake, and for the rest of our lives much of our psychic energy will be directed towards maintaining the solutions we have found. Some of these solutions make life a creative adventure while others are maintained at the expense of psychic, and eventually somatic, well-being.

Anthropologists such as Lévi-Strauss postulate that sexual laws of some kind are inherent in any social structure in that they are the minimal requirement for distinguishing a social group from a herd such as may be found in brute nature. In psychoanalytic theory insight into the complexities of social and sexual integration is attained through the concept of the oedipus complex, the notion of castration anxiety and of the symbolic structures to which they refer. These relatively sophisticated structures are intricately bound up with language and indeed could not exist without it. Beyond them lies the darker, infra-verbal and pregenital area, less weighted semantically (which, therefore, led Freud to designate this the prehistoric part of the individual's psychic story). In this early phase psyche and soma might appear to coincide although the extensive charting of these laboriously mapped areas of the mind (the principal cartographers after Klein being Winnicott and Bion) tend to show that the psyche grows out of the soma almost from birth. To attain the primitive psychosomatic level of existence is rather like trying to recreate the experience of original awareness as mystics do. Any research into psychosomatic pathology must struggle with the unknowns of this early phase of psychic functioning. The psychic material which enters into the primordial fusion of mother and nursling is composed of smells, sounds, and visual and tactile sensations. These are in themselves despatializing factors and this no doubt favours the setting in motion of one of the earliest of psychic mechanisms, subsumed under the concept of projective identification. These mechanisms will dominate until such time as language spatializes and limits the psychic structure, thus delimiting the inner and the outer world, while at the same time the infant begins to inhabit his soma. He becomes embodied. Little Oedipus comes to terms relatively late with the problems caused by the difference between the sexes, the narcissistic mortification of the primal scene and the relinquishment of his erotic and aggressive

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A contribution to a Symposium on 'The Psychoanalytic Process'.
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- 437 -

incestuous wishes. We are concerned here with the much smaller Narcissus who must come to terms with the definitive loss of the magical breast-mother and with the ineluctable demand to create psychic objects which will compensate for his loss. His capacity to create the symbolic structures necessary for this achievement will be circumscribed in large part by the limits of his parents' unconscious fears and desires. The mythical moment in which the fusional identity with the mother is relinquished requires a mother who herself is prepared to accept the loss of the magical union. This loss might be considered as the primordial castration in an individual's life. Many parents, through intense narcissistic identification with their young, tend to spare them the inevitable confrontation with reality beyond the point demanded by their immaturity. The anxieties to which this primal separation give rise are usually qualified by terms such as annihilation and disintegration, and in turn might be conceived of as the prototype of castration anxiety proper. Once again it is a global menace. Frustration, anxiety and conflict have not yet become symbolically attached to the sexual organs.

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
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

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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 irrepressible 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 rest of this paper will be concerned with background material, theoretical and clinical, to elucidate the above points. My hope is to contribute to our knowledge of the silent messages of the body and to stimulate reflection on our intuitive understanding of the psychesoma, so that we may come to know better what we have done, unknowing.

I

Psychosomatic Man

Research into the meaning and treatment of psychosomatic illness is at the crossroads of various scientific disciplines. Although I shall give a bird's-eye view of the psycho-soma and the use of the term psychosomatic I can describe only that picture which may be obtained through the psychoanalytic microscope. This instrument is a highly specific one, concerned with psychical and symbolic functioning rather than somatic transformations; in addition the latter are objects of study for which it was not originally conceived.
Furthermore, from a research point of view psychoanalytic case sampling can scarcely be called an unselected one. In the first place people suffering from disorders of psychosomatic origin seek a physician rather than an analyst for their somatic ills—unless of course they consider they have psychological problems as well. Sometimes however patients who are unaware of suffering from psychological symptoms do turn up in the analyst's consulting room, complaining, e.g. of gastric symptoms or cardiopathy, because a psychoanalytic or psychiatric consultation has been suggested by the consulting physician. In these cases opinion among analysts would be sharply divided as to whether such a request should be met with an offer of psychoanalytic help or not. Some would consider full scale analysis to be the best available treatment if allied to appropriate medical care. Others would advocate a modified form of analytical psychotherapy. Others again would consider the project to be fraught with danger and would regard the presenting symptoms, if unaccompanied by any neurotic manifestations, as a counter-indication for analysis.

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!

**Psyche and soma in psychoanalytic theory**

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
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 set 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 psychogenetic 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. 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 everincreasing 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 hysterias. 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-relations 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. I should like to take two examples of bodily anxiety having nothing to do with psychosomatic causes to illustrate my point. The first concerns a male patient whose mother was black and whose father was white; the second a woman who bore the consequences of polio, contracted in childhood. Both these patients lived their physical problem, black skin and paralysed limb, as though it were a visible sign of castration in both a sexual and a narcissistic sense. They also attached to the somatic facts fantasies of a dangerous and persecuting mother who was held to be responsible for their psychic suffering. These fantasy constructions were helpful, yet it would be absurd to hold that the castration anxiety and the early persecutory anxieties were the cause of the black skin and the polio sequelae. We may be making a similar methodological error if we assume that a peptic ulcer is caused by the fantasy of a devouring-persecuting mother, or that the tubercular bacillus is an introjected part-object with bad intentions. The internalized object, whether total or partial, beneficial or malevolent, is entirely imaginary. It occupies no physical space and leaves no physical trace, even though our metaphorical use of language may lead us to believe that it does. The somatic event, invasion or explosion, will inevitably tend to attract such a fantasy to it as a result of the analytic process, with its stimulation to link primary and secondary modes of thinking, thus creating new ways of feeling and experiencing. These may provide the analysand with new pathways for dealing with psychic tension. This, as I hope to show, is particularly important for people who have predominantly psychosomatic reactions to instinctual and environmental conflict.

There is a further methodological error to be indicated at this point. Since the interaction of psyche and soma could be 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 grays. 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...
The transformation open to somatic explosion. Him. Unconscious available to take their place. Had the effect of a traumatic event in that her habitual defences were overthrown and rendered inoperative and no others were that night but the next morning found her business trip and including reference to a 'sexual appointment'. Was able to procrastinate or in various ways make her husband forget the appointment. Interest, she had contrived a system whereby the couple made 'appointments' to have sexual relations on a given day. Suffer from her with she maintained firmly that sex had no interest for her and that she was pleased to be frigid. Perversions or certain analysts from destruction and death. Result then may be a fantasies, the ego may achieve complete destruction of the representations or feelings concerned, so that these are not registered. Through psychic impoverishment itself from external reality. Those who are interested analytically in psychotic states well know to what extent the mind, which leads an model 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. Two brief examples may clarify this notion. A patient whose character defences were of a rigid uncompromising nature had developed a series of tactics for dealing with sexual anxiety. To begin with she maintained firmly that sex had no interest for her and that she was pleased to be frigid. Since she did not want her husband to suffer from her lack of interest, she had contrived a system whereby the couple made 'appointments' to have sexual relations on a given day. Sometimes she was able to procrastinate or in various ways make her husband forget the appointment. The system worked more-or-less satisfactorily from my patient's point of view. On one occasion her husband sent a telegram announcing an unexpected return from two months business trip and including reference to a 'sexual appointment'. My patient was unaware of any emotional reaction and had no dreams that night but the next morning found her body practically covered with urticaria, the first attack she had known. The sudden news had had the effect of a traumatic event in that her habitual defences were overthrown and rendered inoperative and no others were available to take their place.

Another patient reported a war experience in which a bomb exploded beside him, killing his companions while he was knocked unconscious. He recovered unhurt except that his skin was covered with great patches of psoriasis, an affliction until then unknown to him. We cannot say that the explosion 'caused' the outbreak; it overthrew his usual psychic defences in the face of danger, laying him open to somatic explosion. No doubt everyone has a threshold beyond which his psychic defence-work can no longer cope, at which moment the body bears the brunt.

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 also is 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 Sperling (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 her to the conclusion that these babies do not have a mère satisfaisante ('satisfying mother') but a mère calmane ('tranquilizing 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

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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.

This reference to the parental attitudes indicates that the groundwork for eventual ways of reacting to the oedipal crisis is already being laid down.

At the opposite end of the scale of infantile psychosomatic disorders is the strange malady known as mérycism in which the baby constantly regurgitates and then swallows his stomach contents until dehydration and exhaustion set in. Here the baby has created prematurely an autoerotic object which enables him to dispense with his mother. Observations of the mothers reveal that among other unusual restrictions they impose severe prohibitions on all normal autoerotic activity. 'They react to thumb-sucking as though it were a truly Oedipal masturbation to be suppressed at all costs' (Fain, 1971). In comparison with the tiny insomniacs, the mérycist babies show a significant contrast—they sleep well. The author points out that in order to sleep, a baby must develop the capacity for adequate autoerotic activity as well as the autonomous ability to maintain a protective barrier against stimuli both from within and without. These children succeed in decathecting the sensorium but there is nevertheless a serious symbolic gap in that the mother's absence is in no way compensated psychically; it is totally disavowed through the baby's having precociously created its own protective barrier against her absence, and one which continues to isolate him from her even in her presence. She is the helpless witness of his autoerotic activity.

The external object is first 'perceived' in that part of the body formed by the mouth-oesophagus-stomach area. [For these children] there is a total separation between the instinctual world and the somatic area where the oral impulses make themselves felt, and, on the other hand, the sensorium where stimuli from the outer world are captured.

Thus we see that a kind of primal chasm may be created at this early stage between the id impulses and their eventual representations drawn from the external world. Instinctual aims and autoerotic activity then run the risk of becoming literally autonomous, detached from any mental representation of an object. We may have here the foundation for a subsequent dangerous separation between psyche and soma in adult life. Bion's theory of undigested 'beta elements' seems to me germane to this line of research.

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. A tubercular patient with many other psychosomatic symptoms described her mother in these terms:

She was so demanding, so attached to me, that I had to be constantly beside her. I could never turn to anyone else. She made it impossible. At the same time there was not a trace of warmth in her attitude towards me. As though all she wanted was total power over my physical being. Emotionally she did not recognize my existence ... I know now that my outbreaks of eczema reoccur whenever I feel abandoned by my fiancé. And also during your holidays! But whenever I feel manipulated and controlled I get these crippling back troubles again. Feeling abandoned and being controlled are both ways of bringing my mother back.

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I do not think it would be a misrepresentation of Fain's work to describe the mothers of his observational research as performing an *addictive function*. The baby comes to need the mother as an addict needs his drug—i.e. total dependence on an external object—to deal with situations which should be handled by self-regulatory psychological means. In my clinical work I have found similar imagoes in patients showing 'acting out' behaviour other than addictions and psychosomatic symptoms, notably in perversions and in character patterns marked by discharge reactions. The mother's failure, through being too close or too far away, to fulfil her function as a shield against the stream of stimuli to which her baby is subjected, includes her failure to make sense out of his non-verbal communications. There is then a grave risk that his own capacity to give the rudiments of meaning to what he experiences and to represent psychically his id impulses and their subsequent objects, will be impaired. The differentiation between representation and symbol will also be confused eventually. We are thus dealing with the basic substratum of a wide spectrum of clinical disorders in which individuals are pushed to 'action' in place of psychic activity and containment.

*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 'antiduretics' due to their inability to create neurotic defences, from another standpoint they may also be considered as 'antsipsychotics', in that they are 'over-adapted' to reality and the difficulties of existence. It would be interesting to compare psychotic and psychosomatic structures more fully but this deserves a separate study. The few remarks I would like to make require further elaboration. Although the ego differences are striking from a phenomenological point of view, both states would appear to derive from some breakdown in symbolic functioning and we might expect similarities at some point. Two have already been indicated—a certain quality of object relationship and a tendency to stifle or to lack affectivity.

Ekstein's work with psychotic children gives an insight into certain features which call to mind aspects of psychosomatic patients. Take for example his study of the preoccupation of psychotic children with monsters, and its connection with their inability to contain and to elaborate internal excitement. This research is summarised by Yahalom (1967) who writes:

*The pressure of what he [the psychotic child] wants yet fears, gives ground before his inward drive. He tries to cling to something concrete, reachable by his immediate senses, so that he can escape being overwhelmed by a flood of archaic matter. He then calls upon some creature, a delusional introject, as a kind of substitute superego."

This mechanism is closely allied to the tendency of the psychosomatic personality to cling to the concrete and factual aspects of living and to pursue them with intensity. Yahalom says,

*In order to release an impulse with relief there must be a representation of an 'object' that absorbs the release. This can be called a safety element. The original safety element is the 'satiating mother' and the safety explains the insistent search for a 'mothering echo'."

The 'satiating mother' recalls in striking fashion the 'addictive mother' of infants suffering from psychosomatic illnesses. I hope to show in the second part of this paper the ways in which a similar kind of object relationship is revealed clinically by 'psychosomatic' analysands. In either case—satiating or addictive mother—the children run the risk of not being genuinely object-related. The little patient described in Yahalom's paper revealed typical distortion of true symbolic functioning in her use of words and her lack of affect. A further

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remark of this author's to the effect that psychotic defences sometimes block out awareness of sensation, or even deny those elements in the observing ego which are critically affected by threatened loss, comes remarkably close to the concept of 'operational thinking', the hallmark of the communications of the psychosomatic sufferer.

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 clunging 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. This is also reminiscent of the rituals to which sexual perverts resort when they feel threatened. We have here another example of a failure in symbolization. The ritualistic acts help to overcome castration anxiety which is unduly intense because it has never become truly symbolic of sexual realities (McDougall, 1972a) and is thus used to ward off threats to narcissistic integrity by external means. It is interesting to note that Yahalom, in order to illustrate his point with regard to psychotic traits, takes the
example of a homosexual patient who claimed that 'he fell in love with a partner because of the wonderful smell of his hair'. 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 schisma 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 fulfilments (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.

II

Observations and speculations

When trying to delineate a 'psychosomatic personality' solely on the basis of my own clinical experience I am continually brought up short by the fact that 'psychosomatic' analysands display the most varied of personality structures. But then they came into analysis because of neurotic symptoms and character traits. This may differentiate them from those patients who recognize no psychological suffering and seek help solely for their physical symptoms, whose character pattern has been sharply defined by research workers in the field in different countries. However the apparent dissimilarities may be erroneous. As the analysis of patients with many psychosomatic reactions proceeds, one finds certain analysands who have created strong reactional defences against anxiety to which others have surrendered. Take e.g. the hyperactivity patterns noted by many psychosomaticians in their patients. While I frequently find this character trait in patients whose symptoms are predominantly somatic in conflict situations, I have found just as many in similar circumstances who feel depressed and listless and complain of inability to get themselves going. The overactive others may well be using manic defences against incipient depressive affect and the pull to inertia. With regard to character patterns and specific psychosomatic manifestations I have again come to feel that my first clinical impressions were erroneous. One example will suffice. For a long time I had clinical evidence that my allergic skin-patients showed an exacerbated sensitivity to the environment and tended to protect themselves both physically and psychically from being scratched or bruised. In contrast it seemed that my respiratory sufferers (mostly tubercular or asthmatic) worked to the point of extreme fatigue while their regard to their physical health was not only hardy but indeed foolhardy. But as time went on I found tubercular patients who were like sensitive babies with regard to their physical selves, and eczema patients with Hardy body ideals. Then I came across analysands afflicted with both types of somatic disturbance. Although future research will undoubtedly bring deeper insights into the structural factors allied with the choice of psychosomatic expression, for the present the most promising approach seems to me to be the exploration of a possible 'psychosomatic
mechanism', a specific form of functioning which would predispose an individual to psychosomatic, rather than psychic, creations in situations of stress or conflict. I shall therefore refer in this section to 'psychosomatic' patients – although I cannot define the limits of such a concept – to indicate analysands who tend to react with either psychosomatic maladies or increased sensitivity to infection and a tendency to bodily accidents, when faced with traumatic events and conflictual situations arising either from the past or the present (including the psychoanalytical situation). Although it is theoretically important to differentiate between a truly psychosomatic illness such as nonspecific ulcerative colitis and the contraction of an illness such as tuberculosis, I am mainly concerned at this point with what might be relevant to a 'psychosomatic disposition' and what signs other than somatic illness might reveal its existence. I wish now to give some clinical examples of sexual and relational patterns common to most psychosomatic patients. It will be noticed that these are not specific to people who have declared psychosomatic manifestations. They may nevertheless have a certain prognostic value and make us aware of the threat of eventual somatic transformations under the impact of the analytic process. Because of their non-symbolic quality such manifestations are totally silent before their somatic realization and it is therefore necessary to listen to something which is not there, a psychic gap in which a somatic creation might appear instead of a psychological one. I reiterate that the analysands under discussion all operated a number of neurotic mechanisms (otherwise they would not have been in analysis) and in most cases had not given much importance to, or even mentioned their psychosomatic history.

Sexual and object relations

When psychosomatic analysands talk of their love and sex relations one often finds oneself, once again, listening to a missing dimension. This is in marked contrast to the way in which neurotic patients present love relationships of a neurotic order. Of course neurotic patients seek help primarily for their sexual problems – or for the symptoms which are an unconscious compromise and 'solution' to their conflict. People with psychosomatic reactions to conflict, although they bring problems in the oedipal-genital sector, more often come to analysis because of feelings of hopelessness about all their relationships or because of depressive affect in general. This vague clinical categorization clearly overlaps what are called character neuroses but does not usually include the same fate and failure patterns which 'character problem' patients display. Just as frequently there are no overt sexual problems. However analysis reveals that these analysands, both men and women, speak of their sexual partners, and treat them as though they were feeding mothers upon whom they are desperately dependent. Although sometimes unaware of feelings of emotional attachment these patients cling avidly to their mates and tend to fall physically ill when threatened with abandonment by them. Just as frequently however, psychosomatic personalities reveal what appears to be a contrary pattern – their love objects are highly interchangeable, the central demand being that someone must be there. This 'someone' is cast in the role of a 'security blanket' and thus fulfils the function of a transitional object. Both types of object relation are connected with traumatic early mother–baby relationships, and it is evident that both kinds of dependence are reminiscent of the 'addictive' mothers of the psychosomatic babies studied by Fain and of the 'satiating' mothers of Ekstein's psychotic children.

My attention was drawn first of all to this kind of sexual attachment in analysands who had suffered from pulmonary tuberculosis. With one exception, all had fallen ill at times in their lives when they were facing separation or abandonment by people who unconsciously represented the addictive mother of early babyhood. In each case they had been quite unable to grasp the extent of their pain or bereavement, frequently because they had no inkling of the ambivalent role of the Other, nor of the fact that they were bereft, and therefore could not work through their loss. Instead of opening their hearts to grief it seems they opened their lungs to invasion by tubercular bacilli. I have come across two cases of ulcerative colitis in which there was an identical inability to elaborate feelings of rejection or work through a process of mourning. A case presented by Loriod (1969) of a patient with multiple somatic transformations demonstrates in striking fashion this refusal to experience or give in to mental pain.

Analysis of this desperate clinging to the Other – or undifferentiated Others – yields the insight that this is less a sexual dependence than a protection against the loss of identity feeling and the threat of total annihilation. A patient whose dependence upon her lover was such that any threat or break in the relationship found immediate discharge in somatic symptoms of various kinds would cry at such occasions yet would invariably add that she did not know why she was crying. After four years of analysis she was able to discover that she never felt quite 'real' in any relationship. The inevitable urge towards establishing an equally dependent tie to the analysand led her to continual acting out rather than to the confrontation of the wish and the panic it aroused. 'It's embarrassing for me to tell you this, but as a matter of fact I'm never wholly here' she replied when I once drew her attention to the acting out aspects of her reaction to the analytic situation.

I go on talking normally but I'm always somewhere else. I've been like this all my life—as though I didn't live in my own body. Now it begins to frighten me. Yet everyone considers me so normal. I only feel real, feel that I exist, when I make love.
At other times she said that smoking had a similar effect, it 'pulled her body and mind together so that for a brief moment there is a feeling that one really exists'. Her sexual relations fulfilled the role of a drug. Outside these moments she was deeply afraid of depressive feelings and a tendency towards complete inertia. 'I would like to lie in bed all day with a bottle, like Mary Barnes, without thinking, until I simply stopped being'. This intelligent and apparently well-adjusted analysand also had no apparent sexual problems, and indeed found her sexual experiences highly satisfactory. Like many others with her particular mode of psychic functioning this outward appearance of 'normality' was misleading. In the same way her sexual relationships were called upon to bear a heavy load. One cannot truly possess one's narcissistic integrity nor one's sexuality if one does not symbolically possess one's body. If the sexual relationship is the only confirmation of individual identity or is felt to be the only protection against the unknown dangers of existence, then sexual relations will be invested with considerable and compulsive intensity. Unusual circumstances led to a rupture in the relationship between this patient and her lover. With the loss of her mate she lost everything: her sexuality, her narcissistic self image, her capacity to sleep and her ability to metabolise her food. (Several of my somatizing patients suffered dramatic loss of weight in times of threatened or actual separation from their 'addictive' objects). This patient was threatened with losing her body in every sense of the word. Her concern for her physical health was reduced to nothing, and she became aware, in the light of her past history, that she was exposing herself once more to serious health hazards. What should have been an internal conviction – of narcissistic integrity and individual identity – had constantly to be confirmed externally.

Two important discoveries changed the course of her analysis and her whole mode of psychic existence, and these in turn altered her somatic sensitivity. One discovery concerned her very first experience of masturbation. She was then 38 years old. Under the impact of this tardy discovery she exclaimed one day that for the first time in her life she felt her body belonged to her and had limits. Her attitude to her corporal self changed. Not only did she take more thought for her physical well-being she also began to look prettier in her relations with others, who also began to exist in their own rights. In certain circumstances she became more demanding and in others she felt she had the permission to refuse tasks and demands she did not welcome. It was as though she were aware for the first time of her feelings and their connections with other people. At the same time she made the discovery of transference feelings; instead of acting out to stem a rising tide of panic before any possibility of emotion in the analytic situation, she was able to contain and explore these nascent feelings: in particular, strong emotion around separation-experiences in the analytic relation and feelings of intense rage whenever I failed to understand immediately what she was communicating when it could not yet be expressed verbally. She demanded continual presence and understanding without having to pass through the channels of language. She acted, and felt like, a misunderstood baby. Homosexual fantasies made their appearance in her dreams and her associations around this time and these served ultimately to strengthen her own sexual identity. At the same time her psychosomatic symptoms notably diminished.

I have given this analytic fragment in some detail because in many ways it is exemplary: from the point of view of the affective stifling which so often keeps at bay violent anger and omnipotent demands, and also with regard to the lost links between the physical self and sexual desire. The loss of affective reaction renders object relations pragmatic and decathected and the gap between the body and its instinctual impulses has a deleterious effect on the sense of identity. Further, the masturbation history is invariably disturbed in psychosomatic patients, at least in my clinical experience. Frequently masturbation seems to have been discovered very late in life (anything from 20 to 40 years) or it has been practised in childhood and adolescence but in deviant ways which avoid all contact between hand and genital, and in many cases is devoid of fantasy content. Deviant attempts to fulfil sexual wishes, where these existed, have usually been given up without compensation of any kind. Thus they have neither developed into organized perversional practices, nor been repressed to become the raw material of neurotic symptoms, nor projected and recovered in delusional form. Instead there is destruction of affect and a loss of symbolic representation of sexual desires. This is a sorry state of affairs, for sexual relations risk becoming pragmatic and compulsive and the sexual experience itself suffers from its imaginative impoverishment. There seems little doubt that man's most intensely erogenic zone is to be located in his mind! Thus there is an 'operational' dimension to these patients' sexual lives. In the course of analysis such fantasies as might be constructed to match affective states of which the patient is aware (and this may take several years) are often extremely archaic and disturbing to him. This in turn may precipitate further flights of acting out, so as to leave no space for fantasy or the eventuality of 'holding' a sexual desire. One analysand expressed his dilemma in these terms: 'I cannot bear to caress or to be touched by a girl unless I am going to make love to her immediately'. When asked what would happen if he could not immediately fulfil such a project he found himself at a loss to explain a rising feeling of panic. 'But I have never imagined making love to anyone. I always say to myself that I must plan to have a girl ready to sleep with me each night because I simply can't be alone. I have never in my life experienced a sexual desire'. This patient was able subsequently to allow sexual fantasies to flourish in his imagination, although he felt for a considerable time that he would have to act them out, even though this would occasion certain social risks. Another patient in a similar phase of analysis summed up his feeling in these words: 'But if I become aware of a wish then I have to do everything I can to fulfil it; otherwise what is the good of imagining anything?' The fear of having to sustain the frustration of a desire is only matched by the fear of going mad. A third psychosomatic patient who was also trying to understand his fear of fantasising said: 'But you don't understand. If I just let myself think no matter what, I'll end up like Don Quixote with a saucepan on my head charging at buses'.

The above three patients were all able to 're-sexualise' both their bodies and their minds, so to speak, and to allow sexual
relationships of a meaningful kind to grow into their lives. All three displayed terror at the idea of giving their imaginations some freedom and equal if not greater terror at the idea that the thoughts and impulses would be uncontrollable. We enter here into the domain of retention, clearly having its roots in the anal phase, and the inability to give libidinal meaning to the capacity to retain, originally one's faeces and all they symbolize, later one's thoughts, impulses and inner objects. Fantasies of being poisoned or of risking explosion if one held back discharge impulses was also an important theme, but this leaves the psychosomatic domain and enters into familiar neurotic territory.

This brings me to a clinical fact which entails a certain theoretical confusion and that is my belief that psychosomatic symptoms, which in the first instance arise because of a lack of symbolic representation and affective expression, may often be susceptible to a process of 'hystericalization' or 'obsessionalization' when the analysand is encouraged to invent situations to accompany his somatic symptoms. The resistance to do this is considerable but the results are occasionally rewarding, when a somatic manifestation which has attracted little attention slowly becomes meaningful. The fantasies are often disturbing to the analysand because of their archaic quality or their sadomasochistic content. An ulcer patient, little given to day-dreaming, particularly where his sexual relations were concerned, produced a fantasy of ingesting his partner's faecal matter. This was accompanied with massive erotic excitement and slowly grew to be a compulsive thought. As his experiments in creating fantasies around fleeting emotional states and bodily sensations continued, he began to invent day-dreams whenever he felt the painful sensations which he knew to be premonitory of a recurrence of his gastric pathology. These fantasies were usually of an incorporative nature, drinking sperm, eating skin, biting off nipples

and heads of penises, etc. Not only did his gastric symptoms disappear for the first time in many years but the gain from the point of view of the analytic process was considerable. The gastric symptoms and the whole digestive area became an object of psychic interest to my patient and threw much light on other aspects of his life and character structure. This progress was made in the face of considerable resistance since he feared that the fantasies might drive him crazy and force him to act upon what he imagined. He slowly built up a phobic attitude to these thoughts which acquired all the characteristics of obsessional ideas, and he then attempted to repress them. However, with a certain amount of prodding he allowed them to evolve and to come into connection with other ideas, notably the growth of authentic sexual desire and his first truly libidinal love relationships.

A similar process which took a more 'hysterical' direction was that of another patient with gastric pathology who also had many skin allergies. This patient complained bitterly of the frightening quality of the fantasies which crowded his mind when he was in a state of sexual frustration, and of the analysis which permitted such fantasies to exist.

I keep imagining that some men have tied my testicles with wire, then they throw me forcefully into a deep chasm, again and again, until my testicles are torn off. But the most terrible part of it all is the tremendous sexual excitement it gives me. I'm sure I'm going crazy and it's all your fault!

The day-dream symbolizes an archaic primal scene with a somewhat oedipal overtone: the young man is forced by the men to enter the 'chasmal' woman and the punishment is castration, although as we can see the day-dream starts off as an engulfment of the whole body in the exciting experience. Nevertheless anxiety is slowly becoming attached to the sexual organs, and the whole imaginative 'creation' was a considerable change for this particular patient in view of his earlier more sterile mode of psychic functioning, rather devoid of conscious imagining and with little sign of an unconscious fantasy life either. The main sign of psychic conflict had lain, until then in his somatic explosions which brought him perilously near to death's door. However the point I wish to make is that this patient could not avoid joining the newly created fantasmasoria to the fact that he frequently had outbreaks of eczema around the testicles. Although the eczema continued to occur (notably just before the analysts' holidays) the conjunction of eczema and fantasy allowed a considerable libidinal investment by the patient of his whole genital area.

These patients would seem to fit the category of the babies observed by Spitz (1962) who, because of early maternal failure, never indulge in what he describes as 'normal genital play' that is, spontaneous hand-genital play of infants who have a harmonious and stable relation with the mother. They recall also the infants of Fain's studies whose early contact with the mother prevented their devising autoerotic means to deal with psychic tension, thus damaging extensively the subsequent development of fantasy life. This failure to make absence significant might also be expressed as a failure to internalize 'the breast'. Bion (1962) pointed out that the breast, before being capable of symbolization must first be capable of representation as a state of 'no breast' otherwise it is purely good or bad and cannot in this state become the nexus of further thought and affective elaboration, and so will fail in its symbolic function. In psychotic states the 'good' and the 'bad' become projected outward as idealized and persecuting objects. In psychosomatic structures this does not occur. The different breast representations are simply excluded from the symbolic chain, and decathedected without compensation. Thus instinctual impulses, whether aggressive or libidinal, run the risk of not gaining representation. The early fragmented elements of 'fantasy' which might be supposed to accompany instinctual impulses are thus not stored in ways which allow them to evolve into the material of neurotic fantasy constructions. In consequence there may be little psychic filtration or binding through fantasy links and semantic symbols but a tendency to inappropriate somatic discharge instead. In Winnicott's (1971) terminology this would include people who are constantly 'impinged upon' by the environment, and in parallel
fashion are unable to 'use an object' creatively. Winnicott's concept of the use of an object and of people who fail to achieve this relationship with external objects also applies to those who have primarily psychosomatic solutions to tension and anxiety. Rosenfeld's description (1971) of a similar failure to use an internal or external object is in the statement that the healthy part of the personality is that part which is able to depend on another without fear. All these different theoretical approaches are coming to grips with the same complicated area of human experience and with similar enigmas in psychic functioning. In each case there is a breakdown in object relations due to the attempt to make an external object behave like a symbolic one and thus repair a psychic gap. The object or situation will then be sought addictively. Basically, all addictions, from alcoholism and boulism to the taking of sleeping tablets and pep-pills, are attempts to make an external object do duty for a missing symbolic dimension. This type of psychic functioning is reminiscent of the role of the fetish in the sexual sphere, but is by no means synonymous with it since the latter has succeeded in 'attaching anxiety to the genitals' as Freud put it; it is this anxiety which is then combated by external rather than internal management. The psychosomatic patient has rarely achieved this 'genitalization' of anxiety and is thus keeping at bay terrors of the order of 'primary castration'. It is not surprising that we find in our psychosomatic analysands oedipal constellations similar to those found in sexual perversions (McDougall, 1972a) in which the role of the father is much diminished and the importance of his penis as a symbolic phallic object in the psychic world accordingly weakened. The phallic symbol is still embedded in the mother and so castration anxiety runs the risk of involving the whole body and the self rather than being restricted to the sexual sphere and sexual relations and identity. Their struggle is to feel whole and alive.

The extent to which larval fantasies (Beta elements) which are excluded from symbolic expression in the preconscious find, for the first time, verbal expression and affective counterpart, may determine the possibilities of diminishing the risk of somatic discharge which otherwise short-circuits language, and with it, the capacity to elaborate fantasy. It is possible that constructive (that is protective) fantasy, for dealing with absence and difference, can only be 'stored' as a psychic treasure to the extent to which it is held through words and the early elements of 'thinking' in the sense of Bion's research. The 'attacks on linking' (Bion, 1959) which he ascribes to psychotic states are restricted in psychosomatic personalities to an attack on fantasy life and on the capacity to represent affect. Instead of ego distortions we find a perilously autonomous ego. The absence of neurotic, perverse and psychotic mechanisms is a danger signal for the soma. These same factors also pose problems in severe cases with regard to the advisability of psychoanalytic treatment. There are risks to be weighed in both the somatic and the psychological direction.

**Somatic versus neurotic defence**

The failure to create protective neurotic symptoms may become clearer with a clinical example. Three patients, (two women, one man) came to analysis because of feelings of failure concerning their personal lives. All had suffered from severe bronchial asthma since childhood. Allergies ranging from cats and household dust to grass pollens were held to be responsible for the attacks. As the analysis of these patients proceeded it became evident that the asthmatic attacks followed certain 'geographical laws'. Two of these patients suffered attacks of increasing severity as each drew near to the town or suburb in which the mother lived. The third suffered increasingly in proportion to the distance which separated her from the parental home. One can scarcely avoid comparing this relationship of distance with the neurotic control of geographical space in phobic patients, yet the difference is considerable. In order to create a phobic object, or situation, the mind has had to do a lot of work of an intricate symbolic nature, whether this be revealed in phobias connected with sexual anxiety such as agoraphobia, or whether it is a question of more primitive phobic situations concerning early pregential conflict, such as food and dirt phobias.

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1 Pankow (1969) gives interesting insight into the relation of asthma to psychotic and neurotic body imagery.
known in childhood, while unconsciously they desired magical baby-like gifts in return for their love. Their behaviour was in fact erratic. They desperately wanted to be close to someone yet at the same time they couldn't bear to be in close contact for too long. Any jarring note in the harmony of the relationship was liable to end in immediate rupture. As with my other psychosomatic patients there was a familiar history of infantile masturbation in that none had known normal manual masturbation. One had evolved adolescent rituals in which facces played an important role, one of the women had devised a series of instruments to insert into her anus and vagina while the other had learned to attain erotic excitement by witholding her urine and pressing on her bladder, and in adolescence would reach orgasm by these means.

Mademoiselle L. became interested during analysis in the ostensible fact that her mother's proximity coincided with the severity of her asthma attacks. She slowly pieced together her childhood dependence on this mother, the only person capable of calming her sobbing spasms, and later, her asthmatic attacks. Her father was kept rigorously out of the little girl's room because he was said to make the asthma worse. Other outside influences were also kept at bay. Mlle L. could not run, play or go to school like other children. Even though she had developed few inner psychic means of coping with the myriad situations calculated to arouse anxiety, she nevertheless left home in her early twenties following a violent altercation with her mother over her right to have a man-friend. Apart from statements like 'my poor mother's a bit potty', Mlle L. expressed no strong emotion about her. She was aware of sensations rather than sentiments in her mother's presence. Encouraged to put these into words she was finally able to say: 'I can't bear to touch her. As though her body were covered with filth. Almost as though she might poison me'. These 'sensations' thus slowly evolved into emotions with strong affective content. Mlle L. came to discover that whenever she was angry with her mother she would avoid physical contact with her. As the severity of her attacks decreased her dreams became more frequent and more colourful.2 In some of these dreams the mother was drowning, often smothered under symbolic representations of the daughter's faecal and urinary products. It was possible to construct babyhood fantasies in which she wanted to attack her mother with her bodily products in moments of speechless rage; at other times there was the idea that she wanted the mother to suffer and be stifled as she herself was during her asthmatic attacks. In various ways we arrived at the conviction that she had never quite sorted out her feelings that such feelings would destroy everyone of importance to her. Even though she had developed few inner psychic means of coping with the myriad situations calculated to arouse anxiety, she nevertheless left home in her early twenties following a violent altercation with her mother over her right to have a man-friend. Apart from statements like 'my poor mother's a bit potty', Mlle L. expressed no strong emotion about her. She was aware of sensations rather than sentiments in her mother's presence. Encouraged to put these into words she was finally able to say: 'I can't bear to touch her. As though her body were covered with filth. Almost as though she might poison me'. These 'sensations' thus slowly evolved into emotions with strong affective content. Mlle L. came to discover that whenever she was angry with her mother she would avoid physical contact with her. As the severity of her attacks decreased her dreams became more frequent and more colourful.2 In some of these dreams the mother was drowning, often smothered under symbolic representations of the daughter's faecal and urinary products. It was possible to construct babyhood fantasies in which she wanted to attack her mother with her bodily products in moments of speechless rage; at other times there was the idea that she wanted the mother to suffer and be stifled as she herself was during her asthmatic attacks. In various ways we arrived at the conviction that she had never quite sorted out her body from that of her mother. It became clear that her particular form of masturbation by withholding her urine and squeezing her thighs together also represented a way of holding an idealised mother inside her in fusional union. This brings to mind Fain's mérycist babies who precociously established an autoerotic substitute for the mother by retention of their stomach contents. As with Mlle L. this is a somatic compensation and not a psychic identification, or true internal object representation. It seems that the maternal object had not survived the attacks made upon it. As Mlle L. began to experience the same intense rage in the analytic situation, particularly at times of separation, we discovered her fear that such feelings would destroy everyone of importance to her. If others did not explode she herself would burst. At this point she developed for the first time a series of hypochondriacal fears concerning her body – the body to which she had never given much love or consideration. She also traversed a homosexual interlude on the way to the discovery of her sexual desire and psychosomatic manifestations has been noted by other analysts—e.g. Berne, (1949, pp. 280–297); Sami-Ali (1969).

I would like to emphasize at this point that it was not the fantasies of drowning her mother in urine or killing her with faecal matter which caused Mlle L's asthmatic attacks but her incapacity to tolerate and to elaborate such fantasies in a two-body relationship. It could be proposed that the asthma attacks did in reality carry out the fantasy of a persecuting introject, but this leaves many questions unanswered. Why did such a psychic object fail to arouse elaborated fantasy which might have given rise to the development of a phobia, or even a delusion? At what point did psychic defencework cease to develop or to function and somatic dysfunction arise in its place? The representations and emotions which might well have accompanied her stressful babyhood experiences had neither been projected nor repressed but totally rejected from the ego as though they had never existed. The fantasies in question might indeed be considered to have a universal quality but an adequate mother–baby relationship is required to absorb them and make them meaningful. Mlle L. had clearly not been able to 'use' the parental objects to help her deal with her lively responses to the world and her lively instinctual demands. She had rendered them lifeless and only her body 'remembered'.

I have given this outline of Mlle L's analysis because it followed a trajectory which I have found to be typical with other patients having quite different somatic reactions to inner conflict. The point I am trying to make is that there is an important difference between disorders which are a reaction to unconscious or preconscious ideas, and a disorder which arises in the absence of such fantasy. The dyadic relationship between mother and child has not progressed in certain sectors towards a three person world, nor has it remained caught in the toils of endless projective identification. Instead there has been retrograde movement from a two-body to a one body relationship which we could perhaps call psychosomatic regression. I would like finally, to sum up this 'one body world' and the way in which psychosomatic sufferers tend to regard their bodily selves (compared with patients with other personality structures), and the effect that this unique and primitive type of independence has upon the ego ideal.

The body as a psychic object
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 hysterical 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.

The difference is just as marked if we consider the 'organ speech' of the psychotic (Freud, 1915) which follows the primary mental processes used to make dream thoughts. Freud's example of 'the girl with the twisted eyes' or

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- 457 -

the Wolf-Man 'who worked out his castration complex on his skin' demonstrate, as Freud emphasized, that schizophrenic thought is also widely different from neurotic symbolization. In the latter cathexes remain intact while in the psychoses the attempt to recover one's lost objects results in the patients' 'having to content themselves with words instead of things'.

If we turn now to the psychosomatic patient we must first note that his pathological organic processes, which have nothing imaginary or hallucinatory about them, **will only find mental representation from the time that they inflict physical pain**, otherwise they are obligatorily silent. When once the symptoms break the bonds of silence they still fail to receive much attention in the analytic discourse. Either they are ignored or are referred to in ways that appear to attach little psychological importance to them. This is frequently accompanied by an attitude of blithe disregard for one's physical welfare as though the body were a decathected object even in the face of evident disfunction and physical pain. I had been having these pains for about two years. I didn't know what caused them but I had contrived a way of walking which made them bearable. This went on up until the ulcer perforated', reported one patient. This is reminiscent of the decathexis of the body achieved by certain patients who indulge in psychotic episodes of self-mutilation and whose massive splitting mechanisms enable them to feel no pain. The ability to stand physical pain when it is highly erotized, as in certain sexual perversions, also comes to mind. Although the aims are very different there is some common ground in the psychic mechanisms at work which has its roots in the earliest mental functioning of the baby, and which finds expression in psychotic, perverse and psychosomatic creations.

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 *mercyist* 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 insensitive 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 in 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 hypercathectic 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

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- 458 -
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.

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