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The indissociable unity of psyche and soma:

A view from the Paris Psychosomatic School[1]

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Depending on whether or not psyche/soma is seen as singular or dual, one may construct different systems explaining man and the world, life and death. In the author's view, the discoveries of psychoanalysis offer a perfectly cogent and unique solution to the famous mind/body problem. In transferring the duality psyche/soma on to the duality of drives, psychoanalysis places the origin of the thought process in the body. In Beyond the pleasure principle*, Freud discusses the drastic effect of a painful somatic illness on the distribution and modalities of the libido. He provides a starting point for the Paris Psychosomatic School's psychoanalytical approach to patients afflicted with somatic illnesses. To illustrate the technical implications of this theory the author relates two clinical cases.*

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> Because the mind arises in a brain that is integral to the organism, the mind is part of that well-woven apparatus. In other words, body, brain, and mind are manifestations of a single organism. (Damasio, 2003, p. 195)

The discoveries of psychoanalysis offer a perfectly cogent and unique solution to the old mind/body problem, the psyche/soma dualism. In transferring the duality psyche/soma on to the duality of the drives, psychoanalysis locates the origin of the thought process in the initial conflict. The very definition of drives—the psychical processing of sexual somatic excitation—confirms, in the two theories of the drives, a psychosexual parallel to which Freud had drawn attention as early as 1891.

The field of what one might today call psychosomatic practice (that is, the psychoanalytic approach to patients afflicted with somatic disorders) was not discussed by Freud, although he was to lay its foundations. In *Beyond the pleasure principle* (1920), an essay which inaugurated the second functional dualism and thereby founded the second topography, Freud distinguished between 'pure' and organic-lesional traumas and then went on to note that the existence of a circumscribed lesion seemed to protect the subject from the emergence of a traumatic neurosis. It is here that Freud discusses the powerful effect of a painful somatic illness on the distribution and modalities of the libido.

[1]Translated by Steven Jaron.

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The violence of the physical trauma liberates a quantum of excitation, which is all the more disorganizing in its effect because there has been no preparation for it by means of (signal) anxiety. However, a physical injury or lesion may allow an incorporation of the excess excitation through a 'narcissistic hypercathesis' of the affected organ. On the basis of these remarks, Freud notes that pathognomonic mental symptoms such as melancholia or even chronic dementia praecox may temporarily disappear where there is a simultaneous organic disorder.

This summary provides a starting point for our present psychosomatic approach.

A logical development of psychoanalysis: The Paris Psychosomatic School

While the concept of health in terms of a psychosomatic balance has its origins in Hippocratic medicine, at the present time the assumption that underlies the Paris Psychosomatic School stems from the discovery of the psychoanalytic method. I would like to stress that our form of psychosomatics is fundamentally a logical development of psychoanalysis; I would, in fact, go so far as to claim that in some ways it is its culmination.

In answer to the psyche/soma enigma, Freud offers a remarkable reply, which I summarize as follows: The confrontation is not between the body and its desires on one side, and the psyche and its wishes on the other; rather, contradictory forces may come into conflict at a single somatic site. In his essay 'The psycho-analytic view of psychogenic disturbance of vision' (1910), Freud raises the idea of an organ forced simultaneously to serve two masters, and it is this conflict that gives meaning to an organic symptom. Hysterical conversion makes the body into a language, the symptoms telling an unconscious story, and all mental activity finds its source in the erotic libido.

Confronted with the clinical phenomenon of hysteria, Freud chose to disregard the taboo surrounding the psychical component of certain disorders and did so in a way that draws attention to the vital importance of the sexual—and hence of the body—in the constitution of the psyche.

Dreams, the interpretation of which is the royal road to analytic science, can only be understood with reference to the sleep of an individual. Dreams integrate exogenous and endogenous somatic stimulations in the working through of a psychical process, aimed at maintaining a physiological function, the pursuit of sleep. The interest of psychoanalysis in dreams shows the importance of the somatic dimension in all psychic work. The psychoanalytic treatment of patients suffering from somatic disorders is therefore a return to the very sources of the psychoanalytic quest.

Conceptual and historical background of the Paris Psychosomatic School

It is unusual for patients suffering from a somatic illness to be treated by psychoanalysis rather than by a strictly medical intervention. This means that the suffering body was excluded from the field of psychoanalysis.

Pierre Marty and his team came to the view that ill patients whom they were treating in their role as doctors, surgeons, gastroenterologists, etc. should also be considered from a psychoanalytical perspective. They had been struck by an absence

of a demand and of anxiety in these patients, and had noticed that most of those who were hospitalized seemed 'sensible, rational … unemotional'—as if their affective lives were either frozen or repressed.

Beginning in 1952, Pierre Marty, Michel de M'Uzan, Christian David and Michel Fain worked on psychosomatic theory and published their findings.[2] In 1978, the French Health Ministry authorized them to open the Institut de Psychosomatique (IPSO), which today is also known as Pierre Marty Hospital. It is a day hospital in which close to 50 psychoanalysts work, in addition to being a research and training centre. The patients are referred to the hospital by medical units that remain responsible for medical treatment. Clinical work at the IPSO is exclusively psychoanalytic in orientation (couch or face-to-face) and entirely free as patients are reimbursed by social security.

In the early 1960s in the USA, Sifneos (1995, p. 30) articulated the concept of 'alexithymia' (literally: 'no reading of emotional life'). This was the first description of 'mechanical thinking', a characteristic noted in a number of serious cases. This notion was later replaced by that of 'mechanical life', in response to the objection that the phenomenon was not one of 'thought' but of 'anti-thought'—and also that it was a strategy for survival.

Today, we would tend rather to use the term 'mechanical functioning'—which, in my view, is a traumatized way of functioning. Mechanical functioning is accompanied by a strong cathexis of the physical senses, with patients able to describe at length and in detail what they have perceived. This can be understood as a defence against internal disturbance and disorder.

The other very important concept in this field is that of 'essential depression'. This is a kind of depression characterized not by sadness or pain, but by a lack of desire: patients are tired, they want nothing, they give the impression of being elsewhere and they do not complain. One is again struck by an absence of emotional life and fantasies. Essential depression has been described as 'white depression' or 'depression without an object' because patients deny that they mourn or that they miss someone or something—instead, they 'just feel empty'.

Regression—or rather the lack of a capacity to regress—is a crucial concept in this clinical field. Since these patients do not suffer or mourn, they are unable to regress—for instance they will not stop working nor will they take account of the fact they are tired. The protective superego is replaced by a tyrannical ego ideal. When regression is impossible, it is replaced by disorganization. In our way of thinking of the economy of the human being as a psychosomatic unity, disorganization can include somatic as well as psychic disorder.

In this model, instinctual drives have their source in bodily excitation. Their role is to deal with the tension thus created. If the sum of excitations continues to be excessive, the functional systems become disorganized and the mental apparatus overloaded, thus leaving the way open to somatization. The notions of disorganization, fixation and regression are therefore central to this tightly woven and complex conceptualization, which is difficult to articulate in a few words.

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[2]Among the fundamental studies of the Paris school, see Marty et al. (1994), Marty and De M'Uzan (1963), and Marty (1976, 1980).

There is a whole range of possible failures of psychic structuring caused by early trauma, experienced perhaps before even the acquisition of language. In such cases, character traits or attachment to narcissistic values serve instead of purely mental defences. Recourse to a somatic solution is frequent, and this short-circuits any psychic working through, such as acting out by borderline patients. What occurs then is what some have called an 'acting-in in the body'.

What we have here is a new field, which gives the psychoanalyst a greater scope for action but, at the same time, requires sometimes different technical parameters. Following Winnicott, I would say in regard to this that 'the practice of psychoanalysis also includes psychotherapy', as well as whatever modifications which may be necessary for a patient's psychical organization.

The present extension of the psychoanalytical method to 'non-neurotic', borderline, and psychotic patients, as well as to those who are physically ill, shows that the standard model is often inapplicable in our daily practice in an unmodified form. Changes in the setting and in interpretive technique do not imply any move away from rigorous psychoanalytical practice, aimed at eliciting transference. I would add that handling these difficult therapies requires long experience of classical psychoanalysis. If one is to be flexible vis-à-vis a particular model, one must first have assimilated it completely.

There are many technical considerations to be taken into account when treating such cases in a psychoanalytic setting. Face-to-face sessions are frequently indicated, inasmuch as they facilitate adaptation to the patient's affective state. It must be remembered that patients do not always come on their own initiative, but are often sent by specialists who 'prescribe' psychoanalytic treatment. They have to be met on their own ground. Above all, they need to be encouraged in the early stages by the analyst, who must remain aware of possible shifts in the quality of mental functioning.

A failure of secondary narcissism and the patients' lack of commitment to treatment may make the task of interpretation difficult. The use of associative techniques may, on the other hand, provide access to various topics and serve to establish a 'conversation'. Absolute silence is out of the question with these patients.

I use the term 'conversation' advisedly, since I believe that in every psychoanalytic treatment of this type there is an approach that I would call the 'art of conversation'. To interest such a patient in the thinking process, one must think with him and involve him in the process. I would even go so far as to talk of a kind of 'seduction' that tries to help the patient recognize that nobody has 'nothing to say', no life is without its story, and that no story is without its words, its richness and its sorrows. Everything should be done to support and stimulate preconscious work and thereby help patients to discover and share in the pleasure of constructing emotional experience in discourse.

Two case studies

In certain cases, a somatic disorder—which might be enduring or short lived—must later be integrated into the chain of psychic events which make up a life. This is what forms the work of the psychoanalyst/psychosomatician confronted by those patients

I referred to above, for whom psychoanalysis has been ‘prescribed’. Moreover, one must not forget that it is sometimes a matter of a psychoanalytic cure in which the possibility of dying always remains present in the mind of the patient, as in the following case.

When I first saw P, a 33 year-old patient, I thought that she looked foreign. A beautiful, athletic-looking young blonde woman, she arrived ‘like a tourist’, coming to meet a psychosomatician. She made an amusing comment on the coldness of the consulting room. She was not hostile to the psychoanalytic treatment recommended by her doctors, but she told me immediately that she felt completely unconnected with the sequence of major illnesses she had suffered. She led a healthy life, she said, one with no particular medical history, and she could see no relationship between her inner world and the serious and ‘objective’ somatic health problems that had befallen her in the previous two years: cancer in each breast, treated by chemotherapy and a mastectomy, followed by a cerebrovascular accident.

The analysis was carried out face-to-face, and it took place in a hospital setting of the IPSO. Its distinguishing ‘colour’ was white, and it was characterized by negativity, that is, by an absence of mental symptomatology and the effacement of any emotional sign. We shall see below that white, as a colour but also as a lack of colour, appears in the dream material. The principal direction of the work turned on the signifier of anaesthesia—an actual anaesthesia of the senses. The patient felt neither hot nor cold, and the anaesthesia of her feelings was related to a diktat against feeling and thinking. This sensorial anaesthesia went back to the time of puberty when her periods first appeared. I quote literally from a session: ‘After my period I lost hot and cold’. Part of the psychoanalytic work would consist in relating the present anaesthesia of her emotions to this first anaesthesia concerning the senses.

The main part of the interpretive work related directly to dream and transferential material. I shall only describe three dreams, particular ‘markers’ of the analytic work.

Occurring at about the end of the second year of analysis, a first dream depicted *a landscape like a still life, in which everything was white and frozen—and yet the ice was not cold*. It was to be understood as an illustration of her mental functioning and opened up the associative chain, involving the idea of anaesthesia related to puberty.

Five years later, in a session after the summer holiday, the patient recounted this dream: ‘*I dream that I’m falling asleep, I try to fight against an intrusive and dangerous sleep; I’m sinking down and a black veil is going to cover up my head. I’m afraid, and feel my brain imprisoned in a net. It will stay numb forever. Is this my health problem? Is this death? I fight to wake myself up in the dream and I actually wake up*’.

The patient wept and repeated, ‘A scar which bleeds in the brain is even worse than two cancers’. Interpreted over several weeks as depicting a short-circuit in the brain/genitalia through blood, this dream initiated a process of reappropriating her sexuality, which had been frozen in a denial of femininity. It enabled us to see the traces of her mastectomy as a lack, a gap. She decided to have reconstructive

surgery, which until then she had refused. Her operation was successful and, shortly afterwards, she recounted in a detached, affectless manner a conversation she had had with her mother, in which her mother said she wished also to have her breasts redone—of which the patient approved.

This session was followed by a dream which she was unable to recount straight away because the analyst had cancelled the session: '*Her brain hurt, as it did the other time, but now everything is red, everything burns; she calls the firemen and wakes in an indescribable terror*'.

It was two weeks later when she brought this dream because the day after the cancelled session she had a second stroke. She had woken up with a shooting headache and had tried to get up, but lost her balance. She dragged herself out on to the landing and called for the firemen. She said that she thought she had been 'saved by the dream', which had 'alerted and helped' her 'to react appropriately'.

I thought afterwards that my interpretation of her mother's denial and envy, as well as on the hatred implicit in them, could also have been taken up in the *hic et nunc* of the transference. If she had had her session, we can imagine that the response to her dream would have been: 'Of course we need the firemen to put out what is burning between us here—above all since you think that I'm not satisfied digging around your brain but must, like your mother, also want to have your breasts.' As it happens, I did not give this interpretation, but I did have it inside me. This fire followed a decade of ice.

The patient underwent all kinds of tests to try to determine the cause of the two cerebrovascular accidents that had struck a young woman within a 10 year period. She told me of a conversation she had had with a professor of cardiology, specializing in rhythmology. He said that he suspected a paroxystic tachycardia, which she agreed with. This was something she had been aware of for a long time, but which she had never mentioned.

I was thunderstruck. 'What? You felt it, you knew about it, and you never spoke to me about it, not to me, not to anyone?' I was both stupefied and alarmed, and I felt betrayed.

'No,' she answered calmly, 'I did not speak about it because I like it … *It made me feel like I was alive*'. Her reply seemed incredible. Violent feelings of anger, which are unusual for me, made me realize that it was by this means that she allowed herself the somatic signs of being in love while avoiding the state of actually being in love, thereby dispensing with the object.

Such a redirection into the body, a redirection whose purpose is to avoid the object, is frequently observed by psychosomaticians, and in my patient's case it seemed pathognomonic of her avoidance of subjectivity. With P, the causal link had been destroyed precisely because there must be no trace of a receiver—the object does not exist and nor does the subject. Incarnated thought, that which produces sequences between thoughts, implies the other and, consequently, an awareness that one is a subject of one's desire and one's history.[3]

[3]See Green (1999a). It is notable that for Aristotle language must be able to serve as a vehicle for analogies and metaphors.

Once P had accepted the idea of a negativizing affect, which was thus turned into sensory impressions or, rather, into signs in the body (tachycardia and, most probably, Bouveret's disease), she spoke for the first time of her lack of a love life. This she immediately related to a maternal quasi-nymphomania. There followed a series of painful memories in which the feeling of shame was dominant, arising from experiences of an intruding, brutal sexuality into her imaginary infantile world.

During one session, I told her how it now seemed very understandable to me that it had been so difficult for her to think for herself, and to exist as a woman. Shortly afterwards, she associated on her own femininity in relation to motherhood. Was she able to picture herself as a mother? she wondered.

At this time, she cancelled a week of sessions but then asked to see me before going away. She had had a very bad stomach ache since the previous week, she told me. The gynaecologist she consulted had diagnosed an ovarian cyst. Given her medical history, an appointment had already been made for emergency surgery, during which an extemporaneous biopsy was planned. P told me she was very worried and despondent. I was myself shaken, worried and dismayed in face of what I saw as the savage violence of this irruption of the soma into the long process of constructing an erotic body.

I shall now describe a remarkable session with P, prior to the planned hospitalization.

P was sad and her face sombre. She was silent for a long time. I thought, 'What have you done to me now?', but I did not utter a word.

She then told me a dream she had had the night before: '*I'm at the clinic where I'm supposed to be operated on for the ovarian cyst. I'm in a bed and awaiting the tests. My two breasts hurt. A nurse comes in, which disturbs me, in order to carry out some tests. I pretend I'm asleep in order to escape from her, but she blows anaesthetizing gas into my mouth and nostrils. I'm terrified and imagine behind my closed eyelids that I'm imprisoned by a white veil. I thrash around and end up waking myself up*'. She cried silently, then said she was afraid of the anaesthesia. She was even insisting on having an epidural in order to remain conscious. She had never told me that during the operation for her first cancer she had learned upon waking that they had 'dug around the uterus' in search of polyps … at the request of her mother. Even then, her memory made her retch.[4]

I said, 'Retch?'

She smiled and said, 'An unerotic tachycardia.'

I replied, 'But a traumatic and sexual tachycardia nonetheless, because you've just told me that for the past 10 years you've hidden from me something which you experienced as a rape organized by your mother'.

P cried for a long time, but silently, then said that she had thought she could take care of this alone in her head.

[4]Translator's note. *Haut-le-cœur* is a figurative expression meaning 'to feel like vomiting' or 'to retch'; an almost literal translation is 'the heights of the heart'. It cannot be adequately translated and still retain the association between 'heart' and 'tachycardia', below.

‘In telling me this, you’ve repeated how a woman had intruded into your body.’ I added that this gave fresh meaning to her fears of being overwhelmed.

Silence.

P then said thoughtfully that anaesthesia and sleep often came back to her in her dreams. I took this up again—without really knowing where it would lead—‘white veil, black veil’.

P always told herself how amazed she was that I remembered her dreams, which otherwise would have been forgotten. The signifiers, ‘white veil’, ‘anaesthesia’, ‘effacement’, ‘white’ and ‘frost’, came back to me and I pictured to myself, in a quasi-hallucinatory way, a little girl wrapped in white strips, like an Egyptian mummy, constrained but protected from being penetrated. The black veil in her dream was associated with the first stroke and with what I called earlier a ‘short-circuit of the brain/genitalia’. The white veil was linked in her mind to the anaesthetic and the lab coats, while for me it further evoked the signifier ‘marriage’—that is, the bride’s white veil.

P then recalled another dream dating from about one year earlier, in which *she saw herself asleep on my couch. Her mother wanted to wake her up, but I prevented her from doing so*.

The memory—at that moment—of an old dream in which I stepped in between her and her mother, like a paternal third object, made me suggest another reading of the dream of ‘the white veil’. According to this, her desire to be protected by me, both a ‘woman in white’ and a third object, was condensed with the traumatophilic compulsion to be violated homosexually by a disturbing maternal figure. The act of awakening thus became the resolution to the dream.

P found this all quite interesting, and she left with a smile. She would tell me how the operation had gone … At the end of the week, she rang to ask the secretary if her usual session had been held for her. A pre-operative ultrasound had shown that the lump had all but disappeared and so confirmed the hypothesis of a functional cyst. The surgery that had been planned was therefore cancelled.

The clinical material I have chosen is no doubt extreme, but this was an analysis in which the metaphors that sometimes occurred to me were those of a minefield or of a bomb-disposal expert handling explosives. In choosing this case, I have set out to illustrate the typical clinical work of the psychosomatician at its most difficult, but also at its most gripping.

The second vignette is different. Here, it is a question of a single consultation requested in very dramatic circumstances. Its aim was to evaluate the interest and feasibility of carrying out analytic work with the patient. As will be seen, the consultation was quite particular and, given her predictable death, especially difficult from a countertransferential perspective.

The young woman who came to Pierre Marty Hospital for an appointment that Saturday morning in May was a striking Indian from Pondicherry. She was particularly elegant and dressed in a refined but austere outfit.

She had hardly sat down when she began to cry. She excused herself and hid her face behind her hands. She cried for a long time, and tried to find the words to express how she felt, but she was unable to do so. I told her not to worry, that

she could tell me her story when she stopped crying. We had all the time in the world, I said.

After pulling herself back together, drying her eyes and powdering herself, she told me she was 30 years old and had a little girl of 6 months old. While taking care of the baby at night she fainted twice. The first time, she and her husband were not worried; her tremendous fatigue, like her loss of consciousness, was due to the breastfeeding. Soon afterwards, headaches and another dizzy spell alerted the attending physician, who 'upset the couple' and ordered further tests, which Madame Z did not discuss in detail.

A few days later, they bluntly told her that they had discovered an untreatable cerebral glioma. It was impossible to operate, and no chemotherapy was conceivable. The prognosis was a death sentence: she had between 6 and 18 months to live.

I became completely distraught thinking about what I had first said, that we had all the time in the world. The patient, on the contrary, seemed self-possessed. Her narrative was sober but not cold. She turned around in the armchair, picked up her long hair with one hand and showed me her occiput and the upper part of her neck. Beginning at the cerebellum, she slid her hand downwards towards the base of her neck along the cerebella and rubro-spinal fascicles. 'The glioma is here.' She added that she was always fearful of injuring this spot. As a child at school, she was terrified by physical education. Specifically, she feared rolling over and other exercises in which she had to press on the nape of her neck. One day, a short-tempered female teacher forced her to do a roll and she fell on her side, injuring her cervical vertebrae.

Later, when she was a young woman, a wasp became trapped in her hair and stung her in this very place. She fell into a panic and thought she was going to die.

I was intrigued by the overdetermination of these recollections, and I asked her if the upper neck did not have a symbolic meaning in her culture. I was thinking about certain erotic Indian engravings in which a woman's body is seen from the back and leaning forward, and in which her body is sometimes twisted as far as humanly possible.

While the patient began to speak about a calm and model childhood in a school run by French nuns in Pondicherry, my inner fantasy drifted towards the perilous postures of the *Kamasutra*.

She was the only child of Catholic Indian parents, who were themselves culturally French, from the former trading post of Pondicherry. They were apparently middle class. Her father worked as an accountant in an international import-export company. Her mother had received an education, a rather rare and highly esteemed occurrence, and she taught mathematics in private religious schools.

Her family had come to France 15 years earlier, after the company which had employed her father closed. They would have probably become paupers, and wished to let their daughter study. She was working as an English professor in a high school.

Nothing traumatic, or even painful, emerged in the course of the narrative of her immigration to France. She knew and quite liked Paris. The same company immediately appointed her father to the job he had held formerly. Her family settled in the suburbs, where Madame Z easily made friends.

I noticed that my question about Indian culture went unanswered. Rather, the patient spoke to me at length and with much emotion about her very strong ties to her parents, and especially to her mother. She admired her passionately and felt great affection towards her.

She was a ‘perfect’ mother—attentive and always present, and a confident who anticipated her least wishes, and who, above all, was able to foresee them keenly.

Madame Z began crying as she spoke about her mother, and at that very moment I imagined her mother as ‘octopus-like’. I saw a spider’s web and was caught up in this picture that, I thought, resembled the somewhat vague idea I had of what a mushrooming glioma is.

Madame Z described her adolescence as rather happy. She had no difficulties to speak of and was a good student. She met her husband while at school, and he was her first love. He was orphaned young and was adopted by her parents. They were all quite close to one another. The birth of their little girl was all they had wished for.

I asked her if she dreamed, and if she was interested in her emotional life. She told me she was surprised and panic-stricken by a nightmare she had twice, the first time shortly after giving birth. *She is on the balcony of her flat and can see the street. She recognizes her ‘ex-best friend’ Eve, who is walking up to the entrance to the building. She is afraid and begins to tremble. The friend goes into the building while Madame Z tells herself that she will not open the door opening on to the landing. She runs to attach the door chain. Things become fuzzy, and she does not know if she herself opens the door or if it opens by itself, but she finds herself pulled into the hallway by her friend, who is much taller than in waking life—in the dream she is more than 25cm taller. There is a murderous look in her eye, and the friend crosses her arm behind her head and is going to break her neck.* At that point, Madame Z woke up sweating, her heart beating rapidly.

The story of this friend upset her. It was the only emotional drama she experienced so intensely. They had been good friends at school. Madame Z painted the picture of a passionate friendship, quite common during adolescence. They shared everything. The two young girls got married during the same period and they were each other’s witness at their respective weddings. The two couples moved into the same neighbourhood so that they could see each other whenever they wished. The friends both wanted to have children at the same time. Two years went by and Madame Z became pregnant while Eve turned out to be, or thought she was, sterile. She broke with Madame Z and told her disdainfully that she hoped never to see her again and that she wished she would have every possible misfortune. Two letters from Madame Z went unanswered. The patient was in tears as she told me how her much expected pregnancy became a terrible ordeal. Breaking with Eve, like her curse, obsessed her. She thought only about her, and believed she saw her in the street. She did not understand what happened and she wanted her to pardon her.

I asked her, ‘You want her to pardon you for expecting a child from your husband?’

Madame Z owned up that at bottom Eve had always been jealous, envious and possessive. Thus, this new version of their friendship, characterized by deceit and

moral entrapment, replaced the first idyllic one. I again thought about the too-good mother who anticipated everything, then about Eve and the nape of Madame Z's neck; and the image of a painting by Georges Seurat, *La poseuse de dos* [She shows off her back], reproduced on the cover of the French edition of a recent novel by E. Fottorino (2000), ate away at me. The title of the book, *A fragile territory*, is printed in black letters under the thin neck of a woman. The story is tragic and ends in the drowning death of the heroine, subject to a diabolical repetition caused by an abusive mother.

At this point, I noticed the enigmatic meeting of the patient's narrative and my unusual (for me) imaginary enthusiasm. It certainly had something to do with the fatal diagnostic, but also with the patient's mnemonic condensation concerning a localization in which the logic of unconscious fantasies seemed to intersect with anatomical logic. I further asked myself if the appearance of the first nightmare might be understood as a herald of the glioma. In the 'Metapsychological supplement to the theory of dreams', Freud (1917, p. 223) speaks of hypochondriac swelling which, in the construction of a dream, makes use of the obscure sensation of an endogenous stimulus or somatic disorder in a given part of the sleeper's body.

Finally, questions concerning an organic, unique and diachronic symbolism, or, perhaps, one created afterwards—such as the wider one of organic symbolism in general—among others, could, it seemed to me, be asked.

The result of the consultation was that the patient was referred to a colleague in private practice trained in psychosomatic analysis.

Some more personal theoretical considerations

The first generation of founding psychoanalysts of the Paris Psychosomatic School (Pierre Marty, Michel de M'Uzan, Michel Fain and Christian David, cited above) had the immense merit of opening up a new field of psychoanalytic practice. By bringing to light the psychic modifications at work in the mental organization of patients afflicted with somatic illnesses, they inaugurated a field of research that Freud had sensed in 1920 when he was surprised by the 'healing of the psychic symptomatology' at the time of intercurrent somatic disorders. At the time, Freud noted that 'it must be a question of the distribution of the libido' (p. 33). This original way of approaching the question breaks with the needless debate between organogenesis and psychogenesis, and it seeks to bring to light and explains the paradoxical but observable relationship between somatization and the seeming absence of psychic conflict. Marty (1976) constructed a very coherent theoretical system founded on drive monism, in which only the life drives were subject to 'life movements or 'death movements' (or moments of disorganization). This led him to remain within the terms of the first topography—unconscious, preconscious and conscious—and to describe the 'insufficiencies' or 'deficiencies' of the preconscious system, which he related to extremely precocious trauma impeding the oedipal complex from becoming completed.

Among the second generation of psychosomaticians of the Paris Psychosomatic School, some—in particular Claude Smadja and myself (Aisenstein, 1996; Aisenstein and Smadja, 2001; Smadja, 2001)—have sought to reconsider the fundamental

concepts brought to light by Marty, notably 'mechanical functioning' and 'essential depression', in the light of Freud's post-1920 writings. I think that the second drive theory is indispensable when considering the clinical treatment of psychoses and trauma. Moreover, by failing to treat the negative therapeutic reaction, the trauma neuroses, narcissism and the repetition compulsion, Freud was led to revise his first drive theory. The death drive as I conceive it is characterized by pure unbinding, to which is opposed Eros, as defined by Freud in *An outline of psycho-analysis* (1938b). This is a conceptual tool necessary for thinking about the disorders and failures of psychic working through and thought itself.

Thus, the apparent absence of working through, interpreted by Marty as deficiencies in the course of development, may be understood and interpreted as the result of destruction at work which, from within the human psyche, attacks the process of working through. I have personally been very influenced in my research by the work of André Green on narcissism (2001), destructiveness, and what he calls the work of the negative (1999b).

Nevertheless, unbinding alone—the defusing of the death drive from Eros—does not suffice in explaining the phenomenon of 'mechanical functioning' when the latter is not transitory. I retain Marty's hypothesis that assumes the existence of very early trauma; on the other hand, I think that we must also turn to the concept of the splitting of the ego in the process of defence.

Freud's article 'Splitting of the ego in the process of defence' was left unfinished. In it Freud mentioned the idea of a 'rift in the ego which never heals' (1938a, p. 276). A close reading of this text, like those parts of *An outline of psycho-analysis* (1938b, chapter 8 of part 3) devoted to the notion of splitting, shows Freud on the point of extending his theory of splitting which until then had been restricted to only psychosis and fetishism. Splitting by definition concerns perception and, in psychosis, external reality. I assume the existence of very early splitting specifically bearing on anything concerning endosomatic perceptions (Aisenstein, 2004). In my clinical practice, I have often been confronted with patients who treat their bodies 'like a foreign land'. The body thus becomes the site of enactments that may be explosive, as in the case of my patient P. This slightly different way of trying to explain 'psychosomatic phenomenon' has brought me closer to Winnicott's theses, in which the 'integration of psyche and soma' form the bases of the true self (Winnicott, 1984, 1989). One notes in passing a certain proximity between mechanical functioning and the false self described by Winnicott, specifically regarding the 'conformity' of these patients. But this question, which I have only begun to go into, requires further reflection (Ferenczi, 1951, 1995; Aisenstein, 2001).

I am now convinced that it is no longer possible to neglect the concept of splitting in the field of psychosomatics. My present propensity is to imagine that, in certain cases, in traumatic circumstances, an initial splitting—clinically silent since it concerns endosomatic perceptions—worsens the effect of the radical unbinding of the defused death drives. The conjunction of the two may very well explain the destruction of psychic working through and the putting into place of this enigmatic system of survival we call mechanical thinking: a form of anti-thought which is concrete, cut off from its roots of its drives and disembodied.

In conclusion, I should like to mention Hannah Arendt (1978) for whom living and thinking are one and the same thing.

If psychoanalysis is unique, and irreplaceable, in relation to other forms of psychological treatment, it is so, in my view, because it opens up thought processes and enables the subject to reintegrate into the chain of psychic events even something unthinkable, such as the appearance of a lethal illness.

Translations of summary

Die unauflösliche Einheit von Psyche und Soma: eine Sichtweise der Pariser psychosomatischen Schule. Je nachdem, ob man das Psyche-Soma als singulär oder dual betrachtet, kann man unterschiedliche Systeme zur Erklärung des Menschen und der Welt, des Lebens und des Todes konstruieren. Die Autorin vertritt die Meinung, dass die Entdeckungen der Psychoanalyse eine absolut schlüssige und einzigartige Lösung des berühmten Leib-Seele-Problems ermöglichen. Indem sie die Dualität von Psyche-Soma auf die Dualität der Triebe überträgt, verortet die Psychoanalyse den Ursprung des Denkvorgangs im Körper. In *Jenseits des Lustprinzips* diskutiert Freud die drastischen Auswirkungen einer schmerzhaften körperlichen Erkrankung auf die Verteilung und Modalität der Libido. Er bietet einen Ausgangspunkt für den psychoanalytischen Ansatz, nach dem Patienten, die unter körperlichen Krankheiten leiden, in der Pariser psychosomatischen Schule behandelt werden. Die Autorin illustriert die technischen Implikationen dieser Theorie mit Hilfe von zwei klinischen Fällen.

La indisociable unidad de psique y soma: una concepción de la Escuela Psicosomática de París. Se pueden construir diferentes sistemas que expliquen el hombre y el mundo, la vida y la muerte, dependiendo de si psique-soma se consideran como una sola o dos entidades distintas. Para esta autora los descubrimientos del psicoanálisis ofrecen una solución perfectamente convincente y original al famoso problema mente/cuerpo. Al transferir la dualidad psique-soma a la dualidad pulsional, el psicoanálisis sitúa el origen del proceso mental en el cuerpo. En *Más allá del principio de placer*, Freud discute las consecuencias drásticas de una enfermedad somática dolorosa sobre la distribución y las modalidades de la libido. Aporta de este modo un punto de partida para el enfoque psicoanalítico de la Escuela Psicosomática de Paris para pacientes que padecen una enfermedad somática. Dos casos clínicos ilustran las implicaciones técnicas de esta teoría.

L'unité indissociable de la psyché et du soma : une conception de l'École Psychosomatique de Paris. Selon que l'on considère la psyché et le soma comme une seule ou deux entité distinctes, différents systèmes rendant compte de l'homme et du monde, de la vie et de la mort, sont susceptibles d'être construits. Pour l'auteur, les découvertes de la psychanalyse offrent une solution parfaitement cohérente et unique à la fameuse question du corps et de l'esprit. En transposant la dualité psyché-soma sur la dualité pulsionnelle, la psychanalyse place l'origine du processus de pensée dans le corps. Dans « Au-delà du principe de plaisir », Freud discute les conséquences drastiques d'une maladie somatique douloureuse sur la distribution et les modalités de la libido. Il fournit ainsi un point de départ pour l'approche psychanalytique de l'École Psychosomatique de Paris des patients présentant une maladie somatique. Deux vignettes cliniques illustrent les implications techniques de cette théorie.

L'unitá inscindibile di psiche e soma: Prospettiva della scuola di psicosomatica di Parigi. I binomi uomo-mondo, vita-morte vengono diversamente interpretati a seconda che psiche e soma siano considerate unite o distinte. L'autrice sostiene che le scoperte psicoanalitiche offrano una soluzione unica e perfettamente valida alla dibattuta questione della relazione tra corpo e mente. Nel trasferire la duplicitá psiche-soma in una duplicità degli impulsi, la psicoanalisi pone l'origine del processo mentale nel corpo. In 'Aldilá del principio di piacere' Freud parla dell'effetto drastico di una malattia somatica dolorosa sulla distribuzione e le modalitá della libido. La scuola di Psicosomatica di Parigi prende le mosse da questo concetto nel suo approccio psicoanalitico per pazienti afflitti da malattie somatiche. Due casi clinici illustrano le implicazioni tecniche di questa teoria.

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