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On a Soma-Psychotic Part of the Personality: A Clinical and Theoretical Approach to the Somatic

Grigoris Vaslamatzis **and** *George Chatzistavrakis*

Inspired by Bion, the concept of a *soma-psychotic part of the personality* is suggested. The authors present four clinical vignettes to illustrate certain clinical phenomena in which the body played a key role in the patient's personal history, during the analytic process, or both. Certain aspects of analytic technique with these severely disturbed patients are briefly referred to, including the analyst's reverie and transformational capacity, and some observations made in these cases lead to tentative generalizations on mental functioning and psychosomatic unity. A theoretical model is constructed to contain both data and conclusions, and to offer a solution for the integration of the somatic in psychoanalytic theory.

Introduction

In this paper, I will use a methodology that I believe allows for a distinction among the levels of identification, conceptualization, and theoretical

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containment of psychoanalytic observations.[1] At the basis of this method lies a clinical phenomenon (e.g., transference, unconscious feeling, reverie) taken as a nonsaturated fact, in the sense that this is a first conception of the phenomenon, which also remains open to a new experience or to an alternative understanding. Conclusions (generalizations) are then developed as a first stage of processing, and the method is completed with the transformation of the latter into a theoretical model.

As shown by Wilfred **Bion (1962a)**, psychoanalytic theory is itself a form of transformation of the real analytic experience. For this reason, analysts of different approaches give varying interpretations of the same material. I would like to stress Freud's argument that, already in describing the phenomena, the analyst is superimposing ideas that he/she has internalized. **Freud (1915)** acknowledges, however, that this is followed by classification, association, and processing of the material.

In this methodology, I would agree that observations on the interaction of transference and countertransference, and on the development of empathy, on interpretation and other interventions by the analyst, are all integral parts of the description of the analytic process. These provide an additional dimension, perhaps even a critical one for the completeness of a psychoanalytic model of the psycho-soma.

I will proceed to explore the analytic process in one analytic case and discuss issues of technique in relation to pioneering work on this topic by analysts such as **McDougall (1989)**, **Aisenstein (2006)**, and **Taylor (1987)**, among others. What I suggest for discussion is a model including the different pathologies, on the one hand, and the different theoretical-technical proposals with regard to the primary psychosomatic (physical) organization, on the other. This model is influenced by Bion's work on the origins of thought and of psychic reality (**1962b**, **1967**).

Bion reminds us of what Freud wrote—already in 1911—on the beginnings of thinking, the transition from the body to the mental realm:

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[1] For uniformity of style, we will use the first-person singular rather than plural throughout the text. The case of Ms. B, which we will use as a model to elaborate on technical issues, belongs to the second author of this paper, while Ms. A, Ms. C, and Ms. D are the first author's.

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> Restraint upon motor discharge (upon action), which then became necessary, was provided by means of the process of thinking, which was developed from the presentation of ideas …. Thinking was originally unconscious, in so far as it went beyond mere ideational presentations and was directed to the relations between impressions of objects. [1911, p. 215]

Taking this line of reasoning a little further, Bion suggests that there is a personality function, which he calls *alpha function*, that operates on sensory data and protoemotions (what he calls *beta elements*, which are not representational contents, nor are they recorded in verbal memory). The alpha function transforms the beta elements into alpha elements, i.e., mental elements in the form of pictograms, according to Ferro (2002) and Rocha Barros (2000). This transformation enables alpha elements to be used as thinking and to become dreams or elements of everyday reverie, or to be stored as memories. Alpha elements can be linked together to construct representations of a higher order, while beta elements are suitable only for evacuation. Alpha function develops upon the absence of the maternal breast and tolerance of absence and frustration.

I will represent this as *Soma → Psyche.* Representation and the "mental" emerge out of concrete and sensory experience. Many factors (internal and external) are involved in this process: either facilitating (maternal reverie) or impeding (inability to tolerate frustration, excessive aggressiveness or envy, lack of reverie). In psychotic patients, the process of mentalization becomes partially or totally impeded. The alpha function is not developed and alpha elements are not fabricated. Then we have *Soma → Psychotic Personality.* The psychotic personality hates reality and attacks the links between subject and object, as well as the links between sensory experience and its representation (Bion 1959).

In this part of the personality, the use of projective identification prevails in order to discharge the beta elements that cannot be linked together, so as to create representations and dreams. Besides evacuation, some thoughts in their most primitive expression, in the form of pictograms, are destroyed. There is a destruction of the image, a blotting out, a process of radical suppression, an abolition that causes wounds in the mind (Green 1998). It is a hemorrhage of mental contents and

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functions. The psychotic part of the personality prevails over the nonpsychotic, and the discharges (attacks) aim at destroying both object and self. The psychotic patient lives "not in a world of dreams … but in a world of bizarre objects" (Grinberg, Sol, and Tabak de Bianchedi **1993**, p. 28).

For the patients I describe in this text, the existence of a third component of personality might be possible (I am using an idea of Bion's in a different way): *Soma → Soma-Psychotic*. According to this view, the psychotic organization extends over both the mental and the somatic; it is an interdependent process. We can formulate the hypothesis that, contrary to those cases in which the psychotic part prevails over the non-psychotic, the outcome of the relationship between the soma-psychotic and the nonpsychotic parts of the personality is often quite different. In my opinion, this relates to the existence of a sort of discharge gate leading to the body.

As **Scalzone and Zontini (2001)** pointed out, the term *soma-psychotic* indicates the failure of mental functions. I would add that this failure is followed by a tendency to resort to soma. The "hemorrhage" is contained by the body and is not diffused in the external world of objects. Thus, psychic disorganization is prevented, but at the cost of object-related cathexes.

The Subjects of Observation

My observations were drawn from psychoanalytic therapies and from treatments of patients with severe psychopathology in a clinical psychodynamic setting (as described in **Vaslamatzis et al. 2004**). In this second setting, we treat patients who, although frequently seen in psychiatric services, seldom ask for analysis. The psychoanalytic observations in these cases derive from supervision provided by psychoanalysts in various types of therapies, such as individual psychotherapy, group psychotherapy, and art therapy.

The Case of Ms. A (from the Department of Personality Disorders)

An 18-year-old patient, Ms. A, in her last session in a psychiatric clinic, describes a dream to her treating psychiatrist:

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> Yesterday I had a dream: I was at my mother's family house. Someone was beating me, cutting me, calling me names, making a physical and mental wreck of me. But two young girls came along and killed my aggressor. Then I saw it was my mother. I was one of the two young girls and was pregnant, and because I had nothing to eat, I roasted and ate my mother.

But is this actually a dream? Is there any dream work in progress, or may we consider these dream thoughts to be concrete thoughts related to an ego failure to symbolize? In this case, what we probably have is a collection of unprocessed beta elements, according to Bion, which the patient's self-in-sleep is trying to contain. Following **López-Corvo (2006)**, I argue that Ms. A is probably dreaming in order to “evacuate internal threatening objects” (p. 210), rather than to transform and metabolize them.

Bion described the way in which some raw sensory data and experiences, whether originating from internal or external sources, when not sufficiently transformed, cannot find a place in the mind. As mentioned, he called these protomental phenomena *beta elements*, distinguishing them from *alpha elements*, which, he posited, are the building blocks of the mind (unconscious fantasies, dreams, etc.). The transformation of beta elements into alpha elements takes place through alpha function, which is developed gradually in the newborn infant in interaction with the mother's capacity to contain and process this material—i.e., her own alpha function **(Bion 1962a)**. In Ms. A's dream, the dream thoughts (the contained) almost overwhelm the capacity for dreaming (the container) and nearly destroy it **(Ogden 2003)**.

The concrete thoughts of Ms. A the dreamer lie somewhere in between the dream process (which represents symbolic function) and the *beta element screen*. These are disturbing psychic events that appear to be dreams, but are not, and do not warrant the name *dream* (**Bion 1962a**; **Ogden 2004**) because they are dreamlike, imagistic, concrete, disturbing experiences about which neither the patient nor the therapist have genuine associations. The patient does not feel that this dream is life-promoting, nor can he/she easily distinguish between fantasy and reality, or even between sleep and wakefulness **(Schneider 2010)**.

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Ms. A is not overtly psychotic, but she can hardly distinguish dreaming from reality and cannot face her mother when she is in this mental state. She does not talk to her mother and avoids all contact with her because she is afraid of the confusion caused in her by the mother's physical presence, which prevents her from maintaining control of reality.

The unprocessed experiences appearing in the dream have a strong somatic character (to repeat: beating, cutting, pregnancy, hunger, eating) and could be accounted for by "memories" of preconceptual violent experiences, i.e., archaic physical traumas. We might call it the *protomental dream screen*, which represents the engraving of the nascent body ego **(Lehtonen et al. 2006)** or of the traumatic organization **(Brown 2006)**.

As a final observation on Ms. A's dream, I would like to stress that the termination of the psychotherapeutic relationship during hospitalization is equated to a lack of food, as reflected in the feeling of hunger and the cannibalistic thoughts. It represents the repetition of archaic traumatic experiences of an empty breast.

The patient's history includes the following: at the age of three and a half, she developed psychogenic alopecia following the birth of her sister. At five, she vomited every morning and refused to eat for a whole year. At fourteen, after the death of her maternal grandmother (of whom she was very fond), she plunged into a long period of "an inability to experience feelings." We might call this *essential depression*, according to **Marty (1966)** and **Aisenstein (2008)**, or *protodepression of adolescents* **(Ferrari 2004)**. This may gradually evolve into pathological behavior (e.g., drug abuse, self-mutilation, piercing, provocative public behavior), with frequent periods of weight loss or eventually somatizations.

The Case of Ms. B (in an Analytic Setting)

Ms. B is a 40-year-old, married woman, a judge by profession, and the mother of a 5-year-old boy. She starts analysis at three times per week, her complaint being violent anger outbursts against those close to her, accompanied by persistent sadomasochistic fantasies. She goes through periods of complete inertia during which she finds herself unable to cope and remains in bed for hours on end. This inertia is followed by periods of excessive, hypomanic-like activity, during which she

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drives around in her car incessantly, to the extent that the vehicle has undergone a certain amount of damage due to her impulsive behavior. She takes on all the duties and obligations of her family, and she sleeps very little.

Ms. B is haunted by a strong fear of death, both her parents' and her own. Sometimes she has panic attacks, thinking that she has cancer. She recalls that she has always suffered from one physical ailment or another: colds, tonsillitis, sprains, injuries, bulimic episodes, diabetes mellitus (after her pregnancy), migraines, allergies, fainting spells, and pains in the abdomen and intestines.

The patient's world as it emerges during the analysis seems contradictory and fragmented, and the relationships she forms with others could be described as narcissistic and as part-object relations. She appears to find it difficult to go through a mourning process and to experience the psychic pain connected with the processing of the depressive position. In fact, she cannot bear to accept loss, lack, or separation.

In line with her history, Ms. B continues to suffer frequently from physical ailments, experiencing daily a host of “petit mals” (her expression), while at the same time being deeply cynical and pessimistic. Metaphorically, she “wears dark glasses” (again, her own words)—courting the negative, death, and disorder, and is sarcastic in the face of every positive value. She feels like a terrorist, as though she were carrying a bomb that is about to explode and sabotage the system.

Almost two years after beginning her analysis, Ms. B is feeling physically better, is acting out less, and the extreme fluctuations in her behavior are less pronounced. She is, however, reluctant to attribute this progress to psychoanalysis. Ms. B finds it difficult to talk in an open, direct manner about what she feels, thinks, or fantasizes in relation to her analyst; it is as if she must omnipotently control their relationship continuously. Thus, at one moment she idealizes him, at another she devaluates him, and she consistently relates to him in a narcissistic way so as to persistently deny their distinctness and separateness, and to avoid at all costs feeling dependent on him.

During this period of time, the analyst goes to a congress abroad, and it happens that he has to be absent for longer than anticipated due to a health problem. When he meets Ms. B again, some time after the

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agreed-upon appointment date for their next session, things are very different: two of her close friends and colleagues have become terminally ill with different types of cancer, and the terrifying attack on the Twin Towers in New York has just taken place. Ms. B finds herself especially stressed out and irritable; she is prone to getting into arguments with others, but she is reluctant to connect these feelings with the analyst's absence, tending to rationalize and justify them in order to diminish their importance. She complains of acute pains in the abdomen and intestines, pains that do not allow her to get any sleep.

After the Christmas and New Year's break, Ms. B returns to the analysis and tells the analyst that her physical pain became intolerable during the holidays. She also says that she has had a fever and blood in her stool. Although she was afraid of a cancer being discovered in her bowel, she forced herself to undergo medical tests, which revealed an inflammatory intestinal illness (Crohn's disease), for which she has been prescribed a strict diet and anti-inflammatory treatment.

Following the diagnosis of her illness, Ms. B becomes less narcissistic and turns more to her analyst for support. She is weaker and frightened, but also more at ease with herself; she recognizes that she needs him and endeavors to consider his interpretations. He, for his part, feels rather responsible for the state she is in, and has the feeling that he is unintentionally doing her more harm than good. He begins to doubt his therapeutic skills and whether he can really help her, beset by feelings of weakness, insufficiency, and guilt. He realizes that, while he was experiencing his own health problems and even after those were treated, his analytic function was suspended, as Ms. B's material—especially after the discovery of her illness—touches upon his own fear of death, his own narcissistic needs. He understands that Ms. B's “dark glasses” have become his, too, and that to get over this impasse, he must seek support and sustenance from his cherished good objects and especially from his clinical supervision.

In the analysis, Ms. B focuses on her relationship with her mother, who also suffered from an intestinal ailment. Shortly before Ms. B was born, her mother lost her much-beloved father, the patient's grandfather, and she seems to have been thrown into heavy mourning. For many

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years, she wore black and may also have been taking medication during this period.

When Ms. B was three years old, her mother presented with severe pain in the abdomen and intestinal bleeding that almost killed her. She was finally diagnosed with precancerous polyps in the large bowel, which were surgically removed, and she returned home after a long absence. Ms. B remembers very clearly running up to her, longing to put her arms around her and give her a big hug. In so doing she pressed against the incision in her mother's abdomen. Her mother moaned in pain and slapped her. Then, in tears, the mother tried to hug her, but Ms. B obstinately withdrew. Ms. B's very dependent and extremely sadomasochistic relationship with her mother came to the fore.

One evening, as the analyst leaves his office after a session with Ms. B, the idea that Ms. B might be a member of a well-known local terrorist organization suddenly and unexpectedly crosses his mind. There are rumors these days about imminent arrests of members of this particular organization. He experiences a feeling of being threatened and is somewhat taken aback by this fantasy, but he also has the feeling that his analytic communication with Ms. B has been restored.

A little later, Ms. B relates a transference dream:

> I belong to a revolutionary organization located in a hide-out somewhere in Athens. I'm given the assignment to kill an enemy. I get into a large vehicle, a container, and I approach the driver from behind and strangle him without seeing his face, feeling a savage joy as I do this. Then I think of turning myself in. Punishment doesn't scare me; I will miss our sessions, but I don't care—nothing matters anyway.

Ms. B recognizes that the driver is the analyst and that the vehicle symbolizes his therapeutic function as containment.

This and other, similar material brought by Ms. B to the sessions during this period show that the analyst's protracted and uncontrolled absence, at a moment when the patient was beginning to consider her analytic relationship more seriously, caused her intense feelings of frustration, anger, and envy. There seems to be a revival of her primary, traumatic, and very deprived relationship with her mother. As a result of her

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attack on the therapist, she feels a strong, persecutory guilt. At the same time, the loss of her two friends to terminal cancer makes her desperate: good objects, internal and external, disappear and death seems to prevail. It is as if her worst fear has been confirmed: the object on which she depends is destroyed due to her own destructiveness, and there is no hope for reparation.

Psychic pain seems to overcome the patient's powers of symbolization, and other channels must be used—mainly somatic (physical) ones. The conflict between life and death is acted out in her body; she experiences suffering in the gastrointestinal tract, a direct reference to her mother's illness and to a part of the body involving nutrition and feeding—the receptacle of maternal milk, but also of the analyst's words. (At times, when Ms. B worked well in the analysis and was left with a feeling of satisfaction with herself and the analyst's interpretations, she came to the following session with ulcers in her mouth.)

It is as though a destructive somatic, internal object relationship were activated, one that refers to the primary relationship with her mother and is being repeated with the analyst. The analyst realizes that he is experiencing almost the same feelings that Ms. B experienced in her relationship with her mother, and tries to contain her instead of repelling her, to be alive and to survive analytically—making her feel that her destructiveness is not omnipotent—in order for her to reestablish the good object internally, in a stable and permanent manner. Six years later, as the analysis continues, Ms. B's inflammatory disease is in full remission; there are no laboratory findings of active illness.

To summarize, a somatic symptom—that is, a somatic, concrete expression of a nonsymbolic system activation, according to **Solano (2010)**, an acting in the body—can manage to attract the attention and interest of the symbolic systems of both the patient and the analyst. In order for the symptom to acquire a symbolic and therefore a developmental value, it is crucial that the analyst's containment function and capability for reverie (**Ogden 1994**; **Vaslamatzis 1999**) are equal to the task. In the present case, the analyst's feelings and fantasies seemed to point to a restored alpha function, after the initiation of supervision and his own psychic working through.

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The material and dreams that Ms. B brought to the sessions following the onset of her illness and the intensification of her transference to the analyst are proof of her satisfactory effort to contain and understand her anxieties. Her symbolic processing of her illness calls to mind Ferrari's **(2004)** vertical axis, which refers to the subject's mind-body relationship, “a body emanating sensations, a living body, or corporeality” (p. 53). By contrast, the horizontal axis has to do with interpersonal relations, with the most important interlocutor being the analyst in the transference.

The Case of Ms. C (in an Analytic Setting)

In the first years of her analysis, Ms. C is unable to take in anything I say about her psoriasis, although when she first came for treatment, this psychosomatic condition was relatively active. She responds to my comments with anger, rejecting as “nonsense” my attempts to connect her physical condition to her feelings. My understanding is that she looks upon what I have to say as threatening—not to say intrusive—to her narcissistic equilibrium, and I decide to let things lie. The dermatitis may be all too evident on the body, but not in the mental domain.

From the initial interviews, I learned that Ms. C's first outbreak of psoriasis occurred at the age of six. Later in her analysis, she say that the most severe flare-up occurred one and a half years before she started her analysis. At that time, she was working in another town when she was confronted with an emotional conflict shortly before finishing her formal studies. She broke off her relationship with a young man in Athens and started to date a work colleague, a man ten years older than she, whom she now considers “mad.” She experienced this particular affair with great excitement. On one occasion, after having sex with him, Ms. C fell into a state of confusion, and while driving home had an accident and suffered extensive injury to her shinbone; she was hospitalized for a few days. As the healing process began, psoriatic flares appeared on the same part of her body. At that time, Ms. C was feeling confused, guilty, and emotionally depressed; she abandoned her plans for postgraduate studies in the United States and returned to Athens, where she resumed her relationship with her ex-boyfriend.

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This case illustrates that, when physical sensations are extremely intense and threaten to overwhelm psychosomatic unity, the split between body and psyche offers a defensive solution.

In the course of Ms. C's analysis, I began to think that her short periods of anger and paranoid anxiety—and even those of idealization and identification with me—were expressions of a splitting of her emotional world, underlying a prodromal phase of the psoriatic flare-ups. If split-off elements are contained by the other (as external and internal object), and if a certain relief and processing are achieved, then there is a possibility that the body will not be affected. In Ms. C, the attacks seemed to represent a search for someone to mitigate them, to contain and metabolize them, rather than to destroy the other.

Ms. C's analysis went on for seven years. From the fourth year onward, the dermatologic disorder subsided completely, and at termination she had satisfactorily developed her intellectual and emotional potential in both her professional and interpersonal contexts.

The Case of Ms. D (from the Department of Personality Disorders)

A 26-year-old teacher, Ms. D, had been hospitalized twice before she was referred to us. Her changing and intense symptomatology (among which psychotic and depersonalization symptoms prevailed) had led her therapists to prescribe several treatments of many psychopharmacological types. Her symptoms invariably worsened when she was attaining something valuable, such as a master's degree, a friendship, or even a good therapeutic relationship.

Speaking in a false tone of voice, Ms. D said that, following the suggestion of her psychiatrist, she was consulting us for psychotherapy. She added menacingly that she could not take it any longer; she wanted to do “evil things.” Furthermore, she suffered from “urine leaks.” I suggested hospitalization in order to investigate, among other things, why she needed so much medication of various types, and, in addition to this, the possibility of psychotherapy.

During her hospital stay, Ms. D suffered from—among other symptoms—metrorrhagia, lumbar pain accompanied by unsteadiness when walking, headaches that kept her in bed on weekends during her leaves,

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angry outbreaks against her fellow patients and nurses, and self-mutilations on her arms.

Toward the end of her hospitalization, Ms. D agreed to undergo psychotherapy, which would take place in an adjacent building outside the hospital grounds. But before starting out for her first appointment there, she complained to the staff of dizziness and nausea, and ten minutes after leaving, she called the hospital to say she had lost her way. She said she had fallen down because she was feeling extremely weak, and some construction workers had assisted her. At this moment her mother arrived and helped her reach the building. Due to this little incident, she arrived for her therapy appointment only ten minutes before the end of the session.

Here we can see that the suffering body occupies the forefront. Is it a “masochistic” cathexis of the body, due to failures in primary masochism, as postulated by **Aisenstein (2008)**? For Aisenstein, following Freud, primary masochism refers to the normal experience of the pleasure-pain mixture, where the infant's anticipation of the feeding experience and oral satisfaction creates an increase in painful tension and excitation. If the mother—by oversatisfying the infant, not tolerating his/her crying, and by obstructing differentiation—does not allow the above experience to evolve, pain is disconnected from pleasure. This could lead to a permanent feeling of pain and a constant sense of illness, or to self-destructiveness and an inability to experience feelings of genuine self-fulfillment. Failures in primary masochism, according to Aisenstein, “often lead to borderline personalities who are disruptive and want what they want immediately; they cannot wait or experience desire” **(2012)**.

This is a plausible interpretation. I also assume that Ms. D's obvious pathology with respect to the treatment frame reflects a severely traumatic, archaic mother-infant relationship, and especially an inability to achieve containment.

With regard to the therapeutic process, we cannot overlook the problem of containment of the soma. It would be insufficient simply to state that the subject has been overwhelmed by aggressiveness against the body, or that the body merely reproduces trauma that is medically rationalized. The “German school” of psychosomatic disorders has come

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up with interesting solutions to these issues based on long-term psychotherapeutic hospitalization **(Beutel et al. 2008)**.

What Can Be Derived from these Observations?

I will briefly underline some of my conclusions. On the diagnostic level, we might speak of co-morbidity of borderline personalities and "psychosomatic" disorders, in the broader sense of the term. We might also speak of dysregulation in both the mental and the physical functions, as I have previously shown in relation to patients suffering from brittle diabetes **(Ginieri-Coccossis and Vaslamatzis 2008)**.

Somatization is not identical with physical illness. In the former, it is argued that, to a greater or lesser degree, a representation of the body exists, while in the latter the disorder is created in the body as a "Concrete Original Object" **(Ferrari 2004)**. Often, however, the boundaries are not clear and we are faced with co-occurrences. Indeed, which of these categories best describes the self-mutilations of a borderline patient, an anorexic crisis, or even Munchausen syndrome? In the latter, the body is the recipient of attacks from the subject itself, in order that the subject may become a "medical" patient.

Focusing on the mental functioning of the patients presented, I note that they have the following commonalities:

o An incapability to engage in a dreaming process (failure in the symbolic function and, generally, in the creation of representations) and a counterinclination for acting out and acting in the body (somatic discharge).

o A difficulty in experiencing mental pain (related to loss and separation) and a tendency toward suffering from physical pain, through somatic ailments or symptoms. The absence of the other (the analyst) may function as the loss of the psychobiological-regulatory object **(Taylor 1987)**.

o The defective processing of emotions and sensations and an inability to achieve containment. We might argue that in these patients (see especially Ms. A and Ms. D), "representations are saturated with physicality or emotion"

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(Ferrari 2004, p. 49). As a consequence, containment and processing are prevented, but persist as the patients' “demands” in searching for an analyst.

- The predominance of the body over mentalization. Mental processes are short-circuited, so that sensorimotor, emotional experiences are expressed through the body.

Generally speaking, the discharge of inner stimuli through somatic/physiological functions occurs simultaneously with primitive mental defenses (projective identification, splitting, narcissistic defenses, foreclosure, and/or total splitting between psyche and soma).

Discussion and Conclusions

First of all, I believe that the discharge of a dysregulating process to the soma often implies the shadow of an archaic trauma. This preconceptual trauma leads to an overflowing of beta elements (exceeding the ability to transform them into alpha elements). At a time when the infant's processing capacity is minimal—and sometimes even in combination with an impairment in the maternal containing function—this particular kind of “madness” takes shape. This involves both physiology (psychosomatic diseases, somatizations, the body becoming “delusional”) and mental functioning (inadequate development of symbolic function, alexithymia, operational thinking, splitting, diffusion of identity, etc.). The psychotic function involves the body itself in the sense that the body is “getting mad”: instead of silently containing its functions, it opens up “holes” where there are not supposed to be any; it bleeds or creates useless or even dangerous elements.

All this is observed in conditions like inflammatory bowel disease, psoriasis, asthma, brittle diabetes, chronic pain, and so on. At the same time, mental functions are involved. Here, too, internal cysts, “foreign bodies,” and “black holes” (as the structural void is termed by Grotstein [1990]) are generated. All these are notions used to depict the archaic (Tutte 2004)—namely, very early and unprocessed experiences, which are registered as traumatic and as representational deficits. They cause a kind of mental bleeding in the sense of a loss of mental material due to forceful projective identification.

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I agree with Mitrani's **(1995)** formulation that severe early traumas (e.g., separation, maternal intrusion, existential anxieties, nameless terror) cause somato-sensual excitation and are somatically recorded. They are presented (not *re*-presented) as body memories through the autonomic nervous system, the visceral organs, and the musculature. These body memories remain unmentalized and immutable, encapsulated and isolated, and find aberrant modes of expression such as somatization, somatic symptoms, or physiological anomalies of organ systems.

The Paris Psychosomatic School, highlighting the economic perspective, emphasizes that in these cases, the totality of instinctual excitations is enhanced and the psychic/mental apparatus is overloaded, resulting in somatization. **Aisenstein (2006)** and **Aisenstein and Smadja (2010)** argue that, while in psychotic pathology a splitting and destruction of the perception of external reality prevail, in psychosomatosis (a term having more or less the same meaning as the soma-psychotic part), we have a very early splitting and destruction of the endosomatic perceptions, clinically silent. In most severe cases, such as those involving auto-immune diseases or cancer, this initial splitting is correlated with a state of radical unbinding and defusion between the life and the death drives, which modifies the whole psychosomatic equilibrium of the subject, a self-destructive motion of the death instinct **(Smadja 2011)**. These processes generally develop in nonneurotic patients characterized by a dimension of severe narcissistic loss due to deep and early psychic traumas.

In similar terms, we could think of Bion's **(1962a)** reversal of alpha function and the production of a beta screen, an impenetrable contact barrier composed of beta elements, which cuts the subject off from his very painful internal as well as his external reality. According to **McDougall (1989)**, there is a total split between psyche and soma, and the emotional experience is excluded—foreclosed from the psyche, totally removed from it, and expressed through the body, where it is banished.

Following this line of thought, the question becomes: why, in these patients, is there concurrent or alternating physical and mental dysregulation? There is no easy answer to this question.

Starting with the fact that the newborn's body is the basic part of the first archaic links developed between mother and infant, **Ferrari (2004)**, returning implicitly to the theory of primary narcissism, integrates the

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body with the environment. He thus puts forward the dual perception of the vertical and horizontal elaborative axes mentioned earlier. Observing that in several severe psychopathologies, the patient uses his/her body in a way that turns it into a mere object, Ferrari concludes that “the body, the Concrete Original Object, is the main object of the mind and its primary reality” (**2004**, p. 17).

For **Lombardi (2002)**, another author who focuses on the body-mind link and who is influenced by Ferrari, the body is “the first source, differing from person to person, from which mental phenomena are generated, and against which they are constantly measured” (p. **363**). The psyche develops as the internal, physiological, corporeal stimuli are organized and contained. We may assume that some delicate balance is disrupted and dysregulation occurs at the moment of the “intermediate domain,” in between the bodily sensations and excitations and the protomental function.

Considering these issues from another perspective, that of Bucci's *multiple code theory* as presented by **Solano (2010)**, we could describe the condition of each of the patients discussed in this paper, before the onset of illness, as a *disconnection between the subsymbolic and symbolic systems.* A potent psychic defensive maneuver causes an active blockage of the connections with symbolic systems, so that the various daily incidents inducing a subsymbolic activation cannot generate conscious, distinctive feelings and thoughts about these incidents. Thus, “enactments of sub-symbolic activation fall short of finding symbolic connections that would entail the possibility of restoring meaning through these enactments” (Solano **2010**, p. **1459**).

This active disconnection leads us to a defense mechanism of severe dissociation between psyche and soma, that of disaffectation **(McDougall 1989)**, to attacks on linking **(Bion 1959)**, to foreclosed experience **(Schneider 2007)**, or even to disobjectalization, to the work of the negative **(Green 1999)**. In some patients, this disconnection is essentially deficit based, while in others it is more defensively based **(Solano 2010)**. At any rate, what finally emerges in the clinical picture is a multitude of qualitatively different kinds of mental experiences and levels of symbolic elaboration that go beyond the simplified implicit/explicit (unmentalized versus mentalized) dichotomy **(Lecours 2007)**.

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Green's work on the dead mother syndrome (1986) and its discussion by Gurevich (2008) are also relevant to my observations and hypotheses. In a previous paper, I extensively discussed the incomprehensible, the lack of meaning, and the deadness of the analytic relationship (Vaslamatzis 2008). Gurevich's suggestion, in particular, about a negative developmental course leading to the inability to construct the transitional domain, complements my own suggestions. If the intermediate domain is damaged, archaic anxieties are spread over the psychosomatic level, without the ability to be represented. Perhaps this course determines the soma-psychotic outcome.

Let me note here that these ideas echo—although from a radically different theoretical foundation—Taylor's (1987) proposal on the role of withdrawal of self-objects as a *psychobiological regulating function*, which leads to dysregulation on both biological and psychological levels.

Allowing for differences among the various analytic languages used, I believe that Bion's formulations provide an advanced, abstract conception of the basic somatic and psychic functions, their interpenetrations and relationship. If we take as given the archaic splitting of the psychic organization and the developmental vicissitudes occurring before its structure is finalized, I propose the existence of a *soma-psychotic part of the personality.* This is a concept that adequately represents and contains the psychoanalytic research findings on the relationship between somatic and psychic functions, particularly in patients with a relatively serious somatic and psychic dysregulation.

My experience has shown me that the alpha function is not totally absent in these patients, contrary to what happens with the psychotic personality. That explains, in my view, why it is not rare to witness alternating creative and noncreative periods in analytic therapies with these patients. Something similar occurs in the analyst. The maintaining of his/her reverie function and capacity for transformational elaboration, despite the difficulties, is essential to the creative outcome of the analytic process. Similarly, Bichi (2008), in speaking of patients with serious traumas, emphasizes the alternation during the analysis between “remembering and interpretation … and the representational void and construction” (p. 541).

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In conclusion, this paper proposes the theoretical inclusion of the psychopathology of certain patients with physical symptoms and corresponding analytic phenomena in the concept of a way of functioning at the borderline between the somatic and the psychic (i.e., representation). A traumatic experience in this initial stage leads to a dysregulation and consequently to a soma-psychotic part of the personality, which is activated in a crisis.

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References

Aisenstein, M. (2006). The indissociable unity of psyche and soma: a view from the Paris Psychosomatic School. *Int. J. Psychoanal.*, 87: 667-680. [→]

Aisenstein, M. (2008). Beyond the dualism of psyche and soma. *J. Amer. Acad. Psychoanal.*, 36: 103-124. [→]

Aisenstein, M. (2012). Personal communication.

Aisenstein, M. & Smadja, C. (2010). Conceptual framework from the Paris Psychosomatic School: a clinical psychoanalytic approach to oncology. *Int. J. Psychoanal.*, 91: 621-640. [→]

Beutel, M., Michal, M. & Subic-Wrana, C. (2008). Psychoanalytically oriented inpatient psychotherapy of somatoform disorders. *J. Amer. Acad. Psychoanal.*, 36: 125-142. [→]

Bichi, E. (2008). A case history: from traumatic repetition towards psychic representability, trans. P. Slotkin. *Int. J. Psychoanal.*, 89: 541-560. [→]

Bion, W. R. (1959). Attacks on linking. *Int. J. Psychoanal.*, 40: 308-315. [→]

Bion, W. R. (1962a). *Learning from Experience*. London: Karnac. [→]

Bion, W. R. (1962b). A theory of thinking. *Int. J. Psychoanal.*, 43: 306-310. [→]

Bion, W. R. (1967). *Second Thoughts*. London: Karnac.

Brown, L. J. (2006). Julie's museum: the evolution of thinking, dreaming, and historicization in the treatment of traumatized patients. *Int. J. Psychoanal.*, 87: 1569-1586. [→]

Ferrari, A. (2004). *From the Eclipse of the Body to the Dawn of Thought*. London: Free Association Books.

Ferro, A. (2002a). *In the Analyst's Consulting Room*. East Sussex, UK: Brunner-Routledge. [→]

Ferro, A. (2002b). Narrative derivatives of alpha elements: clinical implications. *Int. Forum Psychoanal.*, 11: 184-187. [→]

Freud, S. (1911). Formulations on the two principles of mental functioning. *S. E.*, 12.

Freud, S. (1915). Instincts and their vicissitudes. *S. E.*, 14.

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Ginieri-Coccossis, M. & Vaslamatzis, G. (2008). Dysregulation and containment in the psychoanalytic psychotherapy of a poorly controlled diabetic patient. *J. Amer. Acad. Psychoanal.*, 36: 33-48. [→]

Green, A. (1986). The dead mother. In *On Private Madness*. London: Hogarth.

Green, A. (1998). The primordial mind and the work of the negative. *Int. J. Psychoanal.*, 79: 649-665. [→]

Green, A. (1999). *The Work of the Negative*. London: Free Association Books. [→]

Grinberg, L., Sol, D. & Tabak de Bianchedi, E. (1993). *New Introduction to the Work of Bion*. Northvale, NJ: Jason Aronson.

Grotstein, J. (1990). Nothingness, meaninglessness, chaos, and the “black hole,” II—the black hole. *Contemp. Psychoanal.*, 26: 377-407. [→]

Gurevich, H. (2008). The language of absence. *Int. J. Psychoanal.*, 89: 561-578. [→]

Lecours, S. (2007). Supportive interventions and nonsymbolic mental functioning. *Int. J. Psychoanal.*, 88: 895-916. [→]

Lehtonen, J., Partanen, J., Purhonen, M., Valkonen-Korhonen, M., Kononen, M., Saarikoski, S. & Launiala, K. (2006). Nascent body ego: meta-psychological and neurophysiological aspects. *Int. J. Psychoanal.*, 87: 1335-1354. [→]

Lombardi, R. (2002). Primitive mental states and the body: a personal view—Armando Ferrari's concrete original object. *Int. J. Psychoanal.*, 83: 363-381. [→]

López-Corvo, R. E. (2006). *Wild Thoughts Searching for a Thinker*. London: Karnac.

Marty, P. (1966). La dépression essentielle. *Revue Française de Psychanalyse*, 32: 595-598.

McDougall, J. (1989). *Theatres of the Body*. London: Free Association Books.

Mitrani, J. L. (1995). Toward an understanding of unmentalized experience. *Psychoanal. Q.*, 64: 68-112. [→]

Ogden, T. H. (1994). *Subjects of Analysis*. Northvale, NJ: Jason Aronson.

Ogden, T. H. (2003). On not being able to dream. *Int. J. Psychoanal.*, 84: 17-30. [→]

Ogden, T. H. (2004). This art of psychoanalysis: dreaming undreamt dreams and interrupted cries. *Int. J. Psychoanal.*, 85: 857-877. [→]

Rocha Barros, E. M. (2000). Affect and pictographic image: the constitution of meaning in mental life. *Int. J. Psychoanal.*, 81: 1087-1099. [→]

Scalzone, E. & Zontini, G. (2001). The dream's navel between chaos and thought. *Int. J. Psychoanal.*, 82: 263-282. [→]

Schneider, J. A. (2007). Panic as a form of foreclosed experience. *Psychoanal. Q.*, 76: 1293-1316. [→]

Schneider, J. A. (2010). From Freud's dream-work to Bion's work of dreaming: the changing conception of dreaming in psychoanalytic theory. *Int. J. Psychoanal.*, 91: 521-540. [→]

Smadja, C. (2011). Psychoanalytic psychosomatics. *Int. J. Psychoanal.*, 91: 221-230. [→]

Solano, L. (2010). Some thoughts between body and mind in the light of Wilma Bucci's multiple code theory. *Int. J. Psychoanal.*, 91: 1445-1464. [→]

Taylor, G. (1987). *Psychosomatic Medicine and Contemporary Psychoanalysis*. Madison, CT: Int. Univ. Press.

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Tutte, J. C. (2004). The concept of psychical trauma. *Int. J. Psychoanal.*, 85: 89, 7-921.
Vaslamatzis, G. (1999). On the therapist's reverie and containing function. *Psychoanal. Q.*, 68: 431-440. [→]
Vaslamatzis, G. (2008). Keeping the analytic relationship alive: a clinical exploration into incoherence and lethargy. *Scandinavian Psychoanal. Rev.*, 30: 106-112. [→]
Vaslamatzis, G., Coccossis, M., Zervis, C., Panagiotopoulou, V. & Chatziandreou, M. (2004). A psychoanalytically oriented combined treatment approach for severely disturbed borderline patients. *Bull. Menninger Clin.*, 68: 337-349.

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