Psychosomatics today

Claudia Spadazzi (Roma)

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"*According to me, any intellectual attempt to make psychosomatics easy clearly shows the true clinical pit in which we are bogged down during our work. We commit ourselves to building a theory, while the right term should be theories*". (D.Winnicott, 1964)

What is the meaning given to the term "psychosomatic" over the last 100 years and what do we currently mean by this word? Is it still meaningful to talk about "psychosomatics"? Or has this term become obsolete because of the reconciliation of the split body and mind coming from new neuroscientific evidence? This theme is so vast that for introducing this afternoon's session it is necessary to stick to some basic considerations.

In everyday language, "psychosomatic" hints at a condition in which a body disorder has an exclusive or main psychogenic origin. Similarly, most medical practitioners refer to a symptom with a probable neuroautonomic origin, generally linked to ANS hyper-activation. For example, some forms of *dizziness, globus hystericus, essential pruritus, palpitation symptoms, neurodermitis, tinnitus, some sexual dysfunctions* and many others.

Instead, in the domain of psychoanalysis, "psychosomatic" means the rupture of the body-mind equilibrium that ensures the subject's health; this leads to an alteration which can trigger a body disorder. Therefore, it represents an impaired psychic

functioning in terms of mentalization which can cause a temporary or even permanent anatomo-pathological alteration. The somatic symptom may be transitory, chronic or it may induce a fatal disease, according to the severity of the psychic disorder.

This concept of psychosomatic disease concept belongs to the Paris Psychosomatic School and was developed by its founders, Pierre Marty (1967, 1968, 1976, 1980, 1981) , together with Fain, de M'Uzan, David, whose school of thought is still alive today. The drive theory is at the heart of this meaning of psychosomatics, according to which part of the unbound drive – where drive is the bridge between body and mind – induces somatization. With a consistent meta-psychological reference, the Paris School of Paris developed the following theoretical model: in addition to 1) somatization, 2) depression, a ground predisposing to the onset of the somatic disease and 3) an impaired ability to represent and process affects (operative thought). Operative thought alters the representation function of the object and, finally, the psychosomatic disease plays a defensive function, even though at different mental levels with respect to other theoretical models.

The theme of this deficit is also present in the theory developed by Sifneos (1975) and Nemiah (1978, 1982), who conceptualized alexithymia as a feature of subjects with a psychosomatic risk. A reduction of neural connection between hypothalamus and cortical regions seems to be responsible of alexythimia.

André Green, rather critical vis-à-vis "psychosomaticiens", reproaches Marty for a sort of biologization and revamps representation as the founding principle. For Green, the "body" is a libidinal instance, the erotic body, to be distinguished from "soma" that is characterized by its biological nature.

In the last five years, several papers have been published in the psychoanalytical literature, which testify to the still strong interest in this extremely complex issue (Press 2016, Bronstein 2011, Smadja 2011, Fischbein 2011). Among these, Press and Smadja fundamentally refer to the theory of the Paris Psychosomatic School. Even the publication curated by Marilia Aisenstein, published in 2016, appears to be in the wake of Marty's tradition, with contributions from Smadja and Bronstein, from Kalinich, Aisenberg, Taylor and others and from the controversial Green. Catalina Brontstein's contribution is related to a fundamentally Kleinian vertex, showing the economic role of the death drive and the function of unconscious fantasies in somatic sensations, as well as the evolution from the Kleinian matrix of the theories

developed by Bion, Meltzer, Rosenfeld, Isaacs and by Winnicott himself. Finally, Karen Gubb summarizes the two main schools of thought in psychosomatics today. On the one hand, the Paris School that defines the model of the "speechless mind" and on the other a model mainly from the U.S., the "speaking body", in the wake of the theory attachment (Sloate,2008, Griffies,2010, Kohutis, 2008). An interesting contribution from Italy comes from Fausta Ferraro on the post-Freudian developments by Solano (2008) on the basis of the model conceived by Wilma Bucci and Lombardi (2008).

According to the classical theory, an organ lesion and its impairment differentiate the psychosomatic disorder from the hysterical symptom, where there is no evidence of a physical or pathological alteration. Starting from Charcot's studies, Freud conceptualized the hysterical symptom as if founded on the conversion mechanism and came up with the "somatic compliance" concept, that is a constitutional or acquired factor that is supposed to predispose to a subject or an organ or an apparatus to conversion.

In addition to these two models, the psychosomatic and hysterical symptom, there is hypochondria, the pathological preoccupation linked to conscious and to unconscious fantasies on body functions. Hypochondria was initially included by Freud among actual neuroses, following the conceptualization of narcissism. It was related to "a damming up of narcissistic libido projected on the body" (Freud, 1917). Then, Rosenfeld (1959, 1964, 1980) developed the concept of "psychotic islands" and of a relationship between hypochondria and psychosomatic states.

While it could be useful to distinguish psychosomatic from hysterical disorders form the theoretical point of view, in most cases, these phenomena are a *continuum* on a psychological and physical level. They overlap according to complex dynamics and are variably intersected with genetic predisposition and with environmental and accidental factors.

In closing our IPD Congress last year, a hint was made to the current debate on the possibility to create a bridge between neurosciences and psychoanalysis, reiterating the relevance of this fundamental connection from many points of view. However, psychoanalytical psychosomatics appears to be very far from bridging this gap, in

that it is always very difficult to have a clear picture of the "soma", with its concrete biological traits, fluctuating from strong hyper-exposure to a sudden evanescence.

It is equally difficult to define the essential relationship between body and mind, which is instead delegitimized by distinguished psychoanalysts (Blass, Carmeli, 2007, 2015,2016), who deny its important role or who fear it may be "dangerous" in terms of identity loss.

But is it still possible to persevere in separating the mental aspects – dreams, emotions, feelings, fantasies, thoughts, associations – from the biological ones – neuronal activity, hormone release, antibody production, lymphocyte activation, cell plasticity and all the human body's infinite activities to preserve the individual from death?

Damasio recalls that:

"the mind emerges from or (within)a brain situated in a body with which it interacts; the mind is rooted in the real body via the brain; it is preserved on an evolutionary level because it contributes to keeping the body alive; and finally, the mind comes from (or within) a biological tissue – nerve cells – that shares the same characteristics as the other body"(2009).

According to R. Lane (2009) and his Group, the aim of psychosomatics is to connect A) the mind to → B) the brain to → C) the information system to → D) the organs. The research field opened up by the fMRI and Pet techniques has made it possible to start understanding the involvement of brain structures and, through laboratory tests, of how the immune, biochemical and autonomic nervous systems work. The new neuroscientific acquisitions will gradually reveal the possible ways leading **from A) to D) through B)** and **C).** Initially, the limit of psychosomatics was mainly due to the very few investigation systems available and to the fact that it was based on intuition and clinical experience; but it also resulted from having sometimes attempted to interconnect the two systems A) and D): the mind and the organ (or the function) hit by disease, the two extremes, without considering the intermediate steps, by supporting the mind-body split, whose "trait", according to Winnicott, is to unite and separate at the same time.

By gradually understanding the communication between A and B and its effect on C and D, it is possible to acknowledge the central role the mind plays in the events linked to somatic processes, both on a physiological and pathological level;

moreover, this adds value to the contribution given by psychoanalysis in terms of an antireductionist vision of medical science. There is no need to stress the non linear character of the A → D process, where the continuous modulation of neurotransmitters, the 10^{15} brain synapses working (one hundred trillion), hormonal changes, the constant fluctuations of the immune systems and the integration of neurosensory perceptions set the stage for the living body to incessantly work to coordinate different systems which tend to homeostasis. Sometimes, this process can also be reversed A←D . For example, the psychic effects of a thyroid dysfunction, where an external factor, the lack of iodine, can trigger clearly depressive symptoms.

The C system consists of the ANS with its immune and biochemical functions; the complex function of the immune system is extremely interesting so as to provide a meaning and sense to symptoms and to disease, which is the primary objective of psychosomatic medicine. In fact, the immune system is configured as a protective instrument for the boundaries of the Self, but also as a self-destructive instrument in its role as the guardian of the delicate equilibrium between the central nervous system and peripheral organs. The fast-growing comprehension of the alterations of the immune system leads to the obsolescence of the historical characterizations of psychosomatic syndromes by the School of Chicago *(gastroduodenal ulcer, bronchial asthma, dermatitis, ulcerative rectocolitis, neuorodermites, essential hypertension* (Alexander, 1950). In fact, an immune hypo or hyper-reactive change can trigger a high number of diseases, ranging from diabetes to most dermatological disorders, from many endocrine pathologies to some types of infertility. An impaired immune control function may lead to some forms of cancer; in fact, it is well known that there is an ongoing early cancer proliferation process in the body which is promptly inactivated by leucocytes. An impaired surveillance function may expose to cancer development. How this “lowering” of the immune surveillance threshold is intertwined with emotional aspects is still to be defined. However, these are new frontiers in the area of pychosomatics.

The very concept of neural Self, mentioned by Damasio, implies the consistent reactivation of the two systems: on the one hand, the individual’s autobiographical elements, organized as representations projected onto maps, that is a sort of incessant redefinition of his or her identity; on the other, the continuous reconstruction of body representations.

A very high number of authors have provided relevant contributions to psychosomatics, but it is beyond the scope of this paper to examine their content, their different approaches, their originality and their outcome. However, it is worth focusing on the neuro-psychoanalytical approach followed by some authors who have better investigated the tension between non-reductionist monism and the dualism embedded in the psychoanalytical matrix. In this sense, it is important to mention E. Gaddini and his paper on the development of the mind written about 50 years ago, which provide a perspective on the unbreakable body-mind unity. Gaddini states:

‘‘*Psychoanalysis is also a scientific form of psychology, especially because it does not pit the mind against the body, but it considers it as a differentiated function of the body. It does not oppose neurophysiology, but it expects to learn from it the neurophysiological functioning underlying the functions of the mind*”.

Therefore, he emphasizes the differentiation of the mental function in a process from the body to the mind (while psychoanalysis follow the reverse process); he focuses his attention on perinatal and intrauterine psychic life and outlines the onset mechanisms of some psychosomatic diseases starting from the ones in early childhood, the so-called “dated syndromes”?. Gaddini conceptualizes the psychosomatic disease as a re-activation of a mental function, altered at a very early stage of development, as an attempt to maintain a cohesive nucleus of the Self. And right at the beginning of the “Notes on the mind-body issue” he says:

“the mind is everywhere in the body”

thus postulating the current neuroscientific knowledge thirty years in advance.

I would like to conclude by hinting at a psychosomatic disease on which I have worked in the last 25 years, both as psychoanalysts and as gynaecologist, precisely in the difficult situation of the medical doctor riding two horses described by Winnicott.

I am talking about psychogenic amenorrhea, that is secondary amenorrhea, functional hypothalamic amenorrhea (FHA) that has an incidence of 3% to 5% among adolescents and young women. It is well known that traumatic experience and extreme fatigue, as well as malnutrition and severe environmental problems

can easily cause the disappearance of the menstrual cycle, as for example during, famine, detention, war, competitive sports training, professional work overload. From a phylogenetic point of view, amenorrhea seems to be an attempt to delay reproduction to less critical periods, thus preventing the child from being born from a mother in very unfavourable conditions. However, amenorrhea is frequent in young women who do not live in a hostile environment, where the factors at issue are not linked to the environment but to their inner world. Clinical experience shows that secondary amenorrhea is often accompanied by a compensated eating disorder, generally associated to a mild obsessive-compulsive disorder. These patients have a normal weight and their only manifest symptom is the disappearance of their menstrual cycle. From the somatic point of view, the hypothalamus-hypophysis-ovary-uterus axis is altered, with no longer any fluctuations of hormones (oestrogens, androgens, progesterone and corticosteroids) that allow for the menstrual cycle to take place. At a higher level, there is an alteration of the gonad control by the hypophysis, with a lower secretion of FSH and LH. On top there is an alteration of the control of the hypophysis by the hypothalamus, with a reduced secretion of Gn Rh. But how is it possible to explain this alteration that is located in the interconnection between the CNS and the hypothalamus? And how can the particular psychic configuration of an individual determine the suppression of the menstrual cycle? This is apparently a problem at a sub-cortical level, presumably in the limbic area. In secondary amenorrhea, neurosciences can pave the way to understanding these alterations in terms of neurotransmitters and of hormonal feed-backs which affect the top-down and the bottom-up brain-hypothalamus-hypophysis relationship. The literature shows that several neurotransmitters, neuropeptides and neurosteroids are implied in the genesis of hypothalamic amenorrhea. In particular, it is interesting to show the alteration of:

↑ghrelin (the appetite-stimulating peptide)

↓leptin (the satiety-stimulating protein hormone), beta-endorphins (neuropeptides)

↑ CRH and corticosteroid hormones,

↑allopregnanolone (a CNS-stimulating pulsatile secretion neurosteroid)

↓β endorphins

The specialized literature attaches great importance to the role of a generic condition of “environmental stress” and to depression and mood disorders, as if a psychic disorder was the effect and not the primary cause of amenorrhea. Psychoanalysis contributes to understanding the inner world of these young patients who have a mild dysmorphism and a more or less compensated eating disorder. The construction of the female identity can encounter many difficulties mainly due to pre-oedipal problems, to issues related to the disidentification from the mother and to fusion-related aspects. The regression to a prepuberal state induced by amenorrhea can be a favourable defensive solution.

It can linked to Embodiment Disorders (Fuchs, 2010) and framed as a Body Dismorphic Disorder related to the perturbed relationship between Body-Subject and Body-Object, which is also responsible for eating disorders. There are different views of “body image” , starting from Schilder’s definition(1924). Gallagher and Vaever (2004) define it: “a system of perceptions, emotional attitudes, and conceptual beliefs that pertain to one’s own body” (2004) . Psychotherapy makes it possible to work through the conflicts related to the body image within transference, thus relatively quickly restoring the hypothalamus-hypophysis function, much longer and better than traditional hormonal therapies.

To talk to gynaecologists, or to M.D. about the psychic aspects of psychosomatic illnesses is very difficult. Medical sciences are rapidly going toward a general reductionism. The effort to find the words for a constructive dialogue with medicine is a precise responsibility of the psychoanalytic community: in the interest of psychoanalysis, of medical sciences and mainly of our patients.

Dr.ssa Claudia Spadazzi

Società Psicoanalitica Italiana

claudiaspadazzi@gmail.com