PHENOMENOLOGY AND PSYCHOSOMATICS

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> *To be ill. To have an illness. The body suffers and is the object of transactions. Medicine proposes remedies, attempts cures. Does the patient seek to be heard through the symptom or rather does the patient – behind the defense that the very symptom has established – seek to be the object of oblivion? Who is it that is speaking, the body (soma) or the psyche?*
> (Vayssé, p. 13)

THAT OLD QUERY

That old Platonic query – the relationship between soul and body – now turns to the question of how somatic phenomena are articulated with psychic phenomena; we wonder how we could best formulate the concept of *Organsprache* – the language of the body – introduced by Freud; we also wonder why some individuals develop psychosomatic disorders rather than psychotic disorders or why they choose a particular organ or develop eczema rather than gastric ulcer.

The current *biomedical model* assigns the problem to the *somatic entity*, comprehended as an array of known organs which interact totally unrelated to subjectivity. It privileges the part of the body associated to *symptom*, emphasizing local suffering as something to be uprooted. That is, applying the Cartesian viewpoint, it discriminates between "organic" pathology – when a specific physical factor is identified – from "functional" –

when such factor may not be identified. In order to explain these phenomena, the biomedical model follows lineal causality, organizing biological factors in an increasingly complex chain of causes and co-causes. The body – to the extent that it may be explored, decomposed, made good, and modified – constitutes in turn a quasi cultural condition that empowers Western medicine to perform certain scientific procedures. This "representation" of the body is not only endorsed by medical wisdom but also by community groups, hence by patients.

Likewise, Descartes in the 17th Century subjects the body to a mechanistic metaphor, reducing it to an *object* ruled by physical laws and at the same time separating the soul from any corporeal influence, banishing it as pure intellect, as a purely *intra*-subjective *ego*. In the *soma* stimuli are transmitted to the brain through the nerves – conceived as hydraulic conductors, and it is through the nerves that muscles create movement. The *pineal gland* is located in the center of the brain; it is essential both from the physiological as well as the metaphisical point of view(1), as it explains the relationship between mind (*res cogitans*) and body (*res extensa*). By means of this gland, the particles of matter, driven by the nerves (spirits), will allow the soul to feel bodily movements, and stimulating in the soul the corresponding feelings, the soul will in turn set the spirits in motion for them to act on the body.

Beyond terminology, the Descartes man corresponds mostly to the man studied by present day medicine, although nowadays the emphasis is put on the nervous system, neuro-endocrine mediators and the parts of the brain – the limbic system, the hypothalamus, the hypophisis – considered to be the linking structures between mental phenomena (cognitive and emotional) and visceral processes (Trombini e Baldoni, p. 15).

However, the conversion symptoms of hysteria first, and later on the physical phenomena of expression or accessory symptoms to emotions, soon demonstrated that this *etiological* system, whereby *anatomic lesion* implies a *pathological function of the organ* in turn producing an *organic disease*, was not enough.

The next attempt was going back to the same pattern but this time positing that the first cause was a systemic or functional *energy disturbance*; this disturbance – situated on the thalamus vegetative regulating centers – brings about a functional disease

(1) Since it constitutes the seat of imagination and common sense.

in one kind of an organ; later, the disturbance becomes chronic causing an anatomic lesion which ends up in somatic disease.

Inverted, this new pattern responds with *vegetative dystony* (functional neurosis of the organ, anatomic lesion of the organ or psychosomatic disease) as a way to solve the once mysterious pathological processes but unable to explain the vegetative disturbance and what it leads to. It is thus posited that behind dystony there is the concept of "constitution" or "disposition" – as obscure as the previous concept was and somewhat closer to the notion of psychism. Now, psychic is placed side by side with somatic, and thus the casual chain is further lengthened with the addition of one more "link" (von Weizäcker). The new formula is now psyche, vegetative dystony, organ functional neurosis, organ anatomic lesion, organic disease (Boss, pp. 19-28).

And now the so-called "psychosomatic disorders" which seemed to have triggered this *dualistic scheme* have nonetheless evolved into a new "pineal gland" transmitting dysfunction from one part to another and viceversa, while psyche and soma are still seen as separate *principles*, one beside the other.

«The idea that there are somatic pathologies generated in part by psychological factors, or conversely, that there are bodily factors which may have an influence on psychic processes, implies a dualistic conception of the human being, which separates the world of bodily phenomena from that of psychic phenomena and that they are connected by a linear causal relationship. Psychosomatic medicine and psychophysiology – as we have already seen – are based mostly on this assumption» (Trombini e Baldoni, p. 209).

Despite the fact that they constitute a major domain of the clinical area, despite the involvement of the body that they entail, psychosomatic disorders do not seem to have raised any specific discussions in clinical phenomenology. It is rather the notion of "body" (both body as a subject and body as an object) that guides these reflections.

THE BODY, THAT AMBIGUOS EXPERIENCE

At first sight, my body appears as the outer look of my being and may be perused objectively. But that does not mean reducing

the body to a *res extensa*, or to a mere "organism" which is studied by anatomy, physiology and the positive sciences, i.e. it is impossible for me to have my body stand at a distance perceiving it totally[(2)] or to consider it a system ruled by physical or physiological laws. In fact,

«In everyday life, in its intimate relationship with itself or with others, the body is not a sophisticated machine made up of replaceable parts, it is not a thing deprived of value or worthy of interest only because of its practical utility» (Le Breton, p. 275).

Absolutely, I may not say "I have a body" because the categories of *having* do not essentially apply to the human being. I do not have a body in the same way as I may have something outside myself or as I may have a tool... The nature of "having" implies something external to the human being as well as possibility of disposing of or getting rid of something.

Nor is the body joined to the spirit; the body is not beside me in as Descartes would describe it; rather, the body is always mine and with me; this is why I cannot part company with it or why it is not attachable property. The "parts" of my body hold together in a unique way; they are «not laid out one next to the other but rather wrapped in one another» (Merleau-Ponty, 1945). My body is not a wrapping that covers my *inner self* or an instrument that mediates my psyche (Sartre, p. 368); there is no *concealing inner* self inside a *concealing bodiliness*. «The notion of a passive body, a mere receptacle, is illusory» (Zivadon e Fernandez-Zoïla, p. 133).

The body does not truly reveal itself until we perceive it as a "lived body" (*Leib*, *corps vécu*), "body as subject", "body proper", that is to say an acting center, as an instance that has been experienced. My body – as *behavior* – displays *intentionalities*: it is a primary founding opening to the world and the "world" is the realm that allows the body to experience itself in all of its possibilities. The body (*Leib*), temporary rehearsal, is never really afforded to me or to the other as completely finished: it simply presents itself in anticipation of the total being. It is dynamic relationship between the body and the world that generates a certain image of the body, an image that not only depends on unique individual history but also on the individual's rapport with others.

(2) I cannot see my back, I only see my face in the mirror.

THE BODY: A STAGE FOR OUR CONFLICTS

In daily life, the body «passes in silence» (Sartre, pp. 369-370) but when it forfeits the prerogatives of our will, it becomes the *scenario for our conflicts*. Disease makes us painfully aware that this body is beyond our command and our possibilities – a witness to the fragile and the finite nature of bodily existence. Thus, an unexpected heart attack, dramatically evinces that another underlying story is also being inscribed on the body (*Leib*) – the story of stress, something our omnipotent reason does not acknowledge at all. The soma becomes the actor of its own biography.

This dim zone – which is the expression of "local" suffering – becomes the object of detachment, is rejected and depersonalized, and the individual approaches it as a mere spectator. But this is only possible if the body is seen as an object, if it is considered *parte extra partes* and the symptom becomes a somatic means of existence (Boss, pp. 174-5). Disease, rather than *somatization,* implies a decuction of relationships with the world and these relationships are now directed to the body (*Körper*). In other words, the body is reduced to the organ and the person becomes prisoner of this "dissident" part. The *incriminated organ* centers the issue; there has been an *offense* against somatic integry; hence, diagnosis is sought for the jeopardized area to recover. It is through these fissures that the body becomes the actor of the unspoken word.

In a society that is willing to accept bodily disease but is not as ready to accept personal troubles, the only way out is to resort to expressing trouble as somatic disease. Thus, individuals defend their dignity instead of accepting the disappointment that may arise from communicating directly. In fact, there is an effective and inextricable concatenation between "culture" and "disease", inasmuch as nobody gets the disease they wish to have but rather the one that society allows them to have. «Nature is turned into an *instrument* by culture while the *lived body* becomes an *object*» (Lang, 1987, p. 94). In order to observe the socially assigned roles it will be necessary to *turn the body into an instrument* in such a way that the individual will not to run the risk of becoming unacceptable.

From this perspective, the existence of any given functional syndrome or psychosomatic pathology allows the individual to continue to live within normal social patterns, because this pathology has – except during crises – less of an influence on daily life than does a phobia or an obsession. The person may seek medical help, a help acknowledged both socially and at work, and if hospitalized, the person may even manage to detach from the problem and revert the situation. Furthermore, when «disease appears, the individual may reappropriate differently the parts that fell into oblivion, even destructive parts of the body, combining them anew in a more positive bodily homeostasis» (Vayssé, p. 44). It is clear, though, that this body (*Körper*) self-help reaches its own limit when the somatic process becomes destructively autonomous, i.e. when it degenerates into a carcinoma[(3)]. Incapable of identification with the body, the individual's emotions eventually turn into a danger for his self.

These patients have a precarious capacity to regulate circumstances and this does not allow them to cope with intensely affective situations; an archaic function is then elicited where body language gains overwhelming presence. The normal unpreparedness of the body dramatically turns into a state of anxiety, expressing that complex dialectic of the individual conserving with his bodiliness. «Anxiety masks our words» (Heidegger, 1965, p. 32). Anxiety pertains to a pre-categorial order of the body, unfathomable, opaque to reason.

Anxiety disappears altogether from the psychic experience, it recedes, and now – transformed – is somatically expressed. We pathetically see this in the suffocation fear of asthma or in the anxiety over death of cardioneurotic phobias. Reason, understood as reflexive conscience, is unaware of the existance of conflict; it perceives no hint of a relationship between a disorder and certain situations – it is not in a position to do so. «Bodiliness is pre-reflexive access to the world, a pathic lived experience of the world» (Lang, 1987, p. 93), which takes the burden of solving the conflict and transform any anxiety associated thereto. The body resolves everything rather in its own way: "your body and its great reason", as Nietzsche put it. These "bodily equivalents" (Lang), when replacing psychic states, express these kinds of states in a more explicit fashion. Whereas the neurotic patient

[(3)] Some authors do not consider this a psychosomatic pathology. Anxiety before death, leads these patients to use denial mechanisms, which Lang denominates «psychotic mechanisms of overcoming» (Lang, 1987, p. 95).

symbolized conflict in an organ or in a system – which allows him to curb the anxiety-related stress derived from unconscious conflict –, the psychosomatic patient can only use it to relieve internal stress[(4)].

Now, a positive or negative interest for any aspect of the body drives the person to body image modification exactly where the perceived acceptance or rejection is accentuated or removed, and in severely precarious cases, it may even come to the destruction of that body image. G. Pankow has shown that phenomena of body *dissociation* also occur in psychosomatic disorders, although here destructive areas and ways of being are totally different from those of psychosis[(5)]. In fact, a sort of compartmentalization takes place at the different developmental levels, which interferes with the process of *appropriation* of the body and reduces the body merely to flesh, the material that supports the "spirit". On the other hand, the "psyche" – now detached from the body – also detaches itself from the world, which it now treats without any affection (*alexithymia*, Sifneos) and – deprived of fantasy and emotions – it exhibits a rather cognitive "white relationship" assimilatable to mere *res cogitans*.

Marty calls this descriptive, factual modality the "operating thought", one that responds to situations impersonally and in an affectively detached way. The same modality repeats itself in bonding to others. For this reason, when the patient is with the therapist, the former describes his physical symptoms accurately and with detail, yet impersonally and with detachment. This patient is the kind of individual who operates in a concrete present level; he is unable to look into the past or future, hence his inability to establish a likely relationship between the onset of the disorder and the transformations in his own biography[(6)].

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(4) It may appen that sometimes psychologic tension vis à vis stressing situations not only shows through physical disturbances due to the instability of the autonomous nervous system or develop an organic disease, but also that it looks for inappropriate behaviors such as alcohol, drugs, pharmaceutical drugs...

(5) Whereas neurotic personality presents a *deformation* of the first experience of the body, the psychotic personality shows a *destruction* of same (Pankow, 1983). For Marty more than an unconscious conflict such as in neurosis, in this pathology there would be an important influence of emotion on the *bodily function*.

(6) For Marty, and the group of the School of Paris, operating thought originates at a different level of development of psychic defenses and the representative and symbolic capacity, which would show a structural deficiency of the pre-conscious. Marty initially uses this term of

How come it is possible to develop this kind of behavior?

A CLOSED WORLD THAT IMPRISONS THE BODY

When early needs are not fully satisfed due to disorganized maternal behavior and insufficient empathetic fostering, depressive disorganization results, which may pave the way for somatization (Kreisler e Szwec). In fact, when the mother is unable to protect the baby acting as a "screen against excessive stimulation", the baby is forced to build his own screen at an early age. However, this early solution will hinder the development of more mature and adequate psychological defenses later in life.

Therefore, as the demands for adaptation to environmental circumstances and stress are constant, the patient simply responds somatically: he remains within developmental stages where feelings, knowledge and bodily sensations are still unified rather than discriminated and verbalized (Kristal, 1974)[(7)]. Mood and feeling are reduced to somatic sensations of pain, the remnants of a closed world imprisoning the body. If affectivity evinces, as Heidegger points out, the way one finds oneself (*Befindlichkeit*) in the world and how one experiences one's body, then affectivity expresses affective atony. Emotive sensations may only be seen in the presence of nervousness, irritability, boredom, sadness, but the individual does not assign any meaning to them[(8)].

L. Kreisler and G. Szwec have called this relational indifference that places all persons together in anonymity, this absence of "anxiety before the unknown" caused by structural failure in the early processes of "attachment" (Bowlby): "void behaviour".

For Onnis and Di Gennaro, however, more than a primary inability to acknowledge and express emotions, there seems to be a tendency to avoid and smother them, as a means to prevent

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"operating thought", then "operating state" and finally a more comprehensive one "operating life".

(7) For Pankow, «it may be assumed that before the manifest appearance of every neurosis, there is a stage of body defense, the same somatized stage of defense that is frequently manifested in the course of analysis in the form of "stagnation"» (Pankow, p. 249).

(8) Unlike what happens in rare moments of cholera or crying bouts.

conflict and maintain family harmony. These are patients that keep rather superficial relations, of little emotive contact, with hypernormal adaptation resulting from strongly depending on and conforming to social demands (Marty and M'Uzan). The function of the body lesion is differentiating the subject from his environment (Mazeran), and with this, it expresses the incongruency of intersubject communication. The symptom would be a perlocutionary function producing an effect on the other[(9)].

This drives us to think that, more than any other pathology, psychosomatic disorders seem to summon the other: the *meaning* of the symptom is «to be captured by the other to whom the symptom is directed» and that it may not be conceived «from a perspective whereby the only reference reality is the individual himself» (Dejours)[(10)]: the symptom communicates a relational role with others as well as with the individual himself: the voices of everyone, the voices of the silence of others, reverberate in our own bodiliness. As G. Pankow has pointed out:

«One has the impression that a physical symptom allows the individual to put up with others, keeping the imaginary world from being warped or a regression from being the only way out. This phenomenon brings together the somatizations that often appear in classical analyses when the individual does not manage to integrate the difficulties of being the way he is with the world and with the other. Such somatization also make it impossible for the diseased to regress» (Pankow, p. 249).

A symptom is not something merely suffered, it is also somatically produced by the individual that used it by way of a strategy to adapt to interpersonal conflict. In this sense, Leder postulates a "phenomenological anatomy" that may unveil the link between events in life and the various modalities of bodiliness. The reasons and areas of influence on the body may

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(9) In fact, bodily presence implies minimum acting, and in it you may differentiate – from the semantic function – mimic or gesture expression that attest to the affective state of the speaker. The body is a linguistic object although it contains certain primary lacking symbolic formations. Therefore, following pragmatic linguistics, it is necessary to *symbolize* acting.

(10) Dejours C.: "Doctrine et théorie psychosomatique". *Revue Française de Psychosomatique, 1,* 1995, pp. 59-80. Quoted by Vayssé, o. c., p. 45.

differ, each aroused at a given point in time in a different way. Moreover, points of impact located on any given part of the body attest that the attack is not sectoral and aimed at any one apparatus or organ, but rather at the person as a whole. Rather than talking of a "functional" problem stemming from the dysfunction of a physiological function, one should say that «it is the overall function of the whole person that suffers through its points of contact with the world» (Zivadon e Fernandez-Zoïla, pp. 133-4).

Rather than looking for the *meaning* of our bodily behavior "inside" ourselves, we have to understand this behavior as constitutively "significant". An introspective analysis of my feelings does not contribute much, other than a few insignificant disorders. A bodiliness without privacy, without signification, is a dead body, lifeless.

THE BODY, AN EXPRESSIVENESS THAT HAS TO BE CONQUERED AND MADE EXPLICIT

In normal life, every individual has words at his disposal and manages them as «possible uses of his body» (Merleau-Ponty, 1945). In these patients, instead, there is a psychic difficulty they almost do not mention; every thing is normal and they have nothing to say. Their narrative structure lacks "dramatics", it is deprived of feelings and fantasies – they have an inability to express feelings and differentiate emotions and sensations. Precisely, as «emotional expression does not reach the realm of conscience, conscience manifests itself by means of the body, in the form of disease» (André *et al.*, p. 132). But what do we really understand by "emotion"?

Since Descartes, emotion has been conceived as a sudden reaction, as a bodily restlessness that makes the soul *leave* the boundaries of reason. But e-motion means, as does *ex-movere*, to move outside oneself towards the world, and to move outside the world toward oneself. Experiencing difficulties and lacking any valid achievements, emotion gets involved in ineffective resolution, *massively* bestowing other qualities to objects[(11)]. The open-ness to the world transmutates at the very time the disturbance sets on. Rather than distancing from the world the

[(11)] Merleau-Ponty refers to Sartre's theory of emotion, which he describes as an abrupt passage from pragmatic conscience to a magic attitude.

subject transfigures the world, it dislocates the habitual, familiar world, with its different strategies. It may so happen that due to intense fear, the individual will cover his eyes in an effort to run away from the meteor hurtling in his direction. The hand on his eyes does not protect him from danger, it simply denies danger by suppressing it *magically* – and this becomes an ineffective behavior.

Can we continue stating that in psychosomatic phatologies there is an inability to experience emotions? Let us rather say that when it is impossible to keep an intolerable emotional event at a distance, the self transfigures the event somatizing it, denying it as something dangerous. «Rather than accepting failure or turning back on his steps, in this existential impasse the individual blows to pieces the objective world that would show him the way (...)» (Merleau-Ponty, 1945, p. 102).

A similar phenomenon is the one mentioned by Pedinielli when he evidences how alexithymia[(12)] is associated to *coping*, allowing the individual to better manage the anxiety generated by stressing circumstances. This *avoidance of coping*[(13)] temporarily suppresses emotional response by fleeing, denying or resignating. Mc Douglas calls this non-acknowledgment "foreclosing affection".

Emotional experience also evinces «the individual's ability to express» insofar as this implies a «relation with the other» (Kaufmann, p. 177), and the various emotion abilities will match different types of expression. Hence, emotion is not an internal psychic fact but a variation of our relations with the other and with the world, which is expressed in our bodily activity, and the various emotion capacities correspond to different types of bodily activity (Merleau-Ponty, 1966, p. 66). This is precisely what the psychosomatic individual conveys. The body is not merely a screen for somatization reaction; rather, the body itself becomes the «expression of its own disorder, in a way more immediate than verbal language» (Lopez Ibor, pp. 151-2).

Linguistic inability is not a disease whose "etiology" may be identified, which would perpetuate resorting to the leap from

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(12) If psychosomatic registry shows the *offensive* aspect of pathology, that of *alexithymia* does so in its *defensive* aspect (Vayssé).

(13) Cannon (1914) posits a model of *Fight-flight* as a response of the body to stress. Later on, Selye (1956) considers a phase of alarm reaction and a second phase of adaptation or resistance, as per the type of stressing situation or whether the organism is a weak type or not.

psychic to organic. One cannot say that what is not communicated verbally or what is communicated somatically imply "acting out", nor can the somatic lesion be considered an *anti-symbol* beyond what is interpretable[(14)].

Then, can it be said – as Marty and M'Uzan did – that psychosomatic sympomts are *mute* as they do not symbolize affects like they do in hysteria and that instead they are the effect of emotions which quality and intensity alter vital balance and finally end up in a dysfunction or a somatic lesion? Not exactly. Verbal language, like any other language, does nothing but develop and specify the essential language that the body is. Before the Spoken *Cogito*[(15)], before the 'cogito' has turned into a statement, there is a *Cogito tacito*[(16)] or lived experience of oneself by oneself, that is, an indeclinable subjectivity that is identified with our bodily existence.

«Primarily, there is no language on *the body. Rather, the body itself is its very first language»* (Bousquié, p. 65).

The body far from being a sheer instrument of expression and representation, manifests itself as a speaker, and furthermore, a first signifier. In this primary bodily experience, Merleau-Ponty finds an *intention to signify* which he dubs "speaking silence" (1964). In this sense, «symptoms are voices of the body rather than simple medical indicators» (Vayssé, p. 156). This is why only by opening up this *symbolic space* of the body, will it be possible to take back up the working of disease that made a *testimony* of the symptom.

Despite the fact that this silent conscience – this "significant intention"[(17)] – sets in motion and animates all expression

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[(14)] The various psychosomatic theories consider that more than a repressed fantasy there is a lack to symbolize conflict. However, even though the contents of discourse remain as *uninterpretable*, "ignorance" that marks the history of these subjects organizes a discourse not from that which is *repressed* but rather from that which *may not be cognited*, because the former circulate as an enigma in the chain of representations.

[(15)] It is only known when we are threatened by limit situations, such as anxiety for death or the look of the other on himself (Merleau-Ponty, 1945, p. 462).

[(16)] Cfr. Merleau-Ponty M.: "Phénoménologie de la Perception", p. 62. This mutuality between perceptive and motor express accurately the notion of "motor formula".

[(17)] The *cogito tacito*, that *silent conscience* is denominated by Merleau-Ponty in "Signes" as "mute significant intention".

experiences, it only allows us an overall, inarticulate perception of the world, it only has an evanescent command of itself and the world; it is still a void to be filled with words. This expressiveness is an incessant excessive truth that wishes to be communicated; it still has to «be conquered, fixed and made explicit by perceptive exploration and speech». «The *Cogito tacito* is *Cogito* only when it has expressed itself» (Merleau-Ponty, 1945, p. 463). And it will be the world, amongst «all expressive operations, the one to sediment and constitue an intersubjective acquisition» (p. 221).

Now, the function of *expressing* is not only communicating with speaking subjects, but also *taking possession of meanings* (*ibid.*). Precisely, this is what is compromised in so-called psychosomatic patients. Therefore, it is not just a matter of listening to "*speech by the body*" but also to *embody speech*. It will be the "miracle of expression"[(18)] that will defeat the censorship that they usually entangles and oppresses these phenomena, the censorship that considers that they are not even worthy of being uttered.

In this sense, any psychotherapy will always strive to capture the instant when a certain silence becomes a word and the word, silence, so that language will not be the mask concealing the self but rather most valuable witness.

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(18) As Merleau-Ponty (1945) points out.

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