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Narcissism and the Problem of Hypochondria.

Autor: Charles Hanly

I propose to examine two concepts of narcissism by mean of a consideration of cases of hypochondria. Freud conceived of narcissism as a first, primary, phase of libido and, as development takes place, as a special developmental organization of it, the ego ideal. Narcissism is the first of libido because the mind of the infant only slowly develops the capacity to differentiate between self and object (Freud, 1914; Ferenczi, 1913). Thus the first organization of libido is primary narcissism even though the beginning of the capacity to differentiate subject and object is simultaneously set to work by the infant's experience of hunger which brings about a differentiation between hallucinatory images that do not satisfy and the object that satisfies (Freud, 1895) – the first beginnings of our long and, often enough painful, education to reality and the pursuit of pleasure through object love. Here we can also discern the beginnings of a grade within the ego which gradually develops into the ideals of conscience, the demands of moral imperatives and critical self-awareness in which the differentiation between subjectivity and objectivity is grounded. Conscience is largely fueled by aim inhibited narcissistic libido and the adult residues of infantile omnipotence that become ego ideals and the imperatives of conscience (Hanly, 1984); the ego's striving for real need satisfaction and knowledge of reality is fueled by object love. Freud considered narcissism and object love to be two interacting organizations of libido as did Grunberger (1975). Freud (1914) differentiated these two organizations and (1924, 1926) sketched out the structure and dynamics of

a continuous line of development in the organization of narcissistic libido. But, in Freud's theory, narcissism and object love are forms of sexual libido. Sublimation involves a conversion of object libido into narcissistic libido, an increase in one is at the expense of a decrease in the other (Freud, 1926).

Kohut (1971) followed Freud in also discerning a line of narcissistic development but took an additional step in declaring it to be independent of object libido. This hypothesis enabled Kohut to postulate the diagnostic category of narcissistic personality disorders differentiated from obsessional and hysterical neuroses each with an aetiology of its own. Narcissistic personality disorders are caused by parental deprivations during stages of narcissistic development; the classical neuroses are caused by object relational sexual trauma or conflicts arising from sexual development. Kohut (1977) took the decisive step in the construction of self psychology by adding the hypothesis that narcissistic libido is not only temporally primary as Freud (1914) had affirmed, it is psychologically primary in the sense that, for example, the Oedipus complex becomes a pathogenic organization and dynamic only because of a parental failure of mirroring and of providing an object suitable for idealization. This theory of the Oedipus complex attributes its potential for pathology to failures in the object relations provided by the parents. Here self psychology and the relational psychology that has largely replaced it are in agreement. Conceptually and logically neither self psychology nor relational psychology can be true, if the classical theory is true since they are contraries i.e. both cannot be true.

I propose to explore the question as to which theory is more probable by exploring clinical material drawn from the analysis at four times weekly of two patients who had significant hypochondriacal symptoms. I choose patients with hypochondriacal symptoms because of the importance such symptoms have in the self psychological nosology of the narcissistic personality disorder (Kohut, 1971). But before doing so let me first briefly consider three psychoanalytic terms that are central to the clinical description and understanding of the somatization involved in hypochondriacal symptoms in order to be as clear as possible about the "leap" from the psyche to the soma which remains as obscure, puzzling, yet obviously occurring, as the "leap" from the soma to the psyche. These terms are "affects", "somatization" and "symbolization".

Affects

I shall work with the idea that an affect is an instinctual impulse that has encountered an internal or external barrier to its gratification or has overcome such a real or imagined barrier. Feelings of anger, hate, frustration, inadequacy, shame or humiliation caused by disappointed libidinal or aggressive wants, among which are narcissistic wants, occur when internal or external barriers to gratification win out. In contrast, affection, gratitude, admiration, joy, triumph, pride, exultation, hubris, elation, contentment and equanimity appear to be released by overcoming an obstacle to the satisfaction of an instinctual want. Consider, for example, the joyful, triumphant caper of an Italian soccer player or a Canadian hockey player who has just scored a goal. Given the fundamental place philosophers from Plato (Philebus) to Mill (1863) and Freud (1900) have assigned to pleasure and pain in human motivation, we can, perhaps, treat the group of negative affects as varieties of pain and the group of positive affects as varieties of pleasure. However, we must make an exception of signal anxiety because of its special role in identifying danger and external impediments to satisfaction and in setting in motion internal impediments. Anxiety is involved in the causation of defensive somatizations, but the somatizations may fail giving rise to a more generalized anxiety state. For example, when a patient of mine suffered thoracic pain and numbness, he would also experience diffuse anxiety about having a heart attack. The anxiety had more than one source: he was anxious about being in the care of a non-medical analyst and was testing my confidence and composure; he experienced anxiety of infantile origin about the love of his mother which he only felt when he was ill; he had anxiety about his phallic, competitive strivings and about his own professional competence. The anxiety about his physical health, of which he was conscious, was painful but it was a tolerable substitute for the transference anxieties. Other patients may fall into severe, diffuse anxiety

states along with somatizations. They do not develop secondary anxieties on the basis of their somatic complaints; rather, the anxiety overflows the somatizations giving rise to objectless dread which often enough causes dissociations that drain away all affect leaving behind an empty, uprooted, disturbing feeling of quietude – the opposite of a feeling of disorganized elation.

Affects like thoughts may be conscious or unconscious. This view is consistent with Freud's (1923) understanding of negative therapeutic reactions, "... as far as the patient is concerned this sense of guilt is dumb; it does not tell him he is guilty; he does not feel guilty, he feels ill" (pp. 49-50). We will need the hypothesis of unconscious affects when considering psychosomatic symptoms. When somatization substitutes a physical symptom for a psychic trauma it renders the affects unconscious leaving the physical symptoms to take their place. Affects are especially amenable to this conversion because of the psychological and physical duality of their expression. As McDougall (1989) put it, "Emotions are essentially psycho-somatic" (p. 95).

Somatization

Nothing more eloquently testifies to the efficacy of the psychic unconscious than psycho-somatic symptoms. We are at once reminded of the evocative title of a major work on the subject Theaters of the Body (McDougall, 1989). In ballet, the body evokes affects by means of motion and gesture. If the body can be a theater in which psychic conflicts are produced, it is because, as Freud (1923) said, "the ego is first and foremost a body ego..." (p. 26). Freud's first investigations into the nature of hysteria, made it clear to him that disparities can exist between the body ego and the body. One man may experience a steady stream of largely preconscious, but sometimes conscious, sensations that communicate the beneficent adherence of his genitals to his body sustaining an implicit sense of wholeness and competence, while another may experience sensations, which he experiences as emanating from his genital zone, that arouse in him an embarrassed, anxious impression of a hole, a phantom absence, where he knows his genitals to be. The castrated genital, of the negative Oedipus complex, belongs, like the phantom limb, to the body ego.

However, we must not forget that the living anatomical body is itself, the source of the psychic life in us that causes disturbances in our experience of our bodies. (One could equate Freud's idea of the body-ego with Merleau-Ponty's (1945) corporeal schema, a concept which also underwrites the potential for ambiguity in the living body as distinct from the anatomical body, if Merleau-Ponty had not subjected the anatomical body to a phenomenological reduction. This reduction involves an attitude of evasion toward two realities that we avoid at our peril: (1) the anatomical body is itself organic, alive and ontologically prior to the mind (2) the anatomical body is itself the source of that very psychic life that causes disturbances in our experience of our bodies.) The diagnostic understanding of psychosomatic symptoms requires a constant attention to organic causes, to psychological causes and to their entwined conjunctions. Freud's (1905) formulation of Dora's somatic symptoms is a paradigmatic integration of organic, drive, object relational and historical factors. It is because the ego is a body ego that the psycho-somatic ambiguity necessary to somatization is possible. This potential for ambiguity results from the ability of one part, or organ, of the body ego, once the requisite physical conditions are present, to mimic another part, or organ, of itself (as in Dora's nervous cough) or of another (as in the male with castration sensations) by means of a redistribution of functions. In this way, the infant's sucking on its thumb, fingers or blanket can come to substitute for and refer beyond itself to the pleasure of the breast

Symbolizing

Symbolizing consists of making one thing stand for, refer to, signify or represent another by convention or on the basis of similarity. Thus memory images may be used to stand for individuals, species, and general properties of things or events (Berkeley, 1710) by exploiting an obvious similarity

while recognizing an obvious difference. This symbolizing function sustains thought without language as found in primary process thinking. Plato already knew that while images are natural symbols, words in a language are conventional or artificial symbols. One can easily appreciate the economy and efficacy of the symbolizing function of language by imagining ourselves actually restricted in the fashion of the man lampooned by Johnson who, wanting to sell his house, carried a brick from its walls about the town to demonstrate the substantiality, charm and convenience of the house to potential buyers. A few accurate descriptive sentences of scarcely any weight at all would have served much more conveniently and more efficiently as well.

We can approach symbolism in psycho-somatic symptoms via Freud's (1894a, 1894b, 1895, 1926) use of mnemonic symbols in his explanation of hysterical conversion symptoms and in his later explanation of anxiety symbols (Arrive, 1986). The idea of symbolism in hysterical conversion symptoms was further developed by Groddeck (1916), F. Deutsch (1939) and Engel (1968). Conversion symptoms may symbolize the unconscious painful thoughts and memories the repression of which they make possible by becoming the vehicles of their pain. McDougall (1989) introduced the important and helpful idea of archaic hysteria which opens the way to an understanding of pre-verbal or, even, largely pre-mental trauma that have no other pathways to representation than the rudimentary body ego by means of disturbances in its states and in its elementary infantile functions. In this symbolization we can detect the handiwork of the body ego. Defective, injured or amputated limbs can function as castration symbols. The fear and pity they arouse can mask castration wishes and anxieties.

As noted above, first rudimentary symbol making occurs in the oral stage of infancy as the thumb or its equivalent provides voluntary pleasurable sucking to the infant as a substitute for the greater and more satisfying pleasure of the breast or bottle. Here too similarities are at play allowing the thumb to symbolize the breast because of its physical suitability for sucking and the pleasure it affords. We cannot speak here of analogical thinking but we can speak of two analogical thought precursors: 1) the symbolic associative linkage between the impressions of two similar yet differentiated objects through the substitution of one for the other and 2) a primitive intentionality as the incomplete pleasure of the thumb refers beyond itself to the more complete pleasure of the breast. Symbols, their uses and their meanings may end in poetry but they have their beginning in the involuntary, instinctual life of the body.

Two Clinical Cases

Mr. B was a successful young bachelor accountant who lived in such constant, yet vague fear of some kind of wrongdoing that he was on the verge of abandoning a successful career for which he was well suited. He ruminated painfully about some ruinous error of his that would undermine the finances of a client. His sexual confidence had faltered at least as much as his vocational confidence. From time to time his widowed father came to visit him. On these occasions, while still in his office, he would experience an increase in his depressed feeling of depletion and exhaustion along with rheumatic like pains in his right "gimpy" hip. Medical consultations had offered him no relief. During his sessions, he would complain that his father always failed to do the one thing that could make him feel better – draw a tub of hot water and have it waiting for him upon his return to his apartment, the hot water would ease the pain in his leg and that would ease his depression. "Why", he would rhetorically ask, on these occasions, "could his father, who had nothing else to do, fail to offer such a small kindness?" His associations would drift to memories of his dead mother who had doted on him as the youngest and most promising of her children. To my interpretation, that he wished that she was still alive and able to minister to his needs, he responded with memories of , what struck me as, her possessive attachment to him sometimes accompanied by guilt laden regrets about his failure to attend her death-bed, as his siblings had, because he had been occupied with business commitments. I would make interpretations such as, "And now you want to bring her back by having your father take her place". These interventions released in Mr. B various complaints about his father's shortcomings, centred on a narcissistic complaint that he had often

longed for but had never received his father's real approval. This lack of fatherly approval, he felt, was the source of his depression, his lack of self-confidence and his expectation of humiliating failure. Thus the psychosomatic symptom served two narcissistic needs: to find in his father a substitute for the attentions of his dead mother and to gain from him, in this way, the admiration his mother had so abundantly and freely bestowed on him.

But in the life of Mr. B this apparent narcissistic developmental deficit, caused by a paternal self-object who had failed to mirror him, disguised a conflict. The provocation of what he, at least, experienced as his mother's preference for him, even over his father, left him feeling over-stimulated, incompetent, grandiose and guilty by turns. He guarded against his negative oedipal feelings (including his fear of his mother and a latent rage against her) by putting his father, rather than himself, in the place of the mother. Included in the phantasy behind the gimpy hip was a narcissistic and aggressive turning of the tables on his negative oedipal father animated by a wish to castrate him. His throbbing, painful hip was a "displacement sideways" of his castration anxiety.

In this case, the somatic symptom symbolized both his castrated body-ego and its reversal, the castration of the father. He was not aware of castration anxiety and feelings of phallic ruination or of castration wishes; instead, he was distressingly conscious of pain in his "gimpy hip" with which his ego had formed a friendly, hypochondriacal relation. Relief came from a desomatizing retrieval of these repressed affects into the transference where they eventually made a vigorous appearance. One day he heard his secretary tell him that a Mrs. Hanly had called asking him to come to her home as soon as possible to help with a serious financial problem. As he attended to other matters during the afternoon, he was distracted by thoughts of what I might have done to cause a financial crisis for my family and how he should respond to my wife's request for his help. At the end of the day, he decided to make a visit to my home. When he picked up the secretary's note of the call with the name, phone number and address, he was astonished to find a name that did not even sound like "Hanly". Mr. B's unconscious, anally regressed, castration wishes found their way into a transference enactment.

Since I had no waiting room for my university office, patients came directly to my door and knocked on it. I became aware during this stage of the analysis that Mr. B was coming a minute or two early every day. I was somewhat concerned about being nit-picking, would I not be ungenerously chiding working alliance zeal? But when it persisted, I decided to bring this slight deviation from the frame to his attention. When I rather tentatively brought it up, he trembled and turned pale; he felt accused of a crime; he had wanted some of my time for which he did not have to pay; he had been forcing me to give up my time by stealth; he had been stealing from me. I interpreted to him that this small amount of time represented to him a substantial chunk of me. It was a trivial enough alteration of the frame on the surface but the symbolism of the action and the previously unconscious affects blossomed into conscious elaboration. These transference enactments, their analysis and working through brought about the desomatization of his gimpy hip. There may have continued to be some residual organically caused discomfort in his hip but, if so, it was not sufficient, in itself, to any longer demand his attention. When the patient married he no longer needed his father or his wife to draw baths to soothe his leg; he was happily successful in his career.

Ms. C was an unmarried professional student in her mid-twenties from a religious family. The two things she most wanted from her analysis were to be cured of severe acne that left her face red and scared and to find relief from recurrent false pregnancies which plunged her into severe anxiety and panic. Is acne psycho-somatic? I do not know. Ms. C. experienced it to be "psycho-somatic"; for her, it was the shameful, visible stigmata of her sinful soul. Perhaps, like the angioedema of Engel's (1968) patient, the acne was caused originally simply by hormonal changes of puberty while sexual conflicts contributed to its severity and its failure to clear up spontaneously. At the time, I felt that her demand expected more from me than I could promise to deliver. I said nothing, and wondered what might happen if her analysis

enabled her soul to be less sinful. Ms. C boasted of her liberated sexual attitudes despite her false pregnancies. Missed periods, changes of appetite, nausea, stomach swelling and diffuse sensations convinced her, and some physicians prior to test results, that she was, indeed, pregnant. She would become immobilized with panicky moral dread by the prospect of having an illegitimate child, although she would also masochistically “nurse” the panic by delaying a pregnancy test.

Ms. C’s sexual preference for blacks was a rebellion against her father’s red neck, prejudicial attitudes toward them. Her sexuality had a child-like playful, possessive, teasing and domineering quality, but her practice of presenting herself late at night at the doors of hotel rooms of black jazz musicians who were unknown to her courted danger and aroused concern about her safety. This aspect of her sexuality was gradually replaced by an affair with a married professor at the university. The playfulness and wit of her sexuality in this relationship of several months found expression in her turning her lover’s penis into a puppet, named by a pun on his name which suggested “little pisser”, for which she knitted a diminutive ward robe in which he was dressed during clever dramatizations of spelunking and other adventures of her diminutive hero. As she became aware of the transference meaning of her romance, she broke off the relation, became increasingly disinterested in sex and, eventually, succumbed to a period of frigid celibacy. She upbraided her analyst for this pathetic achievement of more than two years of analysis, “Analysis is supposed to cure frigidity not cause it”. However, she was able to acknowledge that she had never known orgasmic genital pleasure and that her sexual liberty only overrode and had not altered her frigidity.

My interpretations were guided by the idea that her apparently liberated sexuality was a counter-phobic denial of her real anxieties. Although she initially repudiated the interpretations based on this idea, she did so with witty, ridiculing and derogating scenarios of the failings of her “little Freudian analyst”. She gasped with astonished recognition when the repetition was pointed out to her, that she was playing with me as she had before played with the penis of her professorial lover. There followed a period of working through her transference which released in her dreams of the Oedipal father to whom so much of her libido had remained attached along with a gradual blossoming of genital sexuality and her eventual choice of an eminently suitable partner.

Her false pregnancies had conflicted causes. In her phantasy, she was pregnant with a black baby. This phantasy was an attempt to wreck a humiliating revenge upon her father for a grave narcissistic injury that had set her against him when she was an oedipal girl and a punishment of her “clandestine” sexuality that would bring down upon her head, once more, his indignant wrath and rejection. As she worked through the affects bound to this phantasy and its motives and acted out her oedipal transference wishes, in an affair with a professor, her false pregnancies came to an end. This development assigned to the analysis the task of adequately resolving her intertwined underlying narcissistic and oedipal conflicts, including, especially, her oedipal wish for father’s baby. This work was sufficiently accomplished to permanently remove the symptoms and to enable her to marry and to have real pregnancies with a man she loved.

Sometime during the last phase of her analysis, Ms. C’s acne completely cleared up. The acne may only have been an organic symptom of organic causes; Ms. A’s view of it, as the visible sign of her hidden sinfulness, may have had only a meaning or interpretive and not a causal relation to it. If so, it would have been similar to a symptom of Mr. D., a patient who believed that a growth on his chest was the first stage of his transformation into a woman, a transformation that would end in his death by cancer. When the tumor was surgically removed it was found to be benign. Mr. D’s latent homosexual wishes and castration anxiety may have had nothing to do with the causation of the tumor. What became apparent was that unconscious homosexual wishes and castration anxiety became associatively linked to the visual, tactile and kinesthetic sensations caused by the tumor giving rise to Mr. D’s morbid beliefs about its nature. In these cases, the meaning is fastened onto independently occurring physical conditions on account of their suitability. If so, they are the same as the dream work when it preserves sleep by

constructing a dream scene that provides a satisfying “explanation” of a loud noise, for example, when an oedipal girl dreams that a vase given to her mother by her father has crashed to the floor. What is heard in the dream is an interpretation of the sound heard; the visual image interprets it but does not cause it. And what it reveals is not anything about the nature of the real noise but something about the dreamer. Unconscious processes hunt about in the body for anything that can offer a means of discharge of affects without having to experience their quality. The only interpretation, I made of the acne, on the few occasions when it made its appearance in Ms. A’s associations, focused upon her feelings of sexual shame.

There were more obvious links to the causal work of the psyche upon the soma where the false pregnancies are concerned. The physical changes and sensations Ms. A experienced were not caused by impregnation, although there must have been sufficient organic compliance. The analysis indicates that the symptoms were linked to an unconscious oedipal sexual wish gone sour and vengeful on account of a narcissistic injury which had made relations with black men overwhelmingly desirable and dangerous. These conflicted drive demands brought about some of the bodily changes of a real pregnancy even in the absence of the necessary organic causes. The connection between conflicted wishes and anxiety over the hostile affects which emerged in the transference became clarified, the affects were psychologically elaborated, the somatizations of the false pregnancies ended. By discovering and mourning the loss of the love of her father in childhood, Ms. A was able to give up the rage against him aroused by a narcissistic injury. In this way, she liberated her sexuality from the need to use it to punish her father and herself and restored her ability to love a man whether black or white for his sake and her own.

The analytic process that brought this improvement about did not consist of tracing associations back from the details of the psycho-somatic symptoms. It consisted rather in following up and interpreting the inter-related associative linkages to current unconscious phantasies and memories of her sexual and narcissistic struggles with their attendant affects. For example, when she reported her late night visits to the hotel room of black jazz musicians whom she had met casually at a jazz bar, I would offer her transference interpretations such as, “You want me to be jealous and concerned about you; you believe that I am not; and you don’t want to care whether I am concerned or not”. She could not bear these affects of jealousy and anxiety in herself. This process eventually brought forth the phantasy of having a black baby and the traumatic memory of her sudden loss of her father’s dotting love in her fifth year on account of difficulties she was having adapting to school. At that time, during her Oedipal romance with her father, after he had always indulged his only child and allowed her to wrap him around her little finger, she had been humiliated and devastated by his raging denunciation of her because of her misbehaviour at school and the shame it caused him. She was an only child and was having great difficulty adapting to life with siblings. She took flight into a regressive negative oedipal alliance with mother against father.

Her symptoms gave disguised expression to her wish to have a black baby with its conflicted Oedipal and narcissistic motivations. They did not symbolize the meaning of the wish in the way in which words in a language name that to which they refer. They symbolized by a kind of pantomime or anatomical pictography with censored elements. The symbolization was incomplete. A wish to have a baby is symbolized but the colour of the baby is left mute as are the motives for the colour and for the baby’s illegitimacy by the psycho-somatic symptoms. For the colour of the baby, one has to rely on considerations of paternity, “with whom did Ms. C have unprotected sex”, we may ask. But this question is also naïve and misleading if, as a result of a prejudicial realism, it assumes genital sex when an unconscious phantasy of oral impregnation may have been at work. The wish at work in the formation of the symptom receives its definition from the unconscious phantasy that organizes it. It is this phantasy along with the memories and affects from which it, itself, originates that eventually tell the story and in the affectively charged telling dissolves the symptom.

Reflections

I have emphasized hysterical somatizations in my presentation because it is with them that symbolization more clearly and unambiguously enters into the picture. It is not because I wish to disregard the non-interpretive factors in therapy, or to underestimate them. Nor do I wish to disregard pre-verbal trauma. Any trauma during the early oral phase will be non-verbal. However, these traumas may well involve rudimentary psychic elaboration. Philosophers have long acknowledged (Hobbes, 1651) thinking by means of images which can proceed without words and before language acquisition. Thinking by means of images according to the rules of displacement and condensation is characteristic of primary process thought (Freud, 1900). As soon as there is a capacity to remember, psychic representation, elaboration, signal anxiety and its consequences can also occur. Clinical evidence of very early representation of trauma by means of memory images is difficult to come by but some exist and the derivatives of such very early representations become more easily apparent in free associations (Grunberger, 1975). Theoretically, if the thumb of a sucking infant can acquire the intentionality of representation, memory images of rudimentary kinesthetic sensory experience can also have intentionality. The causal links between libido and reproductive processes in woman were also indicated by the analysis of Mrs. E. who began her analysis after an attempted suicide in her late thirties. She had always suffered severe pre-menstrual symptoms which accompanied periods at two rather than four week intervals. She had tried every available medical remedy without any benefit. But as the analysis progressively uncovered a series of childhood traumas, worked through her suicidal depression and sexual frigidity, the intervals between her periods gradually became normal as did her pre-menstrual discomfort. The influence on subsequent psychic development of traumatic events when the body ego is still much more soma than psyche should not be underestimated. In my view analysts should be open to the indications of these primitive psychic representations and their interpretations because projections, denials and later repressions may be causing the unavailability of the original representations and their derivatives.

Technically, I have found that in order to eventually bring about significant amelioration in cases where oral trauma is involved, it is important to facilitate a movement of the transference forward to the oedipal level.

Theoretically and clinically, I find Schur's (1955) developmental model of somatization helpful and, in particular, its notions of a gradual desomatization, attended by the risk of arrestment and deficit as the psyche develops, and of resomatization caused by later trauma or conflict giving rise to resomatizing regressions. It is coherent with and offers a way of integrating the homeostatic (Alexander, 1950) and symbolic (Deutsch, 1939) models as well as other contributions such as those of Greene (1990) and McDougall (1989). Schur's hypothesis reminds us that the body ego of each person has its own history and, perhaps, that hypochondria reminds us that the balance between what is soma and what is psyche in man is variable until the final somatization of death.

Conclusions

From the evidence, both patients suffered narcissistic injury, although the nature of the injuries was different in each. The narcissistic injury of Mr. B was, in a sense, self-inflicted as a defense against his guilt for having gained an oedipal triumph over his father while also deriving from the frustration of his negative oedipal love for his father and his longing for his approval even of the hidden ambivalence of his positive oedipal rivalry. The narcissistic injury of Ms. C was the result of a traumatic reversal of her father's attitude toward her when she disappointed his own narcissistic need to have a child about whom he could proudly boast. His bright, charming only child had failed him when, in her first coming out in her parochial kindergarten, she turned out to be a serious discipline problem for the school. He turned in rage against her for this betrayal of his high hopes for himself in her. She retreated into a cold enraged hatred of him; her oedipal romance was shattered; she retreated into an alliance with her more educated and refined mother to exile him from her world. However, in both Mr. D and Ms. C the narcissistic

injuries that led to the hypochondriacal symptoms were intrinsically both narcissistic and sexual/object libidinal. Mr. D was terrified by his oedipal victory; Ms. C experienced her father's turning against her as both an assault on her self-esteem and on her oedipal romantic phantasies. This evidence suggests that narcissistic libido and object libido are intrinsically interactive trends of human sexuality. If so, self psychology has enriched our appreciation of the part played by narcissism in psychic development with its delineation of the phase appropriate needs for fusional, mirroring and idealizing narcissistic attachments to suitably empathic objects. The error of self psychology has been to sever narcissistic from object libidinal development and, thereby, disconnect their interaction. This disconnection was "repaired" within the theory of self psychology by reducing the aggressive and sexual drives to "disintegration products" of what appears to be a somewhat spiritualized primordial narcissism investing a nuclear self. The demands of aggression and sexuality have been denied their fateful contributions to what is best and what is worst in human nature. The derogating dismissal of the drives has been taken over into the successor of self psychology, relational psychology. Sometimes, even in our theorizing, it is necessary to return to what has gone before in order to go forward. Sometimes novelty can lead to error and tradition can preserve truth. In my view, therefore, it is classical drive theory that provides us with the best theoretical orientation available for understanding therapeutically the causes of the physical complaints that symbolize troubles of the soul.

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