ISSN: 2584-0142
PSYCHOPEDIA JOURNALS
International Journal of Interdisciplinary Approaches in Psychology (IJIAP)

Somatizations: The Lack of Balance Between the Life Drives and the Death Drives

Dr. Noga Levine Keini, *Ashkelon Academic College. School of Social Work, Ashkelon, Israel*
keini_e@walla.com

Abstract: Physical symptoms are primarily encountered in patients diagnosed with conditions such as conversion disorder, anxiety, masochism, hypochondria, psychosomatic illnesses, and depression. Most etiological explanations for the emergence of these symptoms point to a disruption of the balance between the life drive and the death drive. However, the death drive is mainly experienced by individuals at the beginning or end of life. This explanation aligns with the recognition that psychotherapy and psychoanalysis may assist individuals with mild imbalances, but in cases of severe imbalances, where the influence of the death drive is strong, biological treatment cannot be avoided, and psychoanalysis is not suitable.

Keywords: *Symptoms, Conversion, Anxiety, Hypochondria, Psychotherapy*

1. Introduction

Somatization represents a neglected field, situated at the blurred boundary between psychiatry and medicine. Once diagnostic classification developed, somatoform disorders included somatizations, conversions, hypochondriasis, and psychogenic pain. However, there remains a lack of psychodynamic clarification regarding these disorders, both in the literature and in psychoanalytic articles. Much remains hidden from view. It is known that disturbances in bodily functions and health, related to psychological factors, manifest in conversion hysteria, anxiety neuroses, masochism, hypochondria, and even depression.

In this article, I will focus on the realm of instinctual drives, rather than other important areas. I will not delve into significant fields such as self-psychology or object relations. Such a focus will help us examine the death drive and will also lead to therapeutic conclusions.

The concept of the death drive is controversial. Today, some entirely dismiss it, while others examine it from philosophical or mythological perspectives (Lowenthal, 1983). However, from my clinical experience, I understand that the contrast between the life drives and the death drives is of paramount importance in encouraging physical symptoms. Perhaps it is easier to understand this with the comparison between commission and omission, where the error stems from the life drive, while the omission is caused by the death drive.

1.1 ***The Death Drive***

The identification of a morbid syndrome and its definition as a regression from healthy life due to the pressure of the death drive is based on a clear distinction between this drive and aggression, including a person's aggression against themselves. This is because a person's aggression against themselves or their health may arise from the life drives, and I will return to this point.

The death drive is an innate force, first revealed in the form of a search for non-existence. It resonates with the cry of the infant in distress (the life drive), a voice that also expresses the infant's wish to return to the mother's body, to a state of symbiotic containment that negates its separate existence (the death drive).

At the second level, we recognize that individuation involves separation and loss of the object. Here, the death drive tends to negate the loss and draw towards a renewed unity with the vanished object, as observed in anaclitic depressive states. At the third level, we encounter feelings of guilt regarding the separation that led to the loss, to which components of the Oedipal conflict are added, in which aggressive fantasies intensify.

In stages two and three, the death drive is entirely repressed, and only at the fourth stage does it reappear. For example, in cases of trauma or extensive psychological trauma such as shock on the battlefield, during a disaster, or in suffering caused by terminal illness or degenerative aging (Lowenthal, 1983).

Freud viewed all drives as products of the amalgamation of the two primary forces, Eros and Thanatos, the life and death drives. However, even in his later years, he did not present an answer to the problem of the relationship between the pleasure principle or reality and these two opposing primary forces (Freud, 1926). Freud formulated his psychoanalytic doctrine from various opposing systems: full or empty, present or absent, self or not self, impulse or restraint.

In this spirit, Green suggests not to attempt to discuss the death drive at all without simultaneously considering the life drive (Green, 1986). According to Freud's assertion that the aim of Eros is to connect, unite, and preserve, as opposed to the death drive that urges to disassemble and destroy, Green indicates that mental activity links the distinction in the object

with the relational investment in it, while the death drive diminishes this investment (cathexis withdrawal), thereby pushing towards separation and disintegration. Green refers to this as 'negative narcissism' or 'narcissism of death'—thus, the death drive, in his understanding, is an 'anti-drive.'

Rosenfield (1984) sees 'destructive narcissism' as acting against all libidinal object relations and even against the libidinal parts of the self. Oppositions dominate all early positions towards the object: whether the good mother invites idealization and an uninterrupted attachment, a trap where the aspect of her 'bad enough' nature releases the infant and allows for separation and mourning work.

I have slightly deviated from the drives to the realm of object relations. However, are the drives innate? Primary? Not necessarily. Kernberg (Kerenbeg, 1984) writes that primitive object relations are those that are organized to constitute effects and drives. In this spirit, other authors state: the death drive is merely an internalization of an early sadistic object. It can be agreed that there is no split between drive and object, and that each contains aspects of enhancement and weakening, attraction and rejection, health and illness, life and death. Positive aspects in the representation of the object coalesce into an ideal of the self that radiates basic trust and autonomy. This is a very ancient process, just as the repression of the death drive is so early that it is considered primary, meaning before the formation of the structural framework. Therefore, it cannot be said that there is a conflict between the life drives and the death drive.

Nevertheless, the death drive, or more precisely increased tension between it and the life drives, may impair perception, movement, and even ego functions. Ego functions, which are usually autonomous and free of conflict. At times, the body is preserved, but the ego disintegrates to the point of psychosis: at the other end of the spectrum lies the retreat of an individual who was mentally healthy until a terminal illness brought them closer to death.

1.2 *Hysteria*

Dora arrives at Freud's clinic with shortness of breath, migraines, cough, abdominal pain, and vaginal discharge. She also complains of feelings of confusion and palpitations. Freud refers to these phenomena as "the results of the mysterious leap," meaning the leap from the mental to the physical. He interprets this as erotic responses that, due to trauma, undergo transformation (conversion). Freud also notes hysterical identification and depression. Many years later, Freud again mentions identification, this time in relation to patricide and death: “The early symptoms of (Dostoevsky) in the form of death-like attacks.” Freud interprets it

thus: "You wanted to kill your father, and now you yourself are the father, but a dead father." This illustrates the usual mechanism of hysterical symptoms (Freud, 1928).

Here arises the question of whether the conflict underlying the conversion arises from fixation at the Oedipal stage of development, as a continuation of fixation in the oral stage? Or perhaps the source lies with a hysterical mother? The very link of hysteria with conversion conceals and complicates the clarification of the process, as the background is not identical (Sugerman, 1979). Generally, true conversion symptoms are rare today and predominantly appear in the battlefield, where one can sometimes observe hysterical paraplegia, blindness, and other symptoms. Each such symptom indicates inadequate repression, splitting, and even dissociation. Over the years, symbolic bodily symptoms have gradually shifted to direct signs of anxiety and phobia, and Freud coined the term 'anxiety hysteria' in his time.

Example

Danit (a pseudonym), 34, seeks treatment for asthma, extreme thinness, and frequent diarrhea. She speaks theatrically about various diets she employs. Gradually, severe narcissistic traits, an ambiguous sexual identity, and intense expressions of hatred are revealed. Danit constantly idealizes a lover from her youth while simultaneously expressing venomous hostility towards men. She displays adoration for herself, her qualities, and her body parts, alongside intense hatred for her parents.

At certain periods during treatment, Danit is entirely preoccupied with the headaches that afflict her, while almost completely ignoring my presence. It was not difficult to discern that her "egoistic shell" and aggression cover a depressive core. Conversely, the various symptoms she suffered from also held symbolic significance. Her gasps for breath were akin to a cry for help, and the diarrhea she experienced was an attempt to contaminate her surroundings to purify herself.

Soon, Danit becomes very cantankerous and critical towards me; however, she convinces herself that she evokes many warm and positive feelings in me. The asthma triggers a memory of breathing difficulties associated with an important and beloved figure from her childhood. Therefore, it can be said that the asthma was not merely psychosomatic but a product of conversion identification. Danit was preoccupied most of the time with the effort to defeat and subdue me. Without our having progressed towards insight on this matter, she terminated the treatment. Despite the complex pathology from which she suffered, Danit exemplified how hysteria is the first syndrome in the continuum of somatoform disorders. However, the picture is much more complex, as there are hardly any isolated conversion

phenomena. Conversion symptoms thus indicate early deprivation phenomena that hindered the healthy formation of the life drives, self-existence, sexuality, and aggression.

1.3 ***Anxiety***

From the outset, Freud understood anxiety as libido that had changed its form. Later, he explains it as the ego's response to danger or as a neurotic phenomenon (Freud, 1926). Freud distinguishes between birth anxiety, the anxiety of the id in the helpless infant, pre-Oedipal separation anxiety, castration anxiety, superego anxiety, or moral anxiety. Even after he understood anxiety as a response of the ego, he continued to include anxiety neurosis among those in which no mental complex could be discovered in the background.

Rangell (1968) also views anxiety as a passive, automatic response, differing from neuroses. Physiology may clarify birth anxiety. A great deal of information has accumulated regarding the functions of the senses, and it is quite clear today that exiting from the protective womb into the external world can represent a real trauma. This is likely the source of primary anxiety (Janus, 1987), later termed annihilation anxiety.

In the past, anxiety neurosis was attributed to the fixation of libido at the phallic-narcissistic stage, alongside fears of castration or penis envy, due to a lack of support from the mother in early years, of biological helplessness. Such a lack of support constitutes a real threat to life, as manifested in anaclitic depression.

Today, it is understood that a patient expresses in their anxieties also a fear of death, where the extreme form expressing this is panic attacks that seize both body and mind, representing clear psycho-physiological states. The symptoms of neurotic anxiety indicate the influence of both drives, the life drives: hyperventilation or tachycardia, sweating, palpitations, etc. In contrast, the death drive manifests as a sense of impending disaster, confusion, and even loss of consciousness. Both drives provoke an immediate bodily response. Freud already noted that the anxious patient anticipates a repressed and threatening event, thus the conflict, rather than the trauma, became key to understanding the neurosis (Freud, 1937). Ultimately, within the continuum of bodily symptoms, it seems advisable to place anxiety at the pole of "life drives," those that protect the individual from the terror of death.

1.4 ***Masochism***

Both in primary masochism and in secondary (moral) masochism, the sex and death drives are intertwined (Freud, 1924). Regarding the sexual aspect, the matters are well-known. In moral masochism, the death drive stands behind self-injury, the tendency to become a victim, to win through failure, and to be destroyed by success, and to feel guilt over survival. Depression is very common here (Simons, 1987). Another form of masochism is known as

'malignant masochism.' This form of masochism results from the internalization of a sadistic parent and can sometimes lead to suicide. In order not to render masochism an overly vague and broad concept, I will limit myself here to the realm of physical pain or to the libidinal component of suffering—the eroticization of torment. Levinstein (Loewenstein, 1957) argues that erotic masochism and the experience of pleasure in certain processes of pain is a basic and even normal trait.

Example

A patient report that during love play, his beloved asks him to hurt her through injury and pain. He recounts that in her childhood, she received many beatings from her father, sometimes to the point of losing consciousness. A 36-year-old man suffering from psoriasis and borderline personality disorder developed an infantile transference towards me, even before a stable therapeutic alliance was formed between us. During the summer vacation, approximately nine months after initiating therapy, I went on a break. Upon my return, he described how during the vacation, he felt that all his resistance to therapy had vanished. This resistance (which had disappeared) included aggressive fantasies, which suddenly, during the vacation, transformed into expectation and magical belief: "If I think only good things about her, she won't abandon me again." His wounds on the elbow and knees opened during the vacation and symbolized for him the connecting link with me—libidinization of pain. It turned out that his injuries brought forth the painful connection with his mother, and thus, their exacerbation expressed the psychosomatic aspect of his personality. It was a form of acting in.

Thus, masochism may also serve as a defense against depression, and we regard defense as evidence of life. Therefore, I chose to rank masochism alongside hypochondria at an intermediate level on the scale of influences of life and death drives.

2. Clinical Conclusions

Although we can rarely share with the patient the idea that their bodily symptoms stem, among other things, from a disruption of the balance between the life and death drives, such an interpretation carries significant weight in determining our therapeutic approach and the techniques we choose to employ. The principle should be when a psychophysiological dysfunction is primarily driven by the life drive, as in conversion or anxiety, there is an indication for analytical treatment. However, in cases where the death drive propels pathogenic forces, as in masochism or even in hypochondria, psychosomatic illnesses, and depression, the indication is for a different and direct therapeutic activism. This is because strict adherence to

interpretations of transference or maintaining a principle of neutrality and avoidance may jeopardize the treatment.

Many therapists have found that in treating severe psychosomatic patients, it is entirely impossible to articulate interpretations of transference and resistance. Sometimes it is suggested to provide the patient with form interpretations rather than content interpretations. For example, interpreting silence not merely as resistance but as a message: reflecting a dissonance of inner emptiness or intrapsychic void, and the symptom attempting to fill that void (Lowenthal, 1988).

Finally, I believe it is necessary to say a few words about the difference between negative transference and resistance. Negative transference is often attributed to resistance, regression, and even aggression. By recognizing the death drive, we can distinguish between negative transference and resistance. Resistance is an active defense driven by the life drives. Negative transference, on the other hand, is fundamentally different: it is a late result of deprivation or maternal failure that prevented the formation of a healthy ideal self, which failed to effectively neutralize the death drive.

Transference is also related to countertransference, and this is particularly challenging with psychosomatic and depressive patients: these often deter therapists from empathic closeness. This is because proximity to such patients may evoke in the therapist a repressed and primordial fear of their own death drive. Yet, it is precisely these patients who need a close therapist more than others, one who is perceived as a 'good mother' providing security, support, and suggestion, no less, and perhaps even more than directing insight.

The diagnosis of the bodily symptom, and even its healing, according to the theoretical perspective presented in this article, may not prove that the death drive indeed plays a role in the chain of pathogenic causes leading to symptom emergence. No one has yet succeeded in identifying the *"formless predatory beast lurking in the depths of the unconscious".* (Coltart, 1986).

References

Coltart, N. E. (1986). Slouching Towards Bethlem, or Thinking the Unthinkable in Psychoanalysis. In G. Kohon, *The British School of Psychoanalysis: The Independent Tradition.* London Free Assoc.

Freud, S. (1924). *The Economic Problem of Masochism. S.E XIX.*

Freud, S. (1926). *Inhibitions Symptoms and Anxiety S.E. XX.*

Freud, S. (1928). *Dostoevsky and Parricide S.E. XXI.*

Freud, S. (1937). *Analysis Terminable and Interminable S.E XXIII.*

Green. A. (1986). La Pulsion de Mort. *Record of the 1984 European Psychoanalytic Federation, Marseilles Symposium.* Paris Press.

Janus, I. (1987). Die Bedeutin des Konzepts der Geburtsangst. *Geschichte der Psychoalyse Psyche, 41*, 832-845.

Kerenbeg, O. F. (1984). *Severe Personality Disorders: Psychoanalytic Strategies.* Yale University Press.

Loewenstein, R. M. (1957). Contribution to the Psychoanalytic Theory of Masochism. *J. Am Psychoanalytic Assn., 5*, 197-234.

Lowenthal, U. (1983). The Death Instinct. *Psychoanalytic Review, 70*, 559 – 570.

Lowenthal, U. (1988). *Special Problems with Psychosomatic Patients.* Psychology Verlag Union.

Rangell, L. (1968). Further Attempt to Resolve the Problem of Anxiety. *J. Am. Psychoanalytic Assn, 16*, 371-404.

Rosenfeild. H. (1984). *Narzissmus und Agression.* Hofheim DPV.

Simons, R. C. (1987). Psychoanalytic Contributions to Psychiatric Nosology. *J. Am. Psychoanalytic Assn, 35*, 583-608.

Sugerman, A. (1979). The Infantile Personality. *International Psychoanalysis, 60*, 501-513.