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Hypochondria as an actual neurosis*

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Freud defined hypochondria as an actual neurosis. In this paper the actual neurosis will be interpreted as unbound traumatic elements which threaten the self. In severe hypochondria, breakdowns have occurred, as outlined by Winnicott. The nameless traumatic elements of the breakdown have been encapsulated. The moment these encapsulated elements are liberated, an actual dynamic takes place which threatens the self with annihilation. Projective identification is not possible because no idea of containment exists. The self tries to evacuate these elements projectively, thus triggering a disintegrative regression. However, the object of this projection, which becomes a malign introject, is felt to remove the remaining psychical elements, forcing the worthless residue back into the self. In a final re-introjection, the self is threatened by unintegration. To save the self, these elements are displaced into an organ which becomes hypochondriacal, an autistoid object, protecting itself against unintegration and decomposition. An autistoid dynamic develops between the hypochondriac organ, the ego and the introject. Two short clinical vignettes illustrate the regressive dynamical and metapsychological considerations.

Keywords: hypochondria, actual neurosis, autistoid, breakdown, projective-introjective dynamic, introject

Hypochondria as an actual neurosis

I should like to bring up for discussion an outline of hypochondria that goes back to Freud's concept of hypochondria as an actual neurosis. The intention is to show that the actual of which Freud speaks can be understood as traumatic delivery, as interpreted by Madeleine and Willy Baranger and Jorge M. Mom (1988). The traumatic aspect of severe hypochondria has specific traits, however, which has already been described by Winnicott using his term 'breakdown' (Winnicott, 1974).

Freud's concept of hypochondria

Freud did not deal with hypochondria systematically. He admitted candidly to this shortcoming in 1912 in a letter to Sándor Ferenczi: "I have always felt the darkness in the question of hypochondria to be a great disgrace to

[1]Translated by Tim Davies.

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our efforts but have come up with nothing but suppositions" (cf. Brabant et al., 1993, p. 72).

However, there are isolated observations on hypochondria to be found in Freud's work, especially those which, in the case of hypochondria, apart from anxiety neurosis (insufficient sexual release) and neurasthenia (inadequate release, for instance masturbation), deal with actual neurosis; and relate to paranoia or alternatively paraphrenia, as the other actual neuroses do to hysteria and obsessional neurosis (cf. Freud, 1911, p. 292, fn. 3). Here, actual neurosis denotes states of somatic and current causation; its origin is not to be sought primarily in psychical *conflicts;* the symptoms have no or hardly any symbolic quality.

Freud touches upon the dynamic correlation between these actual neuroses, *inter alia* in his work on neurasthenia and anxiety neurosis:

> For one form of anxious expectation – that relating to the subject's own health – we may reserve the old term *hypochondria*. The height reached by the hypochondria is not always parallel with the general anxious expectation; it requires as a precondition the existence of paraesthesias and distressing bodily sensations. Thus hypochondria is the form favoured by genuine neurasthenics when, as often happens, they fall victims to anxiety neurosis.
>
> (Freud, 1895, p. 318)

En passant, one year later, a little observation is interspersed on the relationship between obsessional neurosis and hypochondria (Freud, 1896, p. 389), which Rosenfeld trenchantly interprets with his instinct for clinical detail, namely that "the anankastic self-accusations might turn into hypochondriacal anxiety" (Rosenfeld, 1989 [1964], p. 210 [translator's translation]).

Freud's most in-depth – a term which is relative (in his collected works there are just barely six pages) – treatment of hypochondria is in 1914 in his text *On Narcissism*. Similarly, to the physically ill patient, he says, the hypochondriac withdraws his interests and libidinal cathexis from the objects of the external world onto his ego and concentrates them upon the organ that is engaging his attention (pp. 148ff.). Freud quotes Wilhelm Busch, who says of toothache sufferers: "Concentrated is his soul in his molar's narrow hole". Admittedly, no pathological transformation of the organ is detectable, yet the erogeneity in the organs changes in parallel with the libidinal cathexis in the ego. By analogy with the damming up of the object-libido in transference neuroses, Freud postulates a damming up of the ego-libido in the case of paraphrenia and hypochondria, since the withdrawn "libido … does not remain attached to objects in phantasy, but withdraws on to the ego. Megalomania would accordingly correspond to the psychical mastering of this latter amount of libido, and would thus be the counterpart of the introversion on to phantasies that is found in the transference neuroses; a failure of this psychical function gives rise to the hypochondria of paraphrenia" (1914, p. 151). This passage – like almost all of Freud's work on narcissism (cf. Rotmann *et al*., 2000) – is dark, yet as a result of the failure to process this damming up by the psychic apparatus

that "helps remarkably towards an internal draining away of excitations (Freud, 1914, p. 152), this libido seems not to target internal objects but extend to the "periphery of the cosmos", finally imploding when the megalomania fails onto "the dimensions of a suffering organ", as Jean Laplanche so wonderfully put it (1974, p. 104 [translator's translation]).

R. Horacio Etchegoyen (2000) has, in my opinion, provided a convincing interpretation of Freud's hypochondria theses in his reflections on the work *On Narcissism: An Introduction*, which I should like to reference briefly:

Etchegoyen equates Freud's paraphrenia with schizophrenia and propounds that, according to Freud, the latter has two distinguishing features: lack of interest in the external world and megalomania (2000, p. 87). Hypochondria operates with narcissistic libido only, not with object-libido like the other actual neuroses (anxiety neurosis and neurasthenia). This libido, withdrawn from the objects of the real world, is fed to the ego and turned into the narcissistic. It cannot be addressed to the objects of phantasy, but leads into megalomania; for Freud that is an intrapsychic processing. "In other words, megalomania is to ego-libido what introversion is to object-libido; when these fail, hypochondria and anxiety respectively arise" (p. 96). If the solution to megalomania fails in paraphrenia, the result is a renewed attempt to tack the libido onto objects again, which differ greatly from the original human objects, however, since the narcissistic world prevails. It targets the body, individual organs, which thus become similar to an 'erogenous zone'.

In *The Unconscious* Freud discusses the relationship of conversion, hysteria, compulsion and hypochondria (1915, pp. 296ff.): the behaviour of a patient who squeezes spots, feels satisfaction as something 'squirts out', but then reproaches himself for having now blemished his skin for ever more is interpreted as a substitute for masturbation and subsequent castration anxiety. Freud sees that "This substitutive formation has, in spite of its hypochondriacal character, considerable resemblance to a hysterical conversion" (p. 298) but senses that it should be conceived of differently and arrives at an initial idea of equating them symbolically, as Hanna Segal (1957) would later go on to articulate (cf. also Ernest Jones, 1916):

> As far as the thing goes, there is only a very slight similarity between squeezing out a blackhead and an emission from the penis, and still less similarity between the innumerable shallow pores of the skin and the vagina; but in the former case there is, in both instances, a 'spurting out', while in the latter the cynical saying 'a hole is a hole', is true verbally. *What has dictated the substitution is not the resemblance between the things denoted but the sameness of the words used to express them.*
>
> (Freud, 1915, p. 299; italics mine)

Freud then places this pathogenic accomplishment in the context of schizophrenic substitution formation!

These theoretical remarks and clinical observations lie strewn before us, like the pieces of a puzzle, without Freud having assembled them or being able to put them together (not even with his second theory of anxiety).

Several important issues arise in my view: What are states of an actual causation? What is to be understood by 'damming up'? Why is the libido transformed into the narcissistic rather than pointing back to human objects?

Actual neurosis as traumatic breakdown

Sigmund Freud was still answering these questions in a very somatic-sexual manner and maybe for that reason failed to spot that such damming up of full actual excitation could be conceived with an entirely different concept of presence. At that time, however, no evolved concept of trauma yet existed. Traumatic experiencing remains present, cannot be processed and cannot become past. Baranger *et al*. (1988) investigate this very aspect and come to their fundamentally important conclusions, heralding a paradigmatic change in the understanding of actual neurosis: "What is 'actual' if the neurosis is not biological, but is the impenetrable wall within the subject which opposes the historicization of some sectors of his existence. It is what may remain in him, present and unintegrable, of the pure trauma" (1988, p. 125).

Traumatic experiences are *not* mental conflicts (even if they can lead to vehement mental conflicts), so they always remain onerously actual. The disruption to mental meaning-making and element formation forces a different encoding, namely in the area of the somatic and sensory sensations, simultaneously forcing encapsulation processes, which are frequently felt in concrete terms. Patients suffering from severe hypochondria sense this encapsulation and associate it almost concretistically as a 'capsule', a 'nucleus of tension', seated deep down in 'the interior of the body', constantly 'throbbing', 'pulsating', capable at any time and sometimes with lightning speed of spreading across the entire soul and the entire body, posing a devastating threat to the self. These nuclei are profoundly effective and permanently virulent, unidirectionally radiant, yet at the same time exert a slipstream.

With this interpretation we have moved away from the drive concept, but Freud's and Etchegoyen's deliberations continue to help us: The self is not to do with narcissistic quantities of drive but with traumatic volumes of excitation which, once released (just like the narcissistic ones), cannot be directed towards objects. The narcissistic libido initially creates the megalomania; in frustrating this accomplishment, which thus takes on the nature of a defence, the quantity must be bundled into a sensory-somatic package and manifests as hypochondria. The traumatic volumes of excitation released pose a threat to the entire system as free radicals, rather. Redirection to the objects fails since the object does not exist in the traumatic. Traumatic excitations are frequently encapsulated, then manifest proximally, somatically.

Now, if such somatically encoded, encapsulated content breaches the dam wall and is released, the traumatic is again present, actual in the form of deluging excitation and threatening the self again. Since they have no mental qualities, they cannot be structurally bound, that is, integrated into shaped notions, fantasies and conceptions; on the contrary, they threaten to destroy the relational links in these complexes. In the words of Freud: they cannot be directed onto the objects of the phantasy. Thus a state of ultimate danger is reached, a death instinct-like development (cf. Baranger *et al.*, 1988), which nevertheless has no constructive effect (cf. Danckwardt, 2014) – in the sense of a necessary regressive movement towards the paranoid-schizoid in the ps-d-rhythm (i.e. the rhythm in which structures and relations are conjoined and detached again in order to eventually enhance their longevity) – but might really end in unintegratedness and dissolution. The self must therefore do everything to get a handle on this danger. The displacement into the hypochondriacally cathected organ might be one such solution. The organ, the body, is thus turned partly into an external object[2] (though, as with Freud, cannot assume any containing function), acting at the same time as a substitute capsule. So it is obvious that the hypochondriac solution is a restitution measure.

Freud (1914, p. 151) emphasizes the "so close" relation between paraphrenia and hypochondria that remains unclear to many authors (see e.g. Etchegoyen, 2000, p. 93, various works in Rotmann *et al.*, 2000; also Sandler *et al.*, 2000, p. 11), but is postulated by others too: Herbert A. Rosenfeld (e.g. 1989 [1964]), Segal and Bell (2000) and others see connections with psychotic and/or schizophrenic processes.

In Freud's day the distinction between unintegratedness and disintegration, which is now accepted in psychoanalysis, had not yet been developed. Nowadays we tend to assign psychotic processes to disintegrative dynamics, which result in the degradation of psychical constructs, giving rise to speedy regenerations by way of a saving grace, in which destroyed and still intact structures are cemented and clustered ad hoc, leading to delusional and hallucinatory shapes, for instance. Nowadays unintegratedness is associated with traumatic and autistic or autistoid conditions, if anything.

Yet the assumption that hypochondria correlates with psychotic processes endures. How might this assumption relate to traumatic delivery and unintegratedness? One suggestion: the liberation of the traumatic element attacks stable structures, in the process leading transiently to disintegrative processes, which may have an ephemeral psychotic quality. If the volume of

[2]This thesis was already championed by Paul Schilder (1925) in his reflections on hypochondria. He proceeds from a phenomenology of the ego-experience and embraces many central aspects like fixation in the narcissistic phase, the role of projection, compulsive introspection and sexualization. He notes: "Self-observation [of the body] therefore means: eavesdropping on one's feelings" (p. 29). The feeling is then turned into perception (p. 34). He adheres to Freud's view that organs which contain an excess of libidinous tension are observed. His phenomenological approach then allows him to establish that the observed organ is made "partly into external world" (p. 30). Then again the close link between hypochondria and depersonalization is evident (p. 32). However, the alterations to the body image follow mental paths "whose symbolic meaning bears a relation to the conflict concerned" (p. 37). For Schilder, then, hypochondria as well as the other actual neuroses are not entirely disconnected from the unconscious meaning.

excitation liberated were able to be bound in psychotic formations, the risk of unintegrated dissolution would be banished. If this solution fails, further malignant regression towards unintegratedness sets in, and is then banished in the hypochondriac organ. Then, however – and here I clash with Rosenfeld (1958, p. 121; 1989 [1964], p. 219) – hypochondria would not be a defence against schizophrenia but a failure of a psychotic restitution and a defence against the dissolution of the self.

So there could be forms of severe hypochondria in which, in the experience of those in question, the traumatically encapsulated potentially threatens the preservation of the self, the "going-on-being" (Winnicott, 1965). The traumatic, then, must have specific features which transcend the usual traumatic qualities.

I should like to suggest looking for these specifics in several forms of severe hypochondria in the 'breakdown', as described by Winnicott (1974, p. 105): "...the *breakdown* has already happened, near the beginning of the individual's life. The patient needs to 'remember' this but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to". Winnicott even admonishes that this breakdown event, which contained no psychical quality, cannot therefore conceivably be mistaken for a traditional trauma concept: "To understand this it is necessary to think not of *trauma* but of nothing happening when something might profitably have happened" (p. 106).[3] Suffered traumas leave behind impressions or images, breakdowns become a void. This, in my opinion, is the reason Winnicott also warns against allowing oneself to be dazzled by psychotic manifestations, as they are a defence against the underlying agony: "It is wrong to think of psychotic illness as a breakdown, it is a defence organization relative to primitive agony..." (p. 104).

Psychogenetic features

Winnicott's thesis is that the breakdown occurred during a time of "absolute dependence" (1974, p. 104), in which the self cannot yet distinguish with any certainty between 'me' and 'not-me'; the Conscious and Unconscious systems are not yet clearly differentiated. It has occurred but cannot be experienced. This catastrophe is 'there' as emptiness or nothing, and the primitive psychic apparatus of the dependent child cannot experience it as an impression or suchlike. They are voids of absolute threat. The breakdown remains, but cannot be sublated. Winnicott puzzles over where this breakdown is stored: he conjectures that it is "hidden away in the unconscious" (p. 104). At the same time, however, he establishes that this is not a case of the suppressed Unconscious or of a phenomenon in the Jungian sense or of a neurophysiological one. Tenuously, he eventually formulates: "In this special context the unconscious means that the ego integration is not able to encompass something" (p. 104).

[3]In extremely simplified form, one might say: every breakdown is traumatic, but not every trauma is a breakdown.

So the breakdown is a traumatic event without the features of the traumatic. A breakdown occurs before an evolved psychic apparatus exists. It is on this side of conscious and unconscious, and eludes any timeframe. *En passant*, Winnicott formulates a very precise theory of time for this phenomenon: "the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience … the patient must go on looking for the past detail which is not yet experienced. This search takes the form of a looking for this detail in the future" (1974, p. 105).

For these reasons it cannot be communicated to an object either, for example, from Unconscious to Unconscious or through projective identification. It has no psychical form, exists in a pure, unimaginable presence, detached from the self and from the object.

These suppositions align with a number of psychogenetic abnormalities in the case of severe hypochondria (see Nissen, 2000, 2010, 2015c): time and again, severe disturbances are discernible in the early relationship with the mother, such as malignant separation experiences (not uncommonly weeks or months long), sudden breaks in contact, envy, own illness or mental captivity of the mother, boundary violations, intrusive (not uncommonly: sexualized) behaviour, oversized amounts of stimulus and so on, in the presence of a frequently (real or mental, e.g. alcoholism) absent father.

It is important now to get some idea of how a small child in absolute dependence might experience these disturbances endopsychically (see also Nissen, 2003, 2017).[4]

The infant expects the breast, and along with Freud I understand this to be a primal fantasy of a mother-child encounter. This expectation requires a positive realization in order for mother and child to be able to become, as Winnicott has repeatedly stressed (e.g. 1987, p. 104). If severe disruptions arise here, which become a breakdown, neither self nor object evolve; the mother-child encounter fails to materialize. At the same time, accompanying impressions and sensations are not transformed into psychical elements. In the language of Bion that means two things: The pre-conception does not become the conception, β-elements do not become α-elements.

The child cannot transform this breakdown alone and – I consider this key – it cannot express it or even communicate it to the object. It needs a primary object which recognizes this catastrophe and can transform it. If, for whatever reasons, the primary object is not capable of that, the emptiness (Winnicott, 1965) or the no-thing (Bion, 1962) occurs. This emptiness is then there, but is not recognizable. If such events cumulate, they give rise to encapsulated, actual nuclei, permanently present, threatening, without being able to be captured. These states must be shielded with further measures. If, in this secondary defence mechanism process, autistic or autistoid

[4]It is important to mark the scientific reference system clearly: it is the endopsychical world, that is, the sources of the relationship disorder can also be located in the child; for example, constitutional envy, frustration intolerance, autistic predispositions and so on, or abnormal development is to be sought in dispositions on both sides.

measures are brought to bear, for example, autistic objects (Tustin, 1989), second-skin formations (Bick, 1968), false self (Winnicott, 1965) or 'as-if' personality formation (Deutsch, 1934), splittings of the ego and object withdrawals arise, taking their silent and invisible yet highly pathogenic toll.

Thus shielded, the states remain concealed, as Winnicott (1974) is constantly highlighting. They also drop out of the interpsychic communication, for one thing, since they have not become psychical; and since the hope of an understanding object does not exist, for another, projective identification fails to materialize.

The autistoid

Such early traumatic states, which are encapsulated and safeguarded by means of secondary measures, can cumulate autistoidly and lead to autistoid personality organizations. It is certainly rare to encounter them in such impetus and destruction, admittedly, but if encountered, then they do actually feed into severe mental damage.

My hypothesis is now that the kernel of the hypochondriac is to be sought in these autistoid-traumatic elements. It is the unthinkable, the mentally elusive in the factuality of the final, objectless state of separation and non-being. The breakdown is the gravitational centre of the encapsulation around which even further, related traumatic states (are able to) then group. If other narcissistic solutions (see Freud) fail, therefore, hypochondria could be one (sic!) answer to the confrontation with a nameless, unthinkable state. For this reason, we must pay heed to the terms selected: The 'fear of death' concept used by hypochondriac people in order to give their distress a name can be fuzzy, psychodynamically, as it may involve a nameless dread or (unintegrated) fear of annihilation and dissolution, as described by Winnicott (1974).

As early on as 1984 David Rosenfeld had referred to these possibilities. He described a hypochondria with predominantly autistic features:

> This type of hypochondria is silent, chronic and more rigid. It reappears in the course of time at intervals of varying lengths and is closely related to autistic objects and an autistic nucleus. This encapsulated nucleus has very little connexion with the outer world... Since these patients rely very little on projective identification, the likelihood of massive projective identification is remote, and the same may be said of the transformation of the encapsulated hypochondria into a somatic delusion. Clinically there prevails an apparent control of the hypochondriac nucleus... the rigidity of this encapsulation can be tentatively accounted for on the basis of a severe splitting. This is not an openly expressed hypochondria, but rather it is opaque, hidden, silent, quiet and dormant. It awakes at intervals in the course of many years but, when it does, it sometimes has a disruptive effect on the therapist due to the bizarre way in which it emerges... The encapsulated area is sometimes seen as almost alien, non-ego, and others as an inanimate foreign object.
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> (1984, pp. 381–2)

If these capsules are released, they can also evoke psychosomatic symptoms; by the same token this could be a consequence of the failure of projective

identification. (The link between psychosomatic capsules and autistic structures had already been worked out by S. Klein in 1980; see also: H. Rosenfeld, 2004; D. Rosenfeld, 2006.) I would posit the thesis that, in the case of monosymptomatic hypochondria, the autistoid nucleus is regularly demonstrable in structural terms.

First intermediate resumé

Freud's approach of conceiving of hypochondria as an actual neurosis is open to a fresh understanding with the definition of the actual by Baranger *et al*. (1988): The actual is the pure-traumatic, which remains throbbingly present and unintegrated, eluding mental processing. However, this necessary determination of the traumatic is still not adequate for determining the specific in several cases of severe hypochondria. Winnicott's breakdown concept helps to understand this specific on a deeper plane: The traumatic has taken place in a phase when the psychic apparatus was incapable of coming to terms with it, that is, it has taken place, but was not experienced. The states are not psychized, unconnectable and indigestible; Winnicott sees the central characteristic in the void. In these events the containing object is absent, the hope of a sublating object is abandoned (see Bion, 1970; Meltzer et al., 1975; Tustin, 1986, 1989). The actual-traumatic is there, and eludes mental processing as well as object sublation and any timeframe. The actual, then, is psychogenetic by nature, namely in the breakdown that has taken place during the absolute dependency phase, but cannot be 'remembered' by the subject alone after the event.[5] If severe early-childhood conflicts or other traumatic experiences can subsequently connect with situations and find expression in such reworked form, including projective-identificatory communication, the void that leaves a breakdown behind it will render this very relief, this scenic relief, impossible. The breaching of the autistoid defence and the occurrence of states of existential threat are triggered by situations, of course, but no subsequent incorporation into a psychical narrative emerges from it. It thus becomes more readily understandable why hypochondriacally ill people cling so desperately to their conviction of being terminally ill, for which there is nonetheless no mental basis. Moreover, the ruminating hypochondriac lamentations, which are not dissimilar to the melancholic ones (see Freud, 1917), are the attempt to express fear prior to a breakdown (see e.g. Bion, 1962, 1970; Meltzer, 2009) and to give the void a name, but also fulfil the function of motor discharge (cf. Freud, 1911, p. 233; also Meltzer, 2009; Beland, 2011) and second-skin

[5]The complicated correlation of historicization ("Nachträglichkeit"/"afterwardsness"), actual neurosis and breakdown cannot be developed here. Winnicott's concept of the breakdown and the Freudian concept of afterwardsness (see also Laplanche and Pontalis, 1972) has been discussed by various authors, however, such as Faimberg, 2005. Eickhoff (2005) also examines this relationship, interprets Winnicott's breakdown – though close on psychosis, if anything – postulating, like Loch (1988), that "there is only the subsequent context-dependent attribution of meaning; the primary vestige … is not discernible" (2005, p. 151). Dahl (2010) comes closer in my view, acknowledging the dual-phasedness, the linear-deterministic reconstruction as also retrograde-hermeneutic construction, in my view leaving what has actually happened to come into its own. For me the breakdown remains 'actual' and eludes 'historicization' (Baranger *et al*., 1988) as long as it is not sublated in the transference relationship (see below).

formation (Tustin, 1986, 1989; Bick, 1968; also Barrows, 2001; Nissen, 2008). Interpsychically, nothing is communicated; an understanding object is not and cannot be there (Nissen, 2013b; 2010; see also e.g. Balint, 1996; or Yorke, 2003). In such a dynamic, hypochondria would then be conceived of as defence against a breakdown.

Defence against the breakdown – first clinical example

The patient, a freelance computer scientist, presents, "convinced" that he "has lung cancer, though medically nothing is amiss". He has "devices with which he is able to measure his lung capacity; his wife regularly auscultates him too." He has "a sexual obsession" too: he fantasizes himself into a "rubber fetish world", in which he "subjugates others sadistically – but fantasy only", he hastens to tell me. Peripherally, he mentions that before giving presentations, which he is for ever having to do for work, he "gets completely stressed, quite physically". His life story has been difficult, he says, he was born prematurely, spent a long time in the incubator. He was the child of a teenager mother, who lived in a "sort of home with a lot of care from strangers". The father was unknown.

The therapy was difficult; not because he was unreliable or failed to cooperate, but because links did not become apparent. He seemed to have no psychical function at his disposal to unconsciously conflate what belongs together. He told me, for example, about a presentation at a company, which had been successful, and also about the dreadful excitement in the run-up to it – but not that he indulged in sexual-perverse fantasies for days beforehand, thus no longer feeling the excitement. I was taken in by a sort of secret folly (Krejci, 2012), as I believed the excitement had lasted till the presentation. Based on this fallacy, I asked him (and myself) why he had not talked about the excitement. Innocently and naively, he replied, "but there was none here anyway"; yet it did not occur to him to mention that he had smothered it with his perverse obsession, whose second-skin function clearly showed. In other situations he got into a manic-psychotic-like condition in which he did an excessive amount of sport. At night, for instance, he would get on his bicycle and ride more than 200 km along country roads. In such states he appeared to be "not altogether himself"; at the same time the accounts had a dangerously suicidal ring to them. Yet he considered himself invulnerable, as if not subject to any kind of mental or physical laws. Not infrequently such excesses collapsed in crises of severe hypochondria, in which for days – nay, weeks – on end, he would test his lungs. Why which conditions occurred and when, whether there could be any links between them (his 'logic' was that he had sensed his lungs were no longer capable of performing in sport, ergo: cancer), nothing was joined up. It is hard to describe, but he produced no evidence and no connections; there were none for him; there were no psychic defences like denial, splitting, isolation, no objectal acting-out while he tried to keep the analyst 'outside'. There seemed to be random concatenations. It had a great deal to do with autistic and autistoid therapeutic phenomena involving emptiness, shallowness, unrelatedness, static situations, lack of emotional flow and the

non-appearance of the unconscious addressing of communications (for an overview, see Nissen, 2008). Feelings of craziness and disorientation soon set in within me; a vague sensation of intracranial pressure arose, preventing me from thinking. I sensed that the analyst – no, to be more precise, the analytical situation – had turned into the autistic object (see Gomberoff *et al*., 1990). Luckily, I succeeded in constructing some abductive caution and facing the patient again with analytical composure. When a hypochondriac crisis once again coincided with a 'sports-mad phase', I asked him, really wanting to know what else had gone down. He replied: "Nothing." Pause "Last week I screwed up a presentation, but otherwise nothing."

It was important not only that this date initially gave rise to a progression, a 'story', that is, that the pre-presentation panic drove him into 'sports-mania' mode and the implosion of a hunch that he would not cope with the product demonstration caused this 'megalomania' to implode into hypochondria. Almost more importantly, however, the patient had an idea that the failure to present himself and the product well was, for him, associated with shouldn't-be-there. For him this realization was a revelation, providing relief at first, then engendering fear. In this context he saw images of his stressed-out mother before him, which instantly stressed him out too. And initially it occurred to him again (I think this was the first time it took on a mental shape) that his mother had long ago told him how bad things were in the home: He had been a cry-baby, she was treated with hostility by all her fellow residents, tried everything to keep him quiet but couldn't stand it and absconded time and again for hours or days on end, leaving her child behind.

This feeling of not being welcome, not being wanted in the world (incubator, home situation) seems to have threatened the going-on-being so much as to produce a breakdown. This 'psychical death' (Winnicott, 1974) was unimaginable and had to be staved off, both on the verge of psychosis and also in (final) hypochondriac terms. Other traumatic images (e.g. the stressed-out mother) were entrained into this silent emptiness. As is only to be expected, the clinical complexity is more complicated than the Freudian schema. However, the actual only became psychical when it manifested in the analytical situation. Of this, Winnicott (1974, p. 105) writes: "The only way to 'remember' in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the *transference*. This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time."

The psychodynamics of releasing the capsule content

From this perspective it becomes more readily understandable that the release of autistoid content poses a great danger to the psychical system. Freud's observations and Etchegoyen's precise interpretation make it possible to gain a better understanding of the clinical observations of psychodynamic processes. However, before the 'narcissistic' solution that we have interpreted as traumatic-autistoid gets a look-in, projective and introjective processes seem to be connected upstream, as Rosenfeld and many other authors (see overview in Nissen, 2003) have demonstrated:

> [The hypochondriacal patient] constantly projects parts of his mental and sometimes physical self as well as internal objects into external objects, but it is characteristic of the disease that the external object, after the projection, is immediately re-introjected by the ego and split off into the body and body organs. In many cases frequent re-projections and re-introjections take place. This process can, however, only be observed by careful analysis.
>
> (Rosenfeld, 1989, p. 215)

Rosenfeld works from the baseline of a failure of benign splitting, resulting in states of confusion (pp. 217–18): "It is my view that as a result of this failure of normal splitting and differentiation between good and bad objects, *abnormal splitting processes* or *mechanisms* develop in an attempt to get rid of the confusional anxieties" (p. 218). The anxiety content is retained after "...the projection of the anxieties ... onto the body or organs of the body" (p. 188).

Earlier still, Klein had observed that these dynamics can give rise to the suspension of the projection mechanism:

> by projecting his terrifying super-ego onto his objects, the individual increases his hatred of those objects and thus also his fear of them, with the result that, if his aggression and anxiety are excessive, his external world is changed into a place of terror and his objects into enemies and he is threatened with persecution both from the external world and from his introjected enemies. If his anxiety is too immense or if his ego cannot tolerate it, he will try to evade his fear of external enemies by putting his mechanisms of projection out of action; this would in its turn prevent any further introjection of objects from taking place and put an end to the growth of his relation to reality....
>
> (Klein, 1973, p. 181)

In my opinion, what Rosenfeld and Klein describe, belongs to the disintegrative processes and should therefore be understood as attempts to ward off the breakdown. They too depict – not on a drive-theory level, but on an object-theory level, the withdrawal from 'cathexes' onto the ego or into the self. I, however, think that these processes are not about interpersonal dynamics – and indeed the objects are not, or not unconsciously manipulatively, involved, even interpsychically. Rather, it is a case of dramatic endopsychic processes, with which the self tries to get away from the threatening unintegratedness.

Although Rosenfeld (1989) acknowledges the regression to the oral, or rather oral-envy level, this process remains underexposed; how, traditionally, the object-psychological approaches even examine barely regressive dynamics which, as I believe, do nevertheless play a decisive role in these rapid projective-introjective processes. The increase in confusional states and the anxiety released weaken the ego and lead to malignant regressions – a vicious circle which, the more the self feels threatened by the traumatic-autistoid content, the less it is able to think an object.

So could the examination of regressive dynamics in hypochondria help to understand the suspension of the projection mechanism, the inner persecution, the quality of the super-ego and the dimension of envy?

If the capsule content is released, parturient decay threatens. As long as the psychic apparatus in the more integrated ego is still capable of facing up to this threat with more evolved defences, projection is deployed by way of preference, since the nameless threat anticipates the breakdown, even if it cannot be thought. It is attempted to get rid of the nameless, parturient elements, which have no psychical quality. These have started their work of releasing psychical structures at the instant of release, however, so that the projection also always embraces libidinous and aggressive parts of the self and the object. So the abnormal splitting processes described by Rosenfeld have already begun. Given that primary objects are invariably sought in the case of such basic threatening processes, the site of the projection would probably be a maternal object. Yet precisely this object has been precipitated by the hope of being a containing one, thus rendering another of Rosenfeld's observations readily understandable ad hoc, to wit the 'immediate' re-introjection. Gutwinski-Jeggle (1997) propounds that the "non-containing" of the projected is immediately experienced as a threatening re-introjection. Unconsciously, however, the object is already affected with the projected. Since it cannot be thought in containing terms, it will experience the projection as a hostile attack in the intrapsychic, and threaten persecution and retaliation.

That is, the regression includes both the self, which is weakened by the re-introjection and subjected to further disintegration, as well as a basic object which threatens to turn into a hostile introject. Concurrent critical entities, strict parts of the super-ego, will register this dynamic with disapproval.

Rosenfeld and others stress the role of envy at this point. Even if I am not sure whether envy plays the pivotal role in the case of the giving-up-hope-of-a-containing-object task, the investigations into envy seem to me to be highly conducive to an in-depth understanding of this dynamic. In Chapter 28 of his *Learning from Experience* (Bion, 1962), Bion has described this dynamic precisely: A child, or alternatively a patient, fearing for his death splits off his feelings of anxiety and projects them together with envy and hate on the breast into the breast (partial object level). In minus K (-K) the breast is perceived as enviously taking away the good or valuable element out of the fear of death and forcibly repressing or forcing back the worthless residue into the child/patient. Worse still, the envious breast robs the child/patient of the will to live. If it comes to re-introjection, a state arises which Bion describes as "without-ness", as "an internal object without an exterior … It is a super-ego that has hardly any of the characteristics of the super-ego as understood in psycho-analysis: it is 'super' ego" (1962, p. 155). It threatens to rob the child/patient of all the features it still possesses, or to destroy them, enviously claiming moral superiority in the process. This process can get so out of hand that every development, every contact with reality is met with destructive attacks on these tendencies and with fresh assertions of exclusive 'moral' superiority. In the most disastrous scenario, the consequence is that alpha elements are not formed, or respectively back-formed into beta elements. "The process of denudation continues till – ♂ – ♀ represent hardly more than an empty superiority-inferiority that in turn

degenerates to nullity" (p. 156). The similarities with Freud's early attempts to describe melancholy are evident: here too, withdrawal of the libido into the ego, until the shadow of the object finally fell upon the ego, which, to adopt Freud's linguistic usage of this time, could be judged by a special agency as though it were an object, the forsaken object (1917, p. 435).

This, in my view, is precisely what fits into the lightning-fast projective re-introjective processes demonstrated by Rosenfeld. The internal primary partial object fuses with parts of the super-ego, a denuding super-ego or else a nihilating introject that accelerates the release. These processes play out in the inner world of the patient.

The ego regresses in parallel, seeing itself as threatened by breakdown. The ego's feeling, which acts out something degrading in its sphere, is perfectly correct. And yet it can neither accomplish the transformation of this threat into the psychical by its own wherewithal nor hope for a sublating object.

The denudation of psychical residues and the (death-wish-like) release continues unhampered until it eventually gets to the final re-introjection, which is heading for agony. This final re-introjection of degrading, dead particles threatens the remaining psychical system with dissolution. Salvation comes in the form of the primary processual shift onto, or now into, the body and the condensation in the organ. Thus the ego may be able to halt the psychical decay, but it descends into an exhausting, ruminating, object-remote dynamic, into hypochondria.

So how come this displacement into the body, into the organ? Is it even wise to talk about the 'body', given that the body counts as a mentally cathected parameter? Aisenstein and Gibeault (1991) and Bronstein (2011) discuss these issues and clearly make the point that the body has long since been yanked out of its "unconscious and vegetative role" (Tausk, 1919). The body, as Schilder (1925) has already shown, has become at least partially an "external object" and has been yanked out of the mental spheres. This external object, which has attained primarily sensory-somatic quality, can now serve as a displacement site (see above, Etchegoyen's suggestion that the choice of object is determined by the prevailing mode).

The organ serves as a vessel for collecting the traumatic-autistoid elements, as a substitute capsule into which the liberated elements are diverted. The result is an autistoid object which is intended to counteract the loss of bonding occurring in encapsulation. In concrete terms it is located visibly, palpably or tangibly, albeit externalized, in the sphere of the ego, but it cannot be thought. It is not possible for the self to make the autistoid elements into psychical ones and to leave the organ in its somatic function. Since the nameless anxiety is lodged in the organ, the self is subjected to a permanent, devastating threat, which it cannot manage on its own.

The self finds itself close to breakdown, in an increasingly sensation-dominated, autistoid world; hope of containment has been abandoned, in a world of without-ness, of empty superiority-inferiority, which for its part has degenerated to nothing (Bion, see above). Somatized and dominated by sensations, the body is flattened.

The remaining psychic apparatus is now able to use this particular constellation and to knock up a structure to combat the final breakdown. It acknowledges the empty superiority of the introject, submits to this and offers the organ to the introject by way of appeasement and as a tribute. It thus becomes more readily understandable why the psychogenetically, narcissistically highly cathected body parts frequently become targets for hypochondriacal displacement. The self offers the introject its most 'valuable' organ, though in its hypochondriacal anxiety it has become the devastatingly lethal. The valuable was taken away, the organ made into the lethally dangerous. In this empty, arrogant superiority the introject can then lend its generous support to the inferior disintegration of the self. If the self creates hope again, or even calms down, the introject will function as a malign prompter, disguising itself in a caring way (see also Anna Freud's observations by motherless children playing 'Mother and Child' with their bodies: 1952, p. 1273). Thus camouflaged, it launches into the next "dismantling" (Meltzer *et al.*, 1975). All the hypochondriacs I have experienced in therapies spoke of there being an inner voice or suchlike which, once a degree of calm had set in, eggs them on, saying "better take another look" to check the organ, with the consequence that the entire system collapsed. One patient, daring to go away on her own for the very first time in her life, felt compelled by an inner voice to re-examine the organ, her mantra being: "Then you'll know there's nothing there, and the weekend will turn out fine" – the weekend turned into a hypochondriac nightmare.

That is how ruminating dynamics arise: If the dynamic calms down, the self consolidates, even creates hope, the introject becomes the malevolent, dangerous denuder of hope, the self having been thrust into the next spiral of fear – a vicious circle *ad infinitum*.

The important thing is that these dynamics nearly always play out in a compartmentalized fashion in the patient; for the most part the objects go entirely unnoticed by them; but if it were to be communicated, it would be in affect-repelled form, with no communication from the unconscious to the unconscious. In treatments we must painstakingly deduce for ourselves these dynamics and the content of the communications, even if they lack the unconscious, psychical dimension.

Second intermediate resumé

If the metapsychology of hypochondria makes do with speculation, its psychodynamic complexity is full of unsolved enigmas. There seems to be some degree of concordance in the fact that regressive projective–re-introjective phases are preceded by a severe hypochondriac crisis. The outcome of these cycles is the ongoing enfeeblement of the ego (self) and dramatic objectal transformations. The autistoid flattening inherent in this is hard to understand. The self gets into a state of existential threat, sees its going-on-being threatened by breakdown and at the same time has given up objectal hope. The patients have a 'fear of death', appear to be in a helpless panic, yet the interpsychic (projective-identificatory) communication fails; indeed, even empathic deduction barely still succeeds. The objects regularly react non-

comprehendingly, non-assimilatingly, unaffectedly, dismissively. More important than the reactions of the real objects is the intrapsychic mutation of the primary object craved. Not only does it not assimilate but it threatens to destroy and dispossess psychical residues. This concrete 'super'-ego introject no longer has anything to do with classic super-ego objects but becomes an inconceivable shadow (see also Nissen, 2015a, 2016). In his discussion of Freud's "shadow concept", Roussillon (2015) reaches a similar view: "The shadow is not the object; it is not even a representation of the object – it could be seen rather as the negative of the object" (p. 6). The failure of a renewed projection, in my view, is connected with the fact that this introject is not able and not allowed to be recognized. That would spell the realization (in the Bionian sense) of the breakdown situation – and that must be avoided at all costs (see above). The situation seems insoluble: the present object (here: introject) offers no love and does not contain, but threatens to annihilate; yet without an object, there is no going-on-being. The object must nurture, though it does not nurture; the object must be present, though it is not there as something containing. The weakened self must find a solution: displacement of the traumatic elements into its most 'valuable' organ, which is then offered to the introject. The object remains there like that, although it keeps the breakdown in suspense; to the introject the organ is presented on which existence hangs and which at the same time threatens it. This dynamic could be paraphrased as follows: 'Here is my existence, but annihilation threatens, please let me be' – and with no hope in prospect, the self must then sense that there is only a shadow there, no sublation is redeemed. The elements have found a replacement capsule, but one that cannot exert any containing function; for the body has flattened out into the somatic region dominated by sensations, has lost its psychical shape (*Gestalt*) and the organ has degenerated into the autistic object. There is no development, only perseverance until the dynamic ebbs away.

Hypochondriac dynamic – second clinical example

I would now like to investigate this dynamic-structural summary in detail with the aid of a clinical example (see Nissen, 2000, 2010 also on this point).

A highly intelligent patient comes from a family of intellectuals. For the patient, the father was a complete failure, as an alcoholic. The mother used to campaign for the victims of persecution by dictatorships, virtually living for this involvement. In her social commitment she was unattainable for the patient, totally absorbed, "barricaded herself behind her victim crap". In one session he reports on an acute hypochondriac breakdown:

> *Patient*: I completely surpassed myself last week in the show [= theatre performance], incredibly; was proud and happy as anything. Superb, like a young god. The others were good too, great show. *[Quieter]* Thought, that'll reassure my parents. Didn't stay behind afterwards, though, to party with the others, got straight out of there instead, somehow.
>
> *Psychoanalyst*: You wanted to look for your mother?

> *Patient*: Yes, I think so too, actually thought about ringing them, but didn't do it in the end, don't even know why, something stopped me. Then, still completely euphoric, went to a kiosk, which looked fairly crummy. So there was this woman, awful, grumpy face, not a word; she fished the Coke tin out of a grubby corner and pushed it across the counter, with a bored, hacked-off expression. Didn't give me a second look. Could already sense the euphoria fading as I slid downhill, then walked down to the subway. Panic, emotion, I'm coming apart, everything is disintegrating; didn't really see the cars, the houses properly any longer, spun around, went all dizzy. Then down at the subway I got angry; thought, that bitch; thought, if I was a dictator, I'd have her marched off, she'd grovel. Oh, what the hell: I'd have her pulverized. I was raging, drank the Coke, then saw that it was really grimy, with particles on top; fear, thought, rat poison or suchlike; I would have inhaled that poison, now my vocal cords are knackered, the poison will corrode them. Got out of there in a panic, vocal exercises, half the night, but the fear stayed with me.

The patient subsequently went to see various doctors. That fear, which also intensified into mortal fear of a brain tumour, persisted for a long time.

The patient appears proud, but despite his initially inflated mood, remains self-critical and object-related ("It'll reassure my parents"). But an affective, object-related idea, that is, showing himself to his mother proudly, and she finally beaming at him now; and the hope of still establishing a good rapport with the parents nevertheless, adds virulence to traumatic experiences of an intrusive, simultaneously unattainable mother which he cannot process mentally; 'somehow' he has to get 'straight out of there'. Relying on his own resources, he can no longer fix this mentally.

That is, object-libidinous hopes are still extant in the sublimation, even if a slight withdrawal into the self and into narcissistic delusions of grandeur may already be attestable as well. The hope of a receptive mother, however, is linked with trauma, which segues into the initial turmoil.

He needs an object that is able to receive in a loving-present way. Ever of good cheer, he consistently looks for his mother, who must be sensorily perceptible, however, since the incipient autistoid appearances do not permit more mature modes (hence the idea of calling them). Since it again wrenches open the traumatic flank of an unattainable mother, this idea is inhibited ("didn't do it … something stopped me"). Yet the wish persists and is acted out by the ill-fated walk to the kiosk. He looks for his mother at the grotty kiosk and finds in the woman's attributes – awful, grumpy face, not a word, bored, hacked off, not looking – the non-resonant, non-containing mother. The failure of the external object (Freud) is already an unconscious reiteration, a seeking-out of the traumatic.

The rejection experienced (vanishing of the euphoria) leads to the liberation of the encapsulated content and to the breakdown of the affective idea. These parts elude psychological access and threaten the psychical system. The threat allows initial depersonalized and derealized aspects to become visible (the patient no longer views the world properly). Once again, a two-sided projection should save the day: The internal objects, the kiosk woman and the dismissive yet needed mother, are supposed to bear these poisonous nuclei within themselves, sense destructive fright and terror in the threat,

feel what it is like to beg to be heard, to whine, to plead for mercy and humanity; that is, endopsychic-projective evacuation and sadistic mastery are at work here. The patient puffs himself up into the great dictator (cf. the mother's commitment to persecutees of dictatorships). The raging becomes increasingly ecstatic. The unconscious premonition that the maternal object remains indomitable and unattainable, and will not detoxify, no doubt leads to further escalation: The object is pulverized, annihilated. The fear of dissolution is liberated. Only one path to salvation still remains: the final re-introjection, which is accomplished in concrete terms and perceived as almost ad hoc ego-dystonic.

Here we can see the disintegrative processes that initially lead provisionally to psychotic formations (including megalomaniacal approaches) (see Freud and H. Rosenfeld). They are to be understood as a defence against the break-up, but do accelerate the regressive decay that leads to fragmentation and concretism.

At the instant of pulverized annihilation, the maternal object fuses with the primitive super-ego aspects, seizes possession of the particles and, taking cold revenge, divested of the dimensions that endow meaning and affiliation, forces them back into the patient. That is to say, it not only does not detoxify, but also deprives the kernel of what is probably its last psychical, objectal quality. This super-ego itself becomes dictatorial, destructively menacing, and thus wrests from the self that megalomaniacal part, which loses its inflated size in the process.

The concretistic re-introjection of destructive particles of poison, which are inhaled and not imbibed, destabilizes the patient's psychic system (recall here Fenichel's 1982 [1945] observation, which pointed out that, in the case of hypochondria, the introjection takes place in very bodily, oral, anal fashion, through the breathing or the skin etc.). The patient's regressively weakened ego must do everything to avert the breakdown.

The introject figure now makes possible the restitutive measures portrayed. It permits the patient to offer up one of his most narcissistically cathected organs to the introject for sacrifice – his vocal cords, in which he accommodates the toxic elements. Without functioning vocal cords the patient cannot take to the stage, and the phallic narcissism attached to sagacity, eloquence and musicality since his childhood collapses, that is, the fixated method and hope for attracting the mother's attention. Consequently, the brain, that organ of sagacity, is also soon stricken by the tumour of no longer taming the fear.

The reasons for processing the hypochondriac crisis are grounded above all in the subject's inability to deploy his own resources to change the non-psychic elements into meaningful ones. The autistoid organization further prevents patients from seeking a receptive and sublating object. They remain alone with the threatening unintegratedness, perceived breakdown, cling onto the hypochondriac organ, repeating in their consultations with physicians and therapists the experience of remaining alone with autistoid content. The social communication lacks the psychical and conceptualized, objectal quality; the flow from unconscious to unconscious does not exist, the object *cannot* react adequately at all – not even if it takes pains to understand, however

empathically. The elements must first be communicated projective-identificatorily, the intersubjectively shared qualities named, and the nameless, the unthinkable even fashioned in a creative process (Nissen, 2013a, 2015b).

Conclusion

I have attempted to show that Freud's concept of actual neurosis can be reinterpreted. If the actual is conceived of as something traumatic-unthinkable – as Baranger *et al.* (1988) have proposed – the self must do everything to bind the traumatically excited, for it threatens the entire self and cannot be communicated to an object in a projective-identificatory way, since the hope of containment does not exist. The self heads for a breakdown state, as described by Winnicott (1974). At the moment of liberating the autistoid capsule content, it tries to rid itself of these elements in a disintegrative process and banish them projectively. As a consequence of divesting the psychical structures, a process that starts instantly, the self and object parts are carried along. The object is perceived as non-containing, albeit distilling out the remaining objectal and life-desirous parts, resulting in immediate re-introjection (Rosenfeld, 1989). Regressively accelerating dynamics occur, which might lead to a breakdown following final re-introjection. The hypochondria now comes into its own as a measure of restitution. The remaining ego diverts the autistoid and decomposed content into the hypochondriacally cathected organ and submits to the hollow superiority of the introject. What develops is the ruminating, endless hypochondriac dynamics between ego, organ and introject, which do not subside as a result of mental processing, but simply because the dynamic exhausts itself.

Translations of summary

L'hypocondrie comme névrose actuelle. Freud a défini l'hypocondrie comme une névrose actuelle. Selon l'auteur de cet article, la névrose actuelle se compose d'éléments traumatiques non liés qui menacent le self. Les formes graves d'hypocondrie sont sous-tendues par des états d'effondrement, comme l'a montré Winnicott. Les composants de cet état d'effondrement ont été encapsulés. Dès lors que ces éléments encapsulés se trouvent libérés, on assiste à la mise en œuvre dans l'actuel d'une dynamique qui menace le self d'annihilation. L'identification projective s'avère impossible, car il n'existe pas d'idée de contenant. Le self tente d'évacuer ces éléments en les projetant, ce qui déclenche un processus régressif de désintégration. Tout se passe comme si l'objet de cette projection, qui devient une introjection à caractère néfaste, s'emparait des éléments psychiques restants et forçait le retour de ces parties nuisibles dans le self. Dans un mouvement final de réintrojection, le self se voit menacé par la non intégration. Pour sauver le self, ces éléments sont déplacés vers un organe qui devient hypocondriaque, revêtant l'aspect d'un objet d'allure autistique qui protège contre la non intégration et la décomposition. On assiste alors au développement d'un mouvement autistique entre l'organe siège de l'hypocondrie, le moi et l'objet introjecté. Deux vignettes cliniques servent à illustrer cette dynamique régressive, comme à étayer des considérations métapsychologiques.

Hypochondrie als Aktualneurose. Es wird versucht, Freuds Konzept der Hypochondrie als Aktualneurose neu zu interpretieren. Bei schweren Formen der Hypochondrie haben sich frühe Zusammenbrüche (breakdown) ereignet, wie Winnicott sie beschrieben hat. Diese namenlos-traumatischen Elemente werden eingekapselt. Kommt es zur Freisetzung dieser Kapselinhalte, entsteht eine aktuale Dynamik, die das Selbst bedroht. Das Aktuale kann damit als traumatische Entbindung begriffen werden. Diese Bedrohung kann nicht projektiv-identifikatorisch mitgeteilt werden, da kein containment existiert. Das Selbst versucht, diese Elemente projektiv loszuwerden, damit einen regressiven Zerfall einleitend. Doch das Objekt dieser Projektion entkleidet die letzten seelischen Reste und zwingt den

verbleibenden Rest zurück, wird so zu einem malignen Introjekt. Die finale Reintrojektion in dieser desintegrativen Regression bedroht das Selbst, das zur Rettung die Elemente in ein Organ verschiebt, das hypochondrisch besetzt und zu einem autistoiden Objekt wird. So schützt es sich vor Unintegriertheit und Zerfall. Zwischen dem hypochondrisch besetzten Organ, dem Ich und dem Introjekt entfaltet sich eine autistoide Dynamik. Die metapsychologischen und dynamischen Überlegungen werden an zwei Fallvignetten illustriert.

L'ipocondria come nevrosi attuale. Freud ravvisava nell'ipocondria un tipo di nevrosi attuale, categoria che in questo lavoro viene interpretata come serie slegata di elementi traumatici che minacciano il Sé. Come descritto da Winnicott, i casi più gravi di ipocondria sono preceduti da breakdown i cui elementi sono stati incapsulati; tuttavia, nel momento in cui tali elementi vengono liberati, si verifica una dinamica che minaccia di annullare il Sé. L'identificazione proiettiva non può aver luogo in quanto manca qualsiasi idea di contenimento. Il Sé tenta di evacuare questi elementi proiettivamente, attivando in tal modo un processo di regressione disintegrativa, ma l'oggetto della proiezione, introiettato come oggetto cattivo, sottrae nella percezione del soggetto gli elementi psichici rimanenti riversandone le parti senza valore dentro il Sé. Attraverso un ulteriore processo di reintroiezione, il Sé avverte a questo punto una minaccia di disintegrazione. Per salvare il Sé questi elementi sono allora spostati su un organo del corpo che diventa oggetto dell'ipocondria – un oggetto autistoide che ha la funzione di proteggere dalla disintegrazione e dalla decomposizione. Prende forma a questo punto una dinamica di tipo autistoide tra l'organo ipocondriaco, l'Io e l'oggetto introiettato. Facendo riferimento a due brevi vignette cliniche verranno svolte, rispetto a questo particolare tipo di regressione, alcune considerazioni di carattere psicodinamico e metapsicologico.

La hipocondría como neurosis actual. Freud definió la hipocondría como una neurosis actual. En este trabajo se interpreta la neurosis actual como elementos traumáticos no ligados que amenazan al *self*. En la hipocondría severa, ha ocurrido un derrumbe (*breakdown*), como lo esbozó Winnicott. Los elementos del derrumbe han sido encapsulados. En el momento en que estos elementos encapsulados son liberados, se desarrolla una dinámica actual que amenaza al *self* con la aniquilación. Al no existir la idea de contención, no es posible la identificación proyectiva. El *self* intenta evacuar estos elementos de manera proyectiva, desencadenando así una regresión desintegradora. El objeto de esta proyección, que se convierte en un introyecto maligno, es sentido como que elimina los elementos psíquicos restantes y fuerza a las partes despreciables a retornar al *self*. En una reintroyección final, el self es amenazado por la falta de integración. Para salvar al *self,* estos elementos son desplazados hacia el interior de un órgano que se vuelve hipocondriaco, un objeto austitoide, que protege contra la falta de integración y la descomposición. Se desarrolla una dinámica autistoide entre el órgano hipocondriaco, el Yo y el introyecto. Dos viñetas clínicas ilustran las consideraciones dinámicas y metapsicológicas de la regresión.

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