

Psychosomatic or somatopsychotic? A critical analysis of psychosomatic Medicine

Psicossomático ou somatopsicótico? Análise crítica da Medicina psicossomática

Paulo Cesar Sandler*

ABSTRACT

Objective: To assess the scientific foundations of the so-called “psychosomatic Medicine” underlying all medical and scientific concepts and statements, likewise in any science. Case reports are presented. **Methods:** The following issues were epistemologically tested: (i) the mind causes bodily diseases; (ii) depression causes cancer; (iii) stress causes myocardial infarction and other diseases and (iv) body language. In order to study the statements and propositions, the author used: (i) theories from the Enlightenment period; (ii) positivist theories and (iii) modern science theories. All these theories are presented briefly. **Results:** There is evidence of a spurious split between body and mind, which results in one-sided investigations – without questioning their actual existence. This split is also shown by the psychosomatic Medicine, which has added some additional problems to the field. **Conclusions:** Results of epistemological and psychoanalytic “assessments” enable a critical analysis of the psychosomatic model, without apparently being successful in presenting a holistic approach, and requiring alternatives. Recommended medical management of “psychosomatic patients” is also presented.

Keywords: Psychosomatic Medicine; Psychoanalysis; Health knowledge, attitudes, practice

RESUMO

Objetivo: examinar as bases científicas da assim chamada “Medicina psicossomática”, subjacentes aos conceitos e afirmações em Medicina, como em qualquer ciência. Foi ilustrado com casos clínicos. **Métodos:** as afirmações examinadas foram: (i) a mente causa doenças do corpo; (ii) depressão causa câncer; (iii) estresse causa enfarte do miocárdio e outras afecções e (iv) linguagem do corpo. Utilizaram-se: (i) teorias do conhecimento derivadas do Iluminismo; (ii) positivistas e (iii) ciência moderna. Todas estas teorias do conhecimento são apresentadas de modo breve. **Resultados:** há indicações de uma divisão artificial entre corpo e mente, provocando investigações pendendo ora para um lado, ora para outro – sem se perguntar se estes “lados” existem na realidade. Essa

divisão se reflete no aparecimento da Medicina psicossomática e nos persistentes problemas criados no e por este campo. **Conclusões:** Os resultados do “teste” epistemológico e psicanalítico permitem uma análise crítica do modelo psicossomático, que parece não ter sido bem sucedido em sua corajosa abordagem holística, demandando alternativa. Incluem-se recomendações de conduta médica, no que tange aos pacientes vistos como “psicossomáticos”.

Descritores: Medicina psicossomática; Psicanálise; Conhecimentos, atitudes e prática em saúde

Psychosomatic or somatopsychotic? A critical analysis of psychosomatic Medicine

“Une seule pensée nous occupe; nous ne pouvons penser à deux choses à la fois, dont bien nous prend, selon le monde non selon Dieu»

Pascal¹

INTRODUCTION

Epistemology, the theory of knowledge, studies the knowledge acquisition methods. In the 20th century, it incorporated the scientific philosophy. Generally, medical literature does not heed epistemology in its research and practice. This, perhaps, happens because we use *in situ* epistemology, according to patters, such as significance tests and treatment trials. Hardly are these research rationales questioned. Due to its nature, Psychoanalysis is one of the rare medical specialties that demands constant self-reflection. This happens, for instance, when the analysts, due to their personal analysis, try to minimize the subjective interference of their personality traits. This study suggests the acknowledgment of the rationale, underlying medical research and theory, and using the epistemological

Study carried out at Faculdade de Saúde Pública da Universidade de São Paulo – USP, São Paulo (SP), Brazil.

* Master’s degree in Medicine – São Paulo (SP), Brazil.

Corresponding author: Paulo Cesar Sandler – Rua Inhambu, 1.233 – apto. 11 – CEP 04520-014 – São Paulo (SP), Brasil – Tel.: 11 3045 0115 – e-mail: sandler@uol.com.br

Received on: May 26, 2007 – Accepted on: March 9, 2008

and the psychoanalytical methods. It is justified by misdirection fostering discredit in Medicine and, particularly, in the mutual collaboration between Medicine and Psychoanalysis. The focus of this paper will be on the most difficult and complicated field, the so-called psychosomatic Medicine. The author did not analyze the internal perspectives of psychosomatic Medicine, such as criticisms to methodology; he only tried to detect the underlying epistemological approach.

Real scientific advances are obtained by researchers who start with clinical observations or medical problems and retrospective studies. The interpretation of data obtained call for experience-guided intuition to apprehend material or immaterial phenomena “invisible to the human eye”, and occasionally detected by such people as Darwin, Einstein, Freud, Fleming, Daulsberg – and by experienced clinicians in their daily practice. For instance, an abdominal surgeon facing a patient with kidney stones decided to order a computed tomography scan that showed a tumor at initial stage. Surgery evidenced an adenocarcinoma not yet invading the renal parenchyma. The surgeon intuitively perceived the tumor simply because there was a **suspicious** symptom.

Physicians **implicitly** seem to be epistemologists because they are always dealing with real facts and with methods to know these facts. The unknown is always present when we treat individuals that challenge our knowledge demanding us to find methods to increase our knowledge. A coronary artery may be an unpleasant surprise during surgery if it is actually an intramural vessel. Often we do not know the reactions to the medicines taken. Sentences like “one never knows what one is going to find when opening an abdomen” express this attitude towards the unknown.

Theories of knowledge, however, could be used in a more aware and explicit way, thus avoiding overconfidence in cases when there is no evidence about the causes.

To use the scientific method established by Francis Bacon is to create hypotheses starting with the **empiric** observation of facts. This allows the investigator to test the hypotheses as to their truthfulness and later make generalized theories. The investigator and the methods used interfere with the observed fact, but the investigator’s personality is irrelevant to the fact observed. In wrong science based on intelligence or authority of the researcher, a false fact is created on the basis of the investigator’s personality or knowledge⁽²⁻⁴⁾.

METHODS

We used epistemological methods adapted to Medicine, as is the usual practice. We used the analysis of concepts

and case reports as examples of medical acts related to therapy and diagnosis.

Knowledge cleavages

As medical knowledge developed, specialization became inevitable. Just as the ancient Renaissance scholars, who simultaneously were physicians, mathematicians, philosophers, and later established the divisions of Physics, Medicine, etc., Medical Sciences also established at first a division between clinics and surgery. This division reached proportions of comminuted fractures hindering mutual collaboration, when idea of the whole was lost generating stalled, non-communicating compartments.

Matter and mind

A not yet resolved issue is the cleavage between “mind” and “matter”⁽⁴⁾. Medical research artificially divided physicians into those dedicated to the “soul” or to the “body”. This has been a line of thought since Aristotle, and stressed by Descartes. This cleavage created two different kinds of investigators.

Some of them believe to be able to apprehend reality by restricting their attention to the sensorial system spectrum: vision, red to violet waves; hearing, 8 to 16,000 decibels; taste, touch, smell, related to all proprioceptive perceptions.

Such a restriction will lead us to concrete conclusions if they reach what we call “the mind”. A paramecium or an insect have sensorial systems, but no mind. According to Kant, this is the “naïve realism”⁽⁵⁾. Its improved version is the Positivism, which believes that isolating causes and effects will establish foreseen phenomena. This theory also believes that the observers and the methods used by them interfere with neither the observed object nor the conclusions. This was turned into a religion-like doctrine that allowed some advances in knowledge of the macro universe of large bodies and in tridimensional studies.

I suggest calling the second type “naïve idealism”⁽⁶⁾. This believes that the universe is the creation of an individual mind – the imagination. Its productions cannot be distinguished from a delusional patient with hallucinations: there is no contact with Material Reality. It created the false sciences, described by Popper as mythologies⁽⁷⁾. It infiltrated human sciences to an extent that began to doubt if they really were science.

The first solutions for this division between mind and the matter appeared when it was seen as a paradox between materiality and immateriality, and between the perception of probabilistic phenomenon and the discontinuity of the matter. In 1895, Max

Planck, a physicist, surpassed Ernest Mach's Positivism observing the propagation of light in quantum – small, discontinuous, and probabilistic packages of matter. In 1900, Sigmund Freud, trained according to the standards of the illuministic view in Medicine, anatomical pathology and clinical observation of real facts – he was Virchow's pupil – solved inconsistencies of the positivistic neurology while studying human behavior. He described two forms of a same existence that we call "mind": "Material Reality" and "Psychic Reality"⁽⁸⁾. What we call "reality" presents as material, partially conscious; and immaterial, partially unconscious. Many manifestations of the mind (unconscious) are unknown to the subject, as they are not experienced by the sensorial apparatus. Anxiety, depression, and hallucinations are real, but they have neither color nor smell, they can be observed, but are not seen. Material Realities the physicians deal with are also unconscious, as the pituitary or kidney functions, because noblest organs have no innervations. The "medical eye" is as immaterial as the intimate functioning of the "human substance". It is still unknown, but certainly is of sub-atomic (quantum) nature.

In 1905, Albert Einstein repeated Planck and Freud's achievements, again in the field of Physics. He solved other inconsistencies while studying the light and doubted the artificial division made by physicists in their theories about the same existence we call "light". He integrated the corpuscle theory (material) with the wave theory (immaterial) to explain the transmission and propagation of light⁽⁹⁾. Planck, Freud, and Einstein used immaterial research methods. Planck perceived through intuition that there is a "natural constant"; Psychoanalysis perceived the timeless and infinite nature of the unconscious; Einstein perceived the hexadimensional mathematics. They established the modern scientific bases in different fields by breaking positivistic limits (belief in causality and the observer's neutrality) and of the naïve realism (substantiation). Both are important, because they opened a door to modern scientific investigation and research. However, if we only pay attention to them, we are like visitors at the door, who never enter the owner's house⁽¹⁰⁾.

Psychosomatic Medicine

In the 1930's a brave, totalizing and non-dividing approach was attempted. However, two features limited their scope:

- rivalry: psychosomatic Medicine emerged as a superior rival showing the mistakes made by traditional Medicine. It could solve problems of Medicine and of Psychoanalysis. This was an inhuman control of the former and a detachment from biological reality of the latter;

- this is as story about habits: it used the part to describe the whole. Mistakes made by both physicians and analysts were considered the rule. This could be compared to a listener criticizing all cellos, just because she/he heard one off-key cello. Physicians – if these recommendations were made to real people – should look at the person, the subject. Analysts, if these were real analysts, should consider the biologic nature of disorders. Psychosomatic Medicine, a promise, used what was considered to be Psychoanalysis, at that historic moment and place it was created, to establish a new theoretical background. It did not create or describe its own background. The intent was to confer scientific respectability to Psychoanalysis, according to the positivist doctrine of the 19th century.

RESULTS

Let us examine the medical and psychosomatic statements using the proposed method.

Evidence-based Medicine

Evidence-based Medicine tries to eliminate the immateriality from the medical act itself: the physician's intuition trained through experience.

Trained intuition is the apprehension of reality without using logical reasoning. The epistemological rationale of evidence-based Medicine is a knowledge theory, i.e., the use of statistics in therapeutic guidelines following peer groups epistemological theories established by Kuhn^(3,11). It has not resisted to analyses using its own method⁽¹²⁾.

Overestimation of complementary tests

Medically irrelevant heart ultrasound findings during the 1980s and 1990s stimulated orovalvular implants with marked iatrogenic effects. The knowledge theory used to justify this action was the Positivism: the belief in causes ("murmur") and effects (heart disease).

Valuation of medically trained experience can be seen in disarmed semiology. For instance, we can mention intercostals bulging (the Lemos-Torres sign), when associated to the past history and the clinical state of the patient, it can indicate a pleural effusion. Complementary tests will only confirm the diagnosis and treatment, but they are not decisive. Often, the "clinical eye" or the "animal smell" is based on the illuministic view in Medicine: it is obtained through empiric evidences or by experience^(4,6). That is how the descriptive, syndromal, i.e., non-causal diagnosis appeared.

Freud observed the two main principles of the mental apparatus: pleasure/displeasure and reality. In psychoanalytical terms, medical theories emerging from clinical practice are linked to the reality principle⁽¹³⁾ and those deriving from the investigator's minds follow the pleasure principle. In the cases described above, rivalry and distance from the living medical experience were observed.

"The mind causing diseases of the body"

Contrasting with the naïve realistic idea that "the body causes mind disorders", a rivaling attitude appeared. The theory of knowledge underlying both Medicines, the somatic and the psychosomatic Medicine, does not change, as both use a causal reasoning looking for the "why".

Are there "whys" in other realms except religion? Medicine deals with the "how". The "how" produces general theories that describe **functions** and **relations**, but it does not describe causes. The search for the "why" produces explanations but it does not describe the facts. Medicine outgrew the witchdoctor phase when it abandoned the ambition of looking for the "whys" (regardless of the opinion of some physicians).

As demonstrated by Psychoanalysis, the search for "whys" is linked to not tolerating feelings of helplessness and smallness. Human bodies and minds are not logical and many of their aspects are still unknown. The accurate description is that a genetic problem allows a virus to cause injuries in the anterior horn of the spinal cord (etiopathogenic explanation) and leads to flaccid paralysis of several skeletal muscles (symptoms). This is called poliomyelitis – a name that has its counterpart in the scientifically demonstrated reality. This does not tell us anything about any "why" but describes scientifically several "whys" underlying the symptom (paralysis). To consider the genetic impairment as a cause leads us to a new "why" that cannot be answered. Causality makes us feel like a traveler who disembarks before reaching his final destination. Knowledge without causal connotations encourages useful interventions, such as surgical extirpations or healthcare measures in preventive Medicine.

The psychosomatic Medicine approach has not overcome the historical phase of the "why". It brings to mind the religious pre-medical phase. All texts about the history of psychosomatic Medicine mention its ancient origins⁽¹⁴⁻¹⁵⁾. In the tenth millennium BC, it was believed that diseases were caused by evil spirits and should be treated by spiritual methods. These spirits would occupy the total being and they would be expelled by exorcism or trepanation. Hereby we stress that the immaterial was favored at the expense of the material world.

This cleavage is an epistemological problem that results in advocates on both sides. This cannot solve the problem of physical Medicine that blames others for the mistakes it also makes. Have things improved since then?

Followers of this approach mention its renaissance in the 20th century and accuse Virchow, Helmholtz, and Koch of treating diseases instead of treating patients. Having adopted Psychoanalysis, Franz Alexander, starting with Freud's theories on hysteria, builds a new theory explaining the difference between the psychosomatic patient and conversion hysteria⁽¹⁵⁾. The epistemological problem is that Freud started with his clinical observations to formulate his theory, while Alexander starts with one theory to build another theory that he intended to use in clinical praxis. To make things even more complicated, this new theory emerged in a different context – it observes facts that are different from the addressed ones. If Alexander had started with clinical observations, maybe he would have built a different theory based on Freud's general principles but not specifically applying Freud's approaches. Science teaches us that to discover differs from inventing. This fact made him enter a field different from "real Psychoanalysis"⁽¹⁶⁾. As in physical Medicine, things are built in clinical praxis. Alexander applies known standards and, using psychoanalytic jargon, makes some causal explanations to explain symptoms found in daily practice. He had many followers, although these constructs tell us more about the rational intelligence of the author than about their reality. Maybe they are "a vast paramnesia to occupy the emptiness of our ignorance"⁽¹⁷⁾. Rarely do we find studies in which clinical practice gives rise to theory and not vice-versa⁽¹⁸⁾.

"Depression causes cancer"

Psychoanalytically considering this statement, the diagnosis of Omnipotence can be established. It supposes that patients and physicians could avoid a fact of life: diseases. Psychoanalytical treatment of patients with cancer by analysts embracing these ideas (not all analysts) demonstrates a deep abomination of life. Life includes pain, suffering, and diseases. Besides the burden of disease, the patient has to carry the burden of guilt ridden accusations about merely imagined past. Because the analyst or physician did not know or observe these patients during their whole life and, therefore, cannot affirm or reject the hypothesis that depression causes cancer. Once more, we face the basic epistemological problem of causes and effects.

Several studies approached this idea using statistics believing it would confer scientific validity to the

statement. However, to correlate *ad hoc* two universal phenomena (depression and cancer) may be as useful as to correlate depression with having a nose. There may be valid statistical association but the premise of statistical studies has to arise from clinical observations instead of from the investigator's mind. This kind of statement requires prospective studies to be valid, to be something else than a mere hypothesis.

Available statistical, immunopathological and biochemical studies that apparently "prove" this statement present an additional problem: the diagnosis, which is a basic knowledge in Medicine. It stands for "to know" (gnosis) + "through" (dia).

Medical diagnosis

What "type of cancer" are we talking about? Besides, the word "cancer" has different connotations for laymen. Lymphoma or hepatosarcoma have very different etiopathogenesis. Therefore, the use of the word "cancer" is not justified in research.

Psychiatric diagnosis

What type of "depression" is being considered? Is it endogenous depression? Is it situational depression? Hysteria with depressive symptoms is also classified as depression. P.C. had a non-invasive brain tumor. For eleven months, he was diagnosed and "treated" as being in depression. One day a slow onset coma became apparent. The psychiatrist called a neurologist, who diagnosed the disease immediately when observing a characteristic hiccup. Five hours after surgery, the patient was talking to his family. Studies with sophisticated statistical design and control groups obtain diagnoses through imprecise symptom inventories and not through psychiatric or analytic relationships.

PSYCHOANALYTIC DIAGNOSIS

Instincts and emotions are of biological, phylogenic origin. Analysts use the term "unconscious fantasy" to designate the psychological equivalents of instincts⁽¹⁹⁻²⁰⁾, thus integrating the Material Reality ("instincts") and the Psychical Reality ("psychic equivalents") as two forms of a same existence. On the contrary, to say that we have a "body" and a "mind" probably divides the indivisible. Are names a mere thermometer to measure our inability to understand and communicate real facts?

"Stress causes myocardial infarction"

The word "stress" describes the release of catecholamines during an alarm reaction (fight or flight) and their

action in several systems. In the circulatory system, it is expressed by tachycardia and coronary constriction⁽²¹⁾. Does this go beyond of an acute trigger?

The use of the concept of stress beyond these limits has impoverished the original definition, as stated by the author, Hans Selye. He emphasized that the term "strain" would be adequate when referring to theory about possible external pressure causing diseases. It introduces an imponderable factor that generates guilt, because it uses what has not happened – the absence of stress – as a causal factor. Scientifically, one can never know the outcome "if the person had not been stressed".

Who has been able to find out how not to be stressed? Would it be consistent with the maintenance of life? Nobody asks if the life of bushmen, when having to escape from a bison herd fleeing from lions, or if the life of primitive men facing a bear that already was occupying a warm cavern, or even the Middle Age peasants leaving the walls of their burg were less stressed than we are in our modern society. It took sociologists 300 years to reassess causal beliefs about material poverty and criminality. How long will it take physicians and psychoanalysts to review the trivialization of the stress theory?

Over the last 20 years, psychosomatic Medicine brought together Alexander's attempts and the impoverished use of Selye's theories speaking about "psychological reactions" to physical illnesses (that would be the cause of stress). Alexander's theories have not evolved over the last 50 years.

Body "language"?

One of the most popular ideas used when formulating psychosomatic theories is that of "body language". Is it a metaphor or reality? The consequence of seeing it as a reality is to enunciate and decode it. In real life, observing psychiatric patients or patients in general hospitals we see that "when the mind does not speak, the body speaks". Freud described this phenomenon as "acting-out", the impossibility of interpolating thinking with impulse and action⁽²²⁾.

Phenomena such as sweating, tachycardia, diarrhea, constipation, blushes, hyperpnoea, epigastric or rheumatic pain, and infarction of main organs are not considered acting-out any more, but are seen as symbols that explained – or were explained by – emotional events. For instance, patients with stomach ulcers have a mother eating their mucosa; women afraid of having babies, because they believe they are feces, have constipation⁽¹⁵⁾. Besides the already mentioned wrong diagnoses, the authors ignore *Helicobacter* and the proton pump.

By itself, excessive sweating does not mean anything. It would be wise to verify if it is very hot or if it is related to constitutional or hereditary aspects. It is not advisable to jump to the conclusion that it is related to emotional aspects. It could be lack of contact with the emotions. Mammals without emotional life have a sensorial life and can have stress reactions. Maybe it is impossible to investigate emotions and affections when they are deeply split and unconscious – that is when the body “speaks”.

Psychoanalysis describes deep splitting in the areas of thoughts and the personality that are so severe that they impoverish and avoid the perception of real, internal or external, facts⁽²³⁻²⁵⁾. Splitting characterizes patients seen by psychosomatic Medicine. The so-called “somatic” manifestation separates them from the contact with their emotional world. These psychosomatic theories confound **concretized emotions** with **feelings and sensations**. A better differentiation between feelings, sensations, emotions, affections, and emotional experiences and their vicissitudes has not yet been established, although it would be essential for psychosomatic Medicine. Something similar, still embryonic, can be found in Psychoanalysis as the “alpha function” theory that describes the transformation of stimuli noticed by the sensorial system into elements used to think, dream, and memorize⁽²⁶⁾.

It may be true that if the mind does not speak, the body does it. However, what does the body tell us? There is a contradiction between understandability and the ability to decipher the code of the so-called “body language”. Presently available psychosomatic Medicine tells us that loss of symbolization leads the body to “speak”. Psychoanalytic practice shows that the loss of symbolization causes speech limitation or loss disabling the capacity to verbalize.

In colloquial language, we could say that if the mind does not speak, the body does it, but it only says nonsense. To be more precise, we could say that the body cannot speak properly. It may grunt, snore or pose pre-verbal, non-symbolic expressions⁽²⁷⁾. If psychosomatic Medicine tells us that somebody is not able to symbolize, the body language cannot be qualified as “speech”. Does the investigator use the term “speech” in its concrete meaning? The experience with psychotic patients, with people in acute illness crises or people with functional diseases show us that often the main issue is not to interpret symbols. The problem is to notice the lack of symbolism and the patient’s expression functions as discharge, obstruction or acting-out. It is possible to know these functions in individual or group analysis, and this knowledge may be more relevant than any symbolic attributes given to something that is non-symbolic. One patient in analysis

defecated on the divan; another ran to the toilet. This is not, necessarily, either a symbol or a symptom nor the cause of anything. As Freud said to his peers, who were debating intricate theories, sometimes a cigar is only a cigar. Bion recommended “stopping investigations in Psychoanalysis” giving preference to “investigation of the psyche revealed by Psychoanalysis”⁽²⁸⁾. As in Medicine, Psychoanalysis describes natural functions and dysfunctions but does not explain them.

Generally, the loss of the ability to verbalize – except in neurologic disease – is a symptom of the person’s detachment from itself. Splitting, denial, projective identification, denial, and evasion are present. The aim of this paper is not to define this terminology. That can be found in literature^(13,19,23-26,29). What really interests us is that these mechanisms hinder the lost symbolization by something as precarious as the body. If the so-called “body” could be a useful instrument of auto-communication or hetero-communication, mankind would be spared from developing what we call mind or verbal thought. A sick dog finds an isolated corner. Why should humans be different? If a person isolates itself, why should we call it depression?

These questions are used to indicate the complexity of the issue and the limitations of present theories. More precise investigation tools may be required.

A.R., the first patient with ulcerative colitis I treated, in 1972, surprised me psychoanalytically because he presented more severe psychotic nuclei than many other patients, clearly diagnosed as psychotics whom I had seen in psychiatric hospitals. Experience has shown us the severity of psychosis presented by the phenomena of concreteness of thought and perception displayed by psychosomatic patients. Psychotic nuclei are universal. The issue is how each person deals with how they perceive them.

Freud perceived the universality of neurosis⁽²⁵⁾. Recent advances in clinical observation have also shown that psychosis is universal. Nowadays, we know that neurotic nuclei coexist with psychotic nuclei, that are covered by social aspects of life⁽²⁹⁻³⁰⁾. This is no indication that “everybody is crazy”; it only means that criteria of normality and craziness have to be reviewed. Behaviors considered as “normal” temporarily hide the daily life psychosis. Psychotic behaviors can hide lucidity.

Psychotic patients are people whose primitive psychopathologic traits are clearly evidenced. The degree of these traits’ manifestation varies from person to person, but the psychotic quality persists. They are even considered normal, when they are intelligent enough to find a *locus* in social groups that tolerate or stimulate psychosis. For instance, during wars, countries need people, who, in peaceful times, would be considered delinquents. This is identical to what

happens in Medicine: it is rather difficult to define who is ill. Health and disease are difficult to define: it is commonly accepted that health is the absence of disease. This concept is circular; it does not add anything about both states. The issue of the degree of disease can also be applied to the acquiescent environment: a sedentary patient with heart disease has no symptoms for a while.

R.A., 25 years old, had such severe contractions of the anal sphincter that almost everything he/she conveyed was farts, belching, and gastroesophageal reflux. His/her words, phrases, and reports had this function. The analyst had no doubts that these manifestations required the intervention of a gastroenterologist. More and deeper analysis revealed that sometimes these sphincter spasms were manifestations of fear, an awkward (defensive) way to avoid contact with fear. The analyst helped this patient to broaden his contact with fear and to use alternatives. Together, analyst and physician were able to produce a lasting mitigation of these symptoms that, later on, disappeared. Analysis can neither avoid flatulence, because it is genetically conditioned, nor deal with its consequences, although there may be some degree of mitigation during the sessions. Dealing only with gastroenterological symptoms can cause the indication of extreme solutions, such as gastrectomy or similar measures. "You do not have any disease, go to psychiatrist X". However, if nothing is wrong, why should the patient see another doctor?

R.K.M. had an intuition about herself. Having had eight years of analysis she returned to therapy after ten years. She had a rare invasive sarcoma, probably originated at the uterus, that had been discovered during surgery. She knew something was amiss inside her body. She lived long enough to prepare her death, organizing material issues. She also dealt with the emotional problems of her three children.

Explanations using "death instinct and cancer" would be superficial and mechanistic, impoverishing Freud and Melanie Klein's theories. They would not be realistic as to life as it is, and disrespectful to this brave and realistic woman, who had more strength than a thousand men. Functions of a way of living cannot be separated from those of a way of dying and teach us something about the way of "getting ill". Maybe much of what we call "life" is just a maniac episode; maybe much of what we call "death" is lucidity.

During a session, six months before her death, she was in uncontrollable anguish. It seemed to be something real, something no psychoanalyst could deal with. Analysts deal with unrealistic anguishes. She had to talk with the surgeon that had operated on her twice, but her secretary denied access. During that session, in the exact moment the anguish showed, I suggested calling the surgeon who did not know the patient was

unsuccessfully trying to reach her. I told her: "the secretary will not refuse to call her if another physician tries to speak to her. Would you like me to call her now?" The surgeon answered, paid attention to my opinion and made an immediate appointment. The patient left the session and went immediately to the surgeon's office. This surgeon did something like "direct psychotherapy" no analyst could ever dream of doing. The surgeon did not take the patient over appropriate and allocating the soma while delegating the psychological aspects to the analyst. She was psychosomatic. The analyst also did not appropriate the patient allocating the psyche and delegating the somatic aspects to the surgeon. The analyst was somatopsychotic.

DISCUSSION

Lack of epistemological awareness establishes (i) undue generalizations as well as (ii) hasty conclusions and disposable beliefs in therapeutic models that vary from innocuous to damaging, as time will prove.

The speed to create new psychosomatic theories may only be comparable to the speed to forget them. A plethora of promises of cures replacing Medicine and Psychoanalysis created non-fulfilled promises. Vested in psychoanalytic-like language, based on imaginary and excessive simplification, they created *ad hoc* theoretical explanations that, at most, could be theoretical hypotheses to be empirically tested but immediately became, "*a priori*", dogmas. There were endogamic debates among professionals and peer groups without any practical results or scientific evidence (empirical counterparts in reality) that could turn psychosomatic explanations into something more than mere surmises. The theory thus obtained is indistinguishable from religious beliefs or "skillful manipulation of symbols"⁽²⁸⁾. To what extent did these theories discredit psychoanalysis and become irrelevant in the eyes of laymen, physicians and scientists?

There is a need for transdisciplinary teams, in practice and in theory, in which physicians and analysts seem to decrease the abyss separating them. This abyss harms the patients. It has not been created intentionally but it has been maintained due to historical and emotional (individual) reasons. Among the historical reasons, are the splitting of western thought and the hyper-specialization deriving from sectoral advancements at the expense of the vision of the whole.

Deep emotional factors influence the choice of the two careers, that of the physician and the analyst, and are of an omnipotent nature (besting death, understanding the mind), that harbor rivalries and feelings of superiority – the root of mutual disdain. The analyst is not necessarily better than the doctor at anything regarding

the emotional world; nor is the physician necessarily the only professional who assists that person. Both would gain through a greater awareness of the other one's task. Medical education, in concentrating solely on the fundamental experiences of life and death foresee and opportunity for this. Embedding analysts in general hospitals seems to offer great promise in supplying a failing in their education. However, it is too soon to see if they will repeat the history of psychosomatic Medicine, i.e., of a lost chance.

Perhaps, many real physicians and analysts already were doing, in practice, what psychosomatic Medicine defended – thereby making the rivalry unnecessary. Maybe it would have been useful, as a precept of medical ethics, but not as a new field. The fact that it was not so is underlined by borrowing a theoretical structure from another field that was obtained under peculiar conditions of observation (Psychoanalysis).

CONCLUSIONS

Which practice, deserving to be called “medical”, could be less than “psychosomatic”? What psychoanalytic practice could be less than “somatopsychotic”? “What God has joined let no man separate” may be used as a metaphor. But, it is always bound with “what man has separated God will not join”.

REFERENCES

1. Pascal B. Pensée 145. In: The Great Books of the Western World. Chicago: Encyclopaedia Britannica; 1994. [Versão inglesa, por W.F. Trotter].
2. Sandler PC. Psicanálise e ciência: amigas, parentes ou estranhas? *Alter*. 2001;20(1):115.
3. Sandler PC. Hegel e Klein: a tolerância de paradoxos. Rio de Janeiro: Imago; 2003.
4. Sandler PC. A apreensão da realidade psíquica: um estudo transdisciplinar. Rio de Janeiro: Imago; 1997. v. 1
5. Kant I. Crítica da razão pura. Traduzido por Rohden V, Baldur U. São Paulo: Abril Cultural; 1980. Os Pensadores.
6. Sandler PC. Le projet scientifique de Freud un siècle plus tard? *Rev Fr Psychanal*. 2001; Numero Hors Serie.
7. Popper KR. A lógica da pesquisa científica. Traduzido por Hegenberg L Mota OS. São Paulo: Cultrix; 1974.
8. Freud S. The interpretation of dreams. In: Strachey J. The standard edition of the complete psychological works of Sigmund Freud. London: The Hogarth Press; 1958. v. 6. p. 620.
9. Einstein, A. Relativity: the Special and the General Theory (1916-1952). In: The Great Books of the Western World. Chicago: Encyclopaedia Britannica; 1994
10. Sandler PC. Epistemologia: um resumo crítico sob a ótica de um psicanalista, para uso de psicanalistas. *Rev Soc Bras Psicanal*. 2003;5(1):187-221.
11. Kuhn TS. The structure of scientific revolutions. Chicago: University of Chicago; 1962.
12. Hunink MGM. Does evidence based-medicine do more good than harm? *Br Med J*. 2004;329(7473):1051.
13. Freud S. Formulations on the two principles of mental functioning. The interpretation of dreams. In: Strachey J. The standard edition of the complete psychological works of Sigmund Freud. London: The Hogarth Press; 1958. v. 6. p. 226-8.
14. Kaplan HI, Sadock BJ, Grebb J. Compêndio de psiquiatria. 7a ed. Traduzido por Baptista D. Porto Alegre: Artmed; 1997.
15. Alexander F. Psychosomatic medicine: its principles and applications. New York: WW Norton; 1957.
16. Bion WR. Uma memória do futuro. Traduzido por Sandler PC. Rio de Janeiro: Imago; 1996. v. 2.
17. Bion WR. Evidência. *Rev Bras Psicanal*. 1985;19(1):129-41.
18. Sandler J. Contribuições para uma psicoterapia de grupo com coronariopatas. *Rev Bras Psicanal*. 1976;10(4):445-6.
19. Freud S. Notes upon a case of obsessional neurosis. In: Strachey J. The standard edition of the complete psychological works of Sigmund Freud. London: The Hogarth Press; 1964.
20. Isaacs S. The nature and function of phantasy. In: Klein M, Heimann P, Isaacs S, Riviere J. Developments in psycho-analysis. London: The Hogarth Press; 1952. p. 67-121.
21. Selye H. Textbook of endocrinology. Montreal: Franks WT; 1947.
22. Fenichel O. Neurotic acting-out. In: Fenichel H, Rapaport D. The collected papers of Otto Fenichel. New York: WW Norton; 1954. p. 296-305.
23. Freud S. Splitting of the ego in the process of defense. In: Strachey J. The standard edition of the complete psychological works of Sigmund Freud. London: The Hogarth Press; 1964. v. 23, p. 273-282.
24. Klein M. Notes on some schizoid mechanisms. In: Klein M, Heimann P, Isaacs I, Riviere J, editors. Developments in psycho-analysis. London: The Hogarth Press; 1952. p. 292-320.
25. Freud S. Neurosis and psychosis. In: Strachey J. The standard edition of the complete psychological works of Sigmund Freud. London: The Hogarth Press; 1964. p. 149-56.
26. Bion WR. Learning from experience. London: Heinemann Medical Books; 1962.
27. Klein M. The Importance of symbol-formation in the development of the ego. In: Klein M. Contributions to psycho-analysis. London: The Hogarth Press; 1950. p. 236-50.
28. Bion WR. Uma memória do futuro. Traduzido por Sandler PC. São Paulo: Martins Fontes; 1989.
29. Bion WR. Experiencias en grupos. Traduzido por Nerbia A. Buenos Aires: Paidós; 1963.
30. Bion WR. Differentiation of the psychotic from the non-psychotic personalities. In: Bion WR. Second thoughts. London: Heinemann Medical Books; 1967. p. 43-64.