GRODDECKIAN INTERVENTIONS IN MEDICAL SETTINGS.

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We present Groddeckian psychoanalytic psychosomatics in practice through two case studies. Groddeck pioneered the application of psychoanalysis to organic diseases, but his ideas have not been explored adequately. It is necessary to reappraise his concepts to develop their potential in psychoanalysis. We aim to demonstrate the efficacy of the Groddeckian approach by presenting two cases: a case of conversion of a boy who entered a semi-comatose state due to unattended emotional experiences and a man who developed a "sick role" resisting all medical interventions. In both histories, it is possible to see how disease and subjectivity intertwine in a complex unity of mind and body.

KEYWORDS: psychoanalytical psychosomatics; Groddeck; psychoanalytical technique; psychosomatic medicine.

INTRODUCTION

The aim of this paper is to demonstrate the efficacy of a Groddeckian approach using psychoanalysis to treat patients in medical contexts.

Recent papers, including several published in this Journal, have shown the significance of Groddeck to modern psychoanalytical thought. Poster (2009) identified Groddeck, together with Ferenczi and Rank, as being responsible for a significant paradigmatic shift in the development of psychoanalysis. The label of "wild analyst", which Groddeck himself adopted, is currently seen as representing open-mindedness, boldness and creativity when dealing with psychoanalytical questions (Berman, 2007; Dimitrijevic, 2008). Mészáros (2009) discussed the importance of the Budapest school for intellectuals and psychoanalysts and showed how Groddeck participated in debates on the conundrum of the mind–body relationship. The question of the body was also addressed by Langan (2007) and Gottlieb (2003), placing Groddeck in the central role of discussions on the expansion of psychoanalysis to other realms of reality, far from its origin with the study of neuroses.

In spite of being considered by many authors as the "real" father of psychosomatics (Grotjahn, 1945; Usandivaras, 1979; Will, 1987; Haefner, 1994; Biancoli, 1997; Ávila, 1998, 2003), Georg W. Groddeck suffered a peculiar fate of repression, in particular from the 1930s to the 1960s. From then on, however, his originality was acknowledged, and he received a distinctive place in the history of psychoanalysis (Alexander et al., 1995) as the creator of the concept of the Id, as Freud clearly stated in "The Ego and the Id" (Freud, 1923). However, in the majority of books and papers published on psychosomatic medicine, he is seldom quoted or discussed.

Undoubtedly, this is partially due to the fact that Groddeck's style was often too provocative. In most of his texts, Groddeck (1977, 1978, 1979, 1981) argued in a way that sounds aggressive against what he considered were misconceptions and misapplications of "official" medicine and chiefly against practices that he believed might harm patients. He used to freely express his opinions about the curative power of nature stating that doctors should rely on their patients' own resources to achieve cures. His use of psychoanalytical concepts was also quite free; he applied the notions of resistance and transference in a way that many psychoanalysts would consider excessively vague. This is not surprising since he expressed his desires of independence in his first letter to Freud:

> It is not possible, while advancing such ideas, to use a terminology that differs from the one you have developed. It cannot be replaced, and it suits my purpose, too, if the concept of the unconscious is enlarged. In the *Internationale Zeitschrift*, however, you expressly restrict the meaning of the unconscious. If one extends this meaning, as one must when considering the psychoanalytic treatment of so-called organic illnesses, one goes beyond the frontiers laid down by you for psychoanalysis. (Groddeck and Freud, 1977, p. 33)

Groddeck also used to clearly express (and publish) the intense, complicated and awkward content he identified in the free associations of his patients, and he employed the same frank and contentious style when addressing "conferences" to the sick. The complete course of his speeches in the sanatorium of Baden-Baden (Groddeck, 1978, 1979, 1981) have not been translated to English, unfortunately, as it is an amazing collection of his concepts to be used by patients in their struggle for recovery. Visceral functioning and products, bad desires, angst and envy together with love, gratitude and health -all aspects of human life associated with features of body functions- mark their presence as the elements from which Groddeck extracted the "meaning of disease ".

From the very first chapter of his famous book "*The book of the It*" (Groddeck, 1961), he tries to show how important it is to comprehend the totality of the life of the sick, even if this is resisted by the patient. For him, the disease was a symbolic expression of the inner conflicts agitating the body and soul of the person. The "voice of the unconscious" must be heard, and doctors should be able to understand that the It can appear frequently as body symptoms, instead of being mentally represented, Groddeck emphasized.

> Disease for me is a kind of speech, the meaning of which I, as a doctor, must try to interpret and then decide my treatment accordingly. In my unscientific phraseology, the It, when it wishes for any reason to be ill, chooses something from the mass of possible means in the world around and this it uses to produce certain symptoms, taking this or that definite course, according to its purpose. (Groddeck, 1977, pp. 115 – 116)

Carl and Sylvia Grossman, in *The wild analyst* (1965), pointed out that both Freud and Ferenczi had urged Groddeck to attenuate his discourse and avoid using expressions that could shock readers. This advice was only partially accepted by Groddeck. His writing was always simple, rude and direct, with few technical terms, and the inner core of his discussions was the search of the unconscious structure of diseases and symptoms, either organic or psychical, expressed in their own terms, that is, unbearable to conscious thought and communication. This is even worse when expressed in scientific communications. I tried, in my book "Isso é Groddeck" ("This is Groddeck", Ávila, 1998) to make his ideas more palatable to contemporary readers.

In his biographies, it is clear that the relationships between Groddeck and his colleagues, that is psychoanalysts and doctors, were very difficult (Grossman and Grossman, 1965; Will, 1987) in spite of his success as a psychotherapist and as a physician. In addition to his contentiousness, what probably makes Groddeck practically unknown today is related to his attitudes towards science. For him, the definitive criterion to judge a method or medical intervention was the outcome of a treatment. The unique evidence he looked for was the recovery of the patient's health resulting from an insight of unconscious meanings.

The transparency of his decision to think and write regardless of any "scientific proof" is obvious in his case histories and medical texts. For instance, in "Clinical Communications", he wrote: "That disease of every kind is susceptible to psychotherapeutic treatment cannot be proved; it can only be a matter for trial and experiment" (Groddeck, 1977, p. 203).

Groddeck mocked science and its methods frequently, and this, evidently, is one reason that "serious" researchers and doctors might find it difficult to accept his ideas. With the increasing dependence on scientific and technological approaches in medicine, the inevitable consequence was to relegate Groddeck's ideas to the limbo of oblivion and the author to the halls of fame.

Nevertheless, it is certain that Groddeck's concepts and practices deserve reappraisal. It is also true that they must be investigated and tested for consequent rejection or acceptance on the basis of congruence and utility. In addition, their heuristic power to produce new theoretical perspectives and technical changes must be checked (Schacht, 1977; Ávila, 2007; Mészáros, 2009; Poster, 2009).

One of Groddeck's basic assumptions was the inseparability of body and mind. He came up with this idea before beginning to study psychoanalysis. As he stated:

> Long before I met the above-mentioned patient in 1909, I had become convinced that the distinction between body and mind is only verbal and not essential, that body and mind are one unit, that they contain an It, a force which lives us while we believe we are living. (…) In other words, from the first I rejected a separation of bodily and mental illnesses, tried to treat the individual patient, the It in him, and attempted to find a way into the unexplored and inaccessible regions. (Groddeck, 1977, pp. 32–33)

This unity is far from being acceptable to contemporary scientists. The splitting of the Cartesian concepts *res cogitans/res extensa* 400 hundred years ago is still the basis on which medicine studies diseases as biological entities instead of the biographical events of an ill person, who is an organism but also has subjectivity.

Groddeck is also responsible for changes in the psychoanalytic technique. Similar to his friend and patient Sándor Ferenczi, Groddeck was convinced that the patient should be directly confronted with the intricate purposes of the Unconscious. Trained in the Hippocratic tradition by his master Schweninger, his great experience as a doctor was used to treat severely ill patients, which led Groddeck to deal with the treatment in a very particular way:

> I did not come to psychoanalysis through treating nervous diseases like most of Freud's pupils but was forced to practice psychotherapy and psychoanalysis because of my physio-therapeutic activity with chronic physical complaints. The success of post hoc ergo propter hoc taught me that it is as justifiable to consider the body dependent on the soul and to act on this assumption as vice versa. (Groddeck, 1977, p. 120)

When working as psychoanalysts of patients who suffer from organic ailments, it is this vision of a "whole", of a "unit", that should be reconsidered. Even if this attitude is against the mainstream, the biographical circumstances of patients must be taken in consideration if we want to achieve a thorough change. I wrote in a previous paper: "What gives so problematic a character to the Mind and Body relationship is the interminable struggle between the objectivity aimed at by science, and human phenomena, which cannot be deprived of subjectivity without losing its soul" (Ávila, 2003, p. 99).

The following two case histories illustrate how these Groddeckian conceptions may be adequately used as tools for psychoanalytic interventions in medical situations.

CASE REPORT 1[1]

I was working as a clinical psychologist, teaching medical psychology and attending outpatients in a University Hospital, when a doctor from the gastroenterology department asked for a liaison consultation. By telephone, he told me that a young patient had entered a semi-comatose condition just as the boy was in the process of being released from hospital. Very intrigued, he told me that there was no medical reason for this development and that the boy started sleeping deeper and deeper, refusing to eat and to communicate, until reaching his present superficial semi-comatose condition.

I told the doctor that I was a psychologist and that the patient should preferably be examined by a psychiatrist, since the psychologist's instruments, relationship and language, would be absent. He was very

worried and anxious and insisted, and so I decided to visit the patient.

When I entered the boy's ward, the nurse told me that the doctor in charge had asked her to prepare him for some "resuscitation" procedures, but she would wait until this consultation was over. Then she left me alone with the patient.

I approached him from the side to which his head was turned, but as soon as I sat down, he turned away. I moved my chair in front of him again. He was asleep, but I introduced myself and repeated some information about him such as his name, the place we were, etc. After a few phrases, I had nothing more to say. The patient did not respond at all, so I tried a few more possibilities, like telling him how old he looked to me. Then, silence. I did not know what to do. I felt miserable and impotent. The silence was oppressive, and he snored. Then I told him: "Hey, do not be afraid".

I repeated this once, twice, three times. No answer. Monotonously and moved by unknown reasons, I insisted on the same theme: do not be afraid.

I perceived, under his eyelids, the slow movement of his eyeballs. I insisted for him to talk with me without fear. Then, he opened a tiny gap in his eyelids, and I asked him to tell me what he was feeling. Very slowly and drowsily, he started, telling me that it was no use waking up; it was pointless, and painful. Why wake up, if he would have to face a most frightening experience?

Very carefully I asked him to tell me what he was fearing, assuring him that it would be better to have someone who trusted him and who could try to help. He told me:

"I know. I am going to die".

"Why? How do you know this?" I asked.

Three days before, he told me, he had heard the doctor who was treating him in a conversation with a nurse, say that "this boy would not survive and would die very quickly".

The doctor had been referring to another patient but did not realize that this boy was not sleeping and had received this phrase as his "death sentence".

Of course, for an adolescent, as for many of us, sleep is much better than the process of dying. Our worst fear is to see this dreadful situation approaching. So, he chose Hypnos rather than Thanatos (in Greek mythology, the two brothers, Sleep and Death). Who could blame him for this choice? By sleeping, he could better deal with the terror that would flood his psyche. So, the whole matter was a case of involuntary iatrogenic, but for the patient it was life or death.

Immediately, I told him that this was a misunderstanding and that the doctor was referring to another person. He was astonished and I asked him if he wanted to talk to the doctor. "No", he said, and pointing to the food on his bedside table he asked to eat. He ate with a great appetite and we talked a little more. In the conversation he corrected me: in my first attempts to reach him, I had said that he seemed to be 14 years old. He told me that he was 12, thereby proving that he had been hearing all my words, as well as those of the nurse and doctor who had preceded me. This is why he became progressively scared, hearing the doubts and decisions that the doctors and nurses were expressing and "translating" them as new menaces. His conversion reaction was a deepening of his inappropriate defense to escape from a dangerous situation.

Just after our conversation, the doctors came, evaluated him and called his parents. This patient was discharged from hospital the same day and since then has never returned for health reasons.

CASE REPORT 2

The patient, a 60-year-old man, had been bedridden for the previous 22 years. His primary diagnosis was osteoarthritis, but his clinical situation became much worse since his position brought on several complications: water in his lungs, dysfunction of many organs including the kidneys, gall bladder, etc., myo-asthenia and a severe drop in his immunity.

I started to treat him at the request of his older daughter, a medical doctor. She told me that he was an old incurable patient, renowned in many health services and by many professionals. She had been taking care

of him for a long time. She did not expect great change in his clinical state but asked for my help since she feared his reaction to a great change she planned in her life: she was considering moving away from home to a distant town.

In addition to being treated by several different specialists, this man had had five different psychiatrists treating him over the previous two decades. All of them had failed to hold the patient. This man manipulated medicines and doctors and interrupted all therapeutic attempts. His clinical situation worsened year after year, although the best professionals were periodically consulted.

Now, the daughter was convinced that a stalemate had been reached, and she decided to leave home, abandoning her father to his illness. This opened his defences and he agreed to participate in psychotherapeutic sessions. Mixed feelings and serious arousal turned his treatment into a very intense experience for both of us.

I entered his room in his house and found a reproduction of a hospital room. There was a metal cupboard full of medicine; a rack with shelves with many examinations, X rays, tomographies and medical apparatuses and a sophisticated hospital bed. It was like a kingdom and soon I realized that from the middle of his domain, this man ruled with an iron hand.

During 6 weeks, we analyzed his experiences with his illness. First, he brought a vivid description of his family life and about his motivation to keep them tightly together. Then, he started analyzing himself and the links between his biography and his physical symptoms. Finally, he faced the origin and the core meaning of his disease:

His sickness started with a fall from scaffolding. He injured his spinal column and was hospitalized for 2 weeks, after which his doctors released him, prescribing physiotherapy. But the patient complained of violent pain and was re-admitted to hospital. New examinations were performed, without a definite diagnosis. The man progressed to severe disabilities and the family looked for other medical professionals. A pilgrimage started. Many doctors and clinics were visited -orthopedists, rheumatologists neurologists and pain specialists were consulted but the patient did not improve; there was no relief from his main symptom: the pain.

He was on sick leave for a long time, and after some years of fruitless investigations the social security system agreed to his permanent disability and he retired. After that, he lived in his house and all subsequent treatment was made at home. He got the most diverse diagnoses, but the aetiology of his pain could never be established. Although some psychiatrists suspected a conversion disorder, his suffering and motor difficulties convinced the family that this man was physically ill and accepted the situation.

The composition of his family was the patient, his wife and four daughters. Every one of them lived very close to him: he never permitted any of them to sleep away from home, to travel, to have friends, to date. All of them were single, although the oldest was in her thirties and the youngest was 22 years old. Only two of them had jobs; the doctor and the third daughter who was a secretary in an office nearby. The family had few friends, with most of them being relatives of the father.

The emotional pattern of the family group was of tight ties, warranted by the compulsive control of the father. This man believed that the happiness of all the family was dependent on their union and his idea of this union was physical presence, the maintenance of family rituals and the continuity of stereotyped habits. Under these conditions, his sickness played the vital role of secondary gain (Parsons, 1951 ; Barsky and Klerman, 1983 ; Van Egmond, 2003).

Being ill, this man had a weapon and an instrument of blackmail: any challenge to his authority, he would react with aggravation of some of his symptoms. If a daughter managed to get a boyfriend, her father would make her feel guilty, because he would need her to care for him. In difficult moments, he suffered “emotional emergencies”; on several occasions, he had crises requiring urgent hospitalization.

At the beginning, this man accepted therapeutic assistance in order to control the situation. If a daughter fled from home, the door would be opened allowing others to follow. He would have to face his worst nightmare: solitude. Even his wife, he feared, would leave him, to follow one of her daughters. Alone and sick, he would die. He would consider suicide. He could not bear the separation.

Gradually, he developed the insight about the use of his symptoms and the way they had become his tool to emotionally have power over his family. Clearly, he confessed that from the very beginning of his illness, he knew that what he wanted was to retire at an early age, and "to live" exclusively with his family, or rather, as the "king" within his family. Now, after so many years, he recognized the impossibility of forcing his daughters to live the same choice. But, instead of facing an urgent need to change, he admitted the conscious use of the situation and stopped the psychotherapy. Even so, his daughter, although in great anguish, left home.

DISCUSSION

Georg Groddeck's concepts are original, radical and have not yet been fully explored. His importance as a predecessor in the development of the so-called relational or interpersonal psychoanalysis has been acknowledged (Rudnytsky, 2002; Dimitrijevic, 2008). Poster (2009), after analyzing the close but conflictive triangular relationship between Freud, Ferenczi and Groddeck, points out that the former accepted the dissent of the latter two and remained friends, with all of them benefiting from the creativity and support of each other.

> Motivated by Freud, in both positive and negative ways, Ferenczi and Groddeck analyzed each other and supported each other ' s clinical experiments. Where Freud pioneered in the study of the paternal transference, resistance, and Oedipal conflicts, both Ferenczi and Groddeck pioneered in the use of the maternal transference, the countertransference as a useful construct, the importance of the pre-Oedipal period, and somatic expressions. (Poster, 2009, p. 204)

The relevance and future of psychoanalytical psychosomatics depends on a demonstration of its efficacy in different situations and contexts, mainly in the hospital setting. Here, two case studies are presented with the aim of illustrating the vivid results obtained with the use of Groddeckian interventions to treat patients with what appeared to be medical illness, but whose physical conditions were not improving. What can be derived from the particularities of these case reports beyond the richness of the individual history? We believe based on the heritage of the psychosomatic pioneers that a disease is lived: a personal experience (Groddeck, 1977; Ávila, 2006). Far from denying the biological basis of any disease, we think that the mind cannot be split from the body of the sick; the soul cannot wait hanging in the closet, while the soma is consulted by the doctor using his technical approach.

In both cases, we find the unity of the body and mind demonstrated by the patients' resistance to heal. The boy and the old man did not respond to their medical treatment because their psyche was not understood, and the meaning of their illness was not clear. Corporal transformations can only be expected after a comprehension of the unconscious dimensions of their diseases has been achieved. The body is not a passive instrument, either for the patient or the doctor, but it is always a lived and living body, meaningful and mysterious. Unconscious forces inhabit these bodies and our task is to be aware of this: the body ' s mutterings must be heard and deciphered.

Case 1 shows us the immense power concentrated in the hands of physicians: doctors are seen as the masters of life and death. All care is needed. All tenderness is welcome. Ethics is more than an attitude: ethics is an essential part of medical acts (and of clinical acts in general). If a boy can live a dialogue as the definition of his fate, we should be very aware about the effects of words, phrases, silences and gestures on patients. A psychoanalyst, or a well-trained health professional, can " listen to" some expressions that the patient pronounces or identify some emotional reactions he / she exhibits as these are very important subjective experiences that are being lived during the sickness. Disease is not only a biophysical or biochemical condition; it is a profound change in personal life that affects both body and mind.

The intensive training psychoanalysts receive to understand transferential and counter-transferential feelings of patients prepare them for the emotional meanings of different human experiences. Bold early analysts, such as Groddeck and Ferenczi, taught us that a close relationship with the patient is crucial. As

Berman states: “The image of the wild analyst can serve us, however, as the image of the deeply involved, personally motivated analyst, whose work is intense and emotionally risky” (Berman, 2007, p. 212). This attitude should also not be absent in hospitals and other medical settings.

Case 2 comprises many difficult experiences. What can doctors do when encountering such complexities of secondary gains? At least, they must be aware of the complex meanings experienced by the patient while living his/her disease. How life and disease intertwine in a delicate mosaic, in a solid tissue of new realities? Symptoms and feelings, pain and meanings, disability and family consequences, all of these emerge, and the subject is the author of a complex, original and unknown “product”: his illness. This was imagined by the great psychosomatic pioneer, Georg Groddeck.

Here, we tried to explore some links between life and pathologies; between the personal history and the onset of symptomatology and chronicity of diseases. From a psychoanalytical standpoint we can see how desires, fears and expectations can interfere in diseases to aggravate or ameliorate them. In these reports, using techniques inspired by the ideas of Georg Groddeck, we hoped to reveal some of the interconnections emerging between sickness and subjectivity.

Many other studies are still necessary to prepare the ground for a paradigmatic shift in the way science considers diseases and to change the approach to the individual sick person. Psychoanalysis indeed has a role in the discussion about the intertwining of biological (genetic, physio logical, and environmental) and biographical aspects of becoming sick, recovering or worsening. We think that Groddeckian psychoanalytical psychosomatics may contribute greatly to contemporary clinical therapies and theoretical studies and help to shed light on this very complex matter.

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Notas al final

1 .- Versions of these cases were presented and discussed along with other case reports in Ávila (2002).