Psychosomatic disorders:  
a psychoanalytic category?

Psychosomatic relations are at the level of the real (Lacan, 1988, p. 96)

Introduction

In this paper I will explore some of the arguments surrounding the concept of the psychosomatic and psychosomatic disorders. As will become clear this is an idea which has a difficult history within psychoanalysis, and even today there appears to be no clear agreement as to whether the concept of the psychosomatic has any place at all within analytic discourse. I will begin the discussion by outlining some of the arguments from outside of the psychoanalytic framework - I think it is useful to remember that there is a well established field of psychosomatics in the psycho-biological field, which is, if anything, quite antagonistic towards the (perceived) psychoanalytic interpretation of this subject. I will then move on to examine the arguments within the psychoanalytic domain, with a particular focus on the apparent confusion between conversion and psychosomatics. I will end by putting forward the basis of a theory for the psychosomatic which I believe reclaims this area for psychoanalysis.

Before moving onto the main arguments, however, I want to say something about how I became interested in this topic. Whilst working in a social services mental health drop-in centre I met a client (to use the politically correct term) whom I began to think was exhibiting a number of psychosomatic symptoms. This was before I realised the term ‘psychosomatic’ was problematic at all. I then spent some time counselling this client and in doing so he revealed certain aspects of his personal history which led me to confirm my initial hypothesis. The client had suffered from ulcerative colitis for number of years, culminating in the removal of his bowels. He then suffered from a number of muscular problems which recently culminated in a ‘diagnosis’ of rheumatoid arthritis. He has also experienced liver problems and a number of side effects from the various medications he has been taking for his arthritis and other physical conditions. Tragically this client died before I had the chance to develop the work, and before he had the chance to possibly gain some insight into his situation.

This man had spent virtually the whole of his adult life (he was approaching forty when he died) in and out of hospital for various physical problems. He had also experienced a lifetime of abusive relationships - including physical violence, starting with his father, then his school teachers and in adult life with a number of ‘friends’. His father suffered from rheumatoid arthritis, and he believed that this was something he had inherited - in spite of the fact that when he had the operation for the ulcerative colitis he was told that it would seriously affect his immune system - and rheumatoid arthritis is an auto-immune disease (Martin, 1997).

The more I got to learn about this person’s life history the more I felt overwhelmed by his somatic problems - in fact the counselling was punctuated by him spending time in hospital for his muscular and internal problems. Yet at the same time I became more and more convinced that there was a connection between his psychic
history and his somatic history. But is it enough to say, either to myself or to this person that his problems are 'psychosomatic'? How do you approach such an issue with someone who has a ‘bag’ inside of him instead of bowels, who has spent twenty years trusting the medical profession whilst apparently suffering as a result of such trust, who tells me with almost unconcealed glee that his condition is genetic - and by implication that no amount of talking will change things?

**A problematic concept?**

**The view from outside psychoanalysis**

The idea of psychosomatic illness and psychosomatic medicine pre-dates psychoanalysis (Psychosoma, 1998) but it is only today that there appears to be a growing recognition that most, if not all, physical illnesses have a psychological component to them, and to this extent all illnesses - and all health - may be defined as psychosomatic (Martin, 1997, p. 28). However, this is not the end of the story: in fact it marks the beginning. To start with, as Martin goes on to point out, this recognition is not shared by everyone, and the people most resistant to the idea of psychosomatics are the patients themselves, not the practitioners - be they psychoanalysts or medical doctors. The concept of psychosomatic is taken, wrongly as it turns out, by many people to mean that somehow the problem is ‘unreal’. Showalter illustrates this with the example of Chronic Fatigue Syndrome or ME, which is thought to have a number of contributing factors, including psychological ones, but which many sufferers would rather was simply attributable to a virus - a virus being something ‘real’ and ‘tangible’ (Showalter, 1998, pp. 115-32).

Most writers outside of the analytic field are at pains to point out that psychosomatic disorders are not ‘imagined’ by the subject. Skiba for example writes:

> A common misconception about psychosomatic disorders and illnesses is that they do not really exist, but are merely imagined by the patient. On the contrary, psychosomatic disorders are actually illnesses caused by physiological changes which occur as a result of the mental state we are in (Skiba, 1998, p. 1)

There also seems to be some confusion amongst writers about what exactly is meant by the term ‘psychosomatic’. Martin, who first defines psychosomatic as that:

> ...in which psychological factors play a contributing role in the development of the illness, alongside other factors such as bacteria, high blood pressure or smoking (Martin, 1997: 28)

then proceeds to denounce psychoanalysis as propagating:

> the misleading conception of illnesses as mere phantoms, conjured up by the unconscious mind...(ibid)

which he argues is the other, and popularly held, conception of the term ‘psychosomatic’. Unfortunately, as we shall see below, there seems to be a great deal of confusion as to the nature of psychosomatics within the psychoanalytic field itself.
A sociological perspective

Greco traces the history of psychosomatics from the time of Freud and argues that it can be seen as the emergence of a moral dimension to health - an addition to the purely biomedical approach (Greco, 1993). Within this framework health becomes related to individual choice, and although it has now moved well beyond the psychoanalytic domain, it was within the framework of hysteria that the psychosomatic subject was born - what Greco describes as the ‘psychiatrization of medicine’. The key figures from psychoanalysis at this time (particularly the 1920s) included Alexander, Deutsch and Groddeck.

Psychosomatics also represented new concept of space and time, with the individual no longer being regarded as an isolated, atemporal organism, but a subjective being in a social environment. It also introduced the notion of risk - and of being at risk, which was related as much to lifestyle and psychological (moral) factors as to biomedical factors. Care, or failure to care, for the self became a key issue for individuals - an idea taken up by Parsons and his concept of the sick role. Here, adopting the such a role is a form of socially managed deviance, which is coupled with the moral obligation to seek help and get well. In fact, the biomedical dimension of the illness seeks to authenticate the condition and also to legitimate the position of the doctors.

Although Greco acknowledges that the term ‘psychosomatic’ has moved beyond the confines of psychoanalysis she fails to acknowledge that the term is by no means universally accepted within this field. In fact, it has been heavily contested and this is something I will now turn to.

Psychoanalysis and psychosomatics

A psychoanalytic category?

According to Laplanche and Pontalis psychosomatic disorders are the modern day version of the actual neuroses, which are distinct from the psycho-neuroses. Actual neuroses have their root in the present day situation of the subject (‘actual' here meaning ‘here and now’), whereas the psychoneuroses have their roots in infantile experience and trauma (Laplanche, 1973, pp. 266-9 & 10-12). They also note that the term somatisation can be used to distinguish hysterical conversion from other processes of symptom conversion - somatisation being applied to the latter.

Freud in his Introductory Lectures, distinguishes between the ‘actual’ neuroses and the psycho-neuroses, arguing that only the latter are related to repressed childhood experiences (Freud, 1917, pp. 425-39). The 'actual' neuroses on the other hand are related to traumas occurring in the subject’s contemporary life. The symptoms of the 'actual' neuroses have no psychical meaning - the subject somatises directly without psychical mediation. In contrast, in the psychoneuroses the symptoms are tied intimately to the psychical history of the subject:

Now, however, I must draw your attention to the decisive difference between the symptoms of the ‘actual’ neuroses and those of the psychoneuroses, the first group of which, the transference neuroses, have occupied us so much hitherto. In both cases the symptoms originate from the libido, and are thus abnormal employment of it, substitutive satisfactions. But the symptoms of the ‘actual' neuroses - intracranial
pressure, sensations of pain, a state of irritation in an organ, weakening or inhibition of a function - have no 'sense', no psychical meaning. They are not only manifested predominately in the body (as are hysterical symptoms, for instance, as well), but they are also themselves entirely somatic processes, in the generating of which all the complicated mental mechanisms we have come to know are absent (Freud, 1917, p. 435).

However, Freud does not discount a sexual aetiology for the 'actual' neuroses:

If in the symptoms of the psychoneuroses we have become acquainted with manifestations of disturbances in the psychical operations of the sexual functions, we shall not be surprised to find in the 'actual' neuroses the direct somatic consequences of sexual disturbances' (Freud, 1917, p. 435 italics in the original)

In fact, Freud argues that there is a disturbance in the sexual metabolism which is the origin of the 'actual' neurosis. He is more explicit about this in his Anxiety Neurosis paper of 1895 (Freud, 1895) where he argues that this pathology, which alongside neurasthenia and hypochondria he classes as an 'actual' neurosis, has its aetiology in the lack of sexual satisfaction in the subject’s (contemporary) life. He uses the example of coitus interruptus to show how occurrences of this practice correlate with ('actual') neurotic symptoms in his patients, particularly female ones.

....the mechanism of anxiety neurosis is to be looked for in a deflection of somatic sexual excitation from the psychical sphere, and in a consequent abnormal employment of that excitation (Freud, 1895, p. 55 italics in original)

Although he goes on to say that because this is the realm of biology there is little more psychoanalysis can contribute to the exploration of the 'actual' neuroses, he also posits, in his Introductory Lecture on this topic, the argument that an 'actual' neurosis may be the nucleus of a psychoneurosis.

Fink, on the other hand, argues that psychosomatic symptoms can be seen as the modern day version of conversion symptoms, which are related to the psycho-neuroses, and particularly hysteria (Fink, 1997, p. 115). In doing so, Fink is (perhaps unknowingly) putting himself in the camp of those analysts who attempted to equate all physical ailments with an underlying neurosis (see David-Ménard’s remarks below). However, as I will argue below, there is a complex, and problematic, relationship between conversion and psychosomatics.

Mishima differentiates psychosomatic disorders (PSD) from neuroses and psychoses accompanied by somatic symptoms (Mishima, 1997). The difference, argues Mishima, pivots on the latter being of psychic origin (psychogenic), whilst PSD are somatic disorders influenced by psychosocial factors. This does not help very much because the difference between 'psychogenic' and 'psychosocial' is not discussed! However, the term ‘influenced’ appears to be quite crucial here: an influence is not the same as a conversion, particularly in the psychoanalytic sense. In, for example, hysterical conversion, the subject converts a psychical process, which he or she is unable to bear, into a somatic one. In this sense conversion is used as meaning displacement. An influence, on the other hand, suggests that a number of factors, for example, behaviour, cognition, affect, may all have a bearing on a particular somatic condition, say a migraine, without there being any psychical conversion occurring. Of course, it is also possible that such a conversion could be
the reason for the symptom, which is where the differentiation between psychosomatic and conversion symptoms becomes problematic.

**Conversion in psychoanalysis**

In *Studies on Hysteria* Breuer presents a psychobiological theory of hysteria with conversion as its central aspect (Freud & Breuer, 1893-95). He argues that hysterical conversion is the process by which affects ‘short circuit’ into the parts of the nervous system which control motor and somatic activity. This tends to occur when traumatic memories, particularly related to the subject’s sexual life, are evoked, but cannot be expressed in words. The somatic effect tends to focus on the subject’s weakest point, e.g. a cardiac disorder (the ‘principle of least resistance’).

Such phenomena cannot be described as hysterical if they appear as consequences of an affect which, though of great intensity, has an objective basis but only if they appear with apparent spontaneity as manifestations of an illness. These latter, as many observations, including our own, have shown, are based on recollections which revive the original affect - or rather which would revive it if those reactions did not, in fact, occur instead (Freud & Breuer, 1893-95, pp. 205, italics in the original).

The fact that people are not aware of the connection between ideas and symptoms led Freud and Breuer to develop the concept of unconscious ideas, and the notion of a ‘splitting of the mind’. Breuer criticises Janet’s theory of the hysteric as feeble minded, arguing rather that he or she is preoccupied elsewhere, with unconscious thoughts. The splitting of the mind is a defensive strategy to protect consciousness from distressing, and usually sexual, ideas. Hysterical conversion can now be explained in terms of unconscious ideas manifesting themselves in somatic symptoms.

What is already clear in this early psychoanalytic writing on hysteria and conversion is the central role of the repressed (sexual) idea in the process - although there is still the problem of explaining how the conversion mechanism in Freud’s ‘actual’ neuroses differ from that of hysterical conversion. What is a lot less clear, however, is how to approach the somatic symptoms which many would describe as ‘psychosomatic’ but which are (apparently) unrelated to the subject’s sexual history. One solution to this problem is simply to argue that if one looks deep enough one will find a neurotic structure and thus explain the somatic symptoms. The opposite approach is to accept, as many non-analytic writers do, that there are many psychosocial factors which can produce somatic effects. The former approach falls into the trap of assuming that only neurotic subjects can somatise - which is demonstrably untrue - whilst the latter approach fails to deconstruct the exact nature of such ‘psychosocial’ factors, and how they relate to the individual’s history. For example, a stressful environment can produces somatic effects, an extreme example being cardiac failure, but this does not preclude there being something in the subject’s history, apart from a possible unstable heart, which makes him or her susceptible to such an event.

In order to explore this area further it is necessary to examine in more detail the relation of conversion to psychosomatics. So far it appears that conversion is to be equated with neurosis, and particularly hysteria (though by no means exclusively), whilst psychosomatics are to be equated an unspecified psychosocial condition. However, things are not that simple. David-Ménard points out that Freud appeared
to confuse two different forms of conversion in his case study of Elisabeth von R (Freud & Breuer, 1893-95, pp. 135-81) (David-Ménard, 1989, pp. 17-63). She contrasts conversion through association to conversion through symbolisation. Conversion through association is the result of painful mental impressions and bodily pains being experienced at the same time. Symbolic conversion seems to be a somatising of an idea without the need for an existing (in memory) physical pain. David-Ménard argues that it only symbolic conversion which can be regarded as truly hysterical whilst conversion through association could be in the realm of the psychosomatic.

Freud, argues David-Ménard, attempts to make associations between Elisabeth's bodily positions and certain painful ideas - which are around desire and frustrated love. Conversion is to be seen as 'the seizing of the body in the signifier' (49), which means that all conversion is fundamentally through symbolisation. This can be read as another way of saying that what Freud described initially as conversion through association is not conversion at all - it simply theorises a possible relationship between the psychical and the physical. One should be wary of looking for some causal conversion mechanism. But, she wonders, is Freud still looking for some form of organic base, and ultimately falling back to a notion of conversion through association because it seems more obvious than the rather mysterious notion of symbolic conversion? But, of course, it is only 'more obvious' if one is assuming a dualism of mind and body, psyche and soma, in the first place, and assuming a 'mechanism' which can somehow bridge the gap - and this is by no means obvious!

David-Ménard confronts the 'problem of the psychosomatic' and the 'leap into the organic' made by some analysts between 1912 and 1930 (the term 'psychosomatic' itself was coined by Franz Alexander in 1945) (David-Ménard, 1989, pp. 56-63). She uses an example by Felix Deutsch, who criticised the 'leap into the organic', to illustrate the continuing confusion amongst analysts regarding the nature of hysteria and its relation to conversion symptoms. This example illustrates the problem of trying to establish a relationship between the psychic and the somatic, in this case a patient's foot being affected by circulatory problems, which for Deutsch symbolised the impotent penis. Deutsch is looking for a connection between the subject's physical symptom and something in the psychic register - through looking for a physical aliment which can 'connect' to the psychical - which is precisely the error of conversion through association described above.

**Psychosomatics, conversion and the body**

David-Ménard reminds us that Freud postulated two different bodies for the human subject: a physiological or biological body, and an erotogenic or pleasure body (David-Ménard, 1989). It is the latter which features so prominently in hysteria, and is essentially an imaginary body (in the Lacanian sense). It is the body projected by the ego, and has little to do with the biological systems and processes which constitute the physiological body - except, of course that in hysterical conversion there are effects which take place in the physiological realm, e.g. fainting, vomiting. Thus the appearance of the 'second body' does not resolve the problem of

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1 However, as David-Ménard points out, for Freud the erotogenic body was by no means a representation of the (real, biological) body: 'Instead, the motor discharge in which sexual jouissance consists presupposes the temporary abolition of representations' (David-Ménard, 1989, p. 8).
somatisation. It does, however, help to explain conversion through symbolisation - or rather conversion as symbolisation.

Soler develops a more Lacanian theory of the body, which also emphasises the difference between the biological body and the body as constituted in the imaginary and inscribed through signification (Soler). She also makes some importance remarks about the body, jouissance and the trace - the trace which is all that is left behind of a 'primal' pleasure, a lost 'first time' which the subject is trying to regain. The trace is what is left after the first experience of satisfaction. The signifier represses or annuls this jouissance. What is lost is related to the concept of the libido, which Lacan (in The Position of the Unconscious) defines as an object - the myth of the lamella, which is outside of the subject. This relates to the sexual division of subject and the attempt to regain unity (the myth of Aristophanes). This lost object is not seen as part of another person, but rather as a detached part of the subject. Something is subtracted, which brings libido into play. Jouissance is redistributed outside of the body as 'surplus jouissance' - and it is this which compensates the subject through repetition. The (biological) body and its jouissance are real objects - in the sense of being unrepresentable.

**Lacan and psychosomatics**

I began this paper with a quote from Lacan in Seminar II. With this statement, Lacan appears to confirm the idea that the psychosomatics are not to be seen as conversion symptoms. The context is his argument against Perrier's proposition that psychosomatics operate at the level of the (narcissistic) object relation. Lacan is criticising Perrier's talk on the psychosomatic relation (21 January 1955) where he argues that the psychosomatic patient has a direct relation to the real, rather than to the object. The relation with the therapist reintroduces the narcissistic relation which is necessary to establish an object relation, i.e. a relationship with another human being.

Lacan calls into question the link of object relation with psychosomatic relation:

> If psychosomatic reactions as such suggest something, it is that they are outside the register of neurotic constructs. It isn't an object relation. It's a relation to something which always lies on the edge of our conceptual elaborations, which we are always thinking about, which we sometimes speak of, and which, strictly speaking, we can't grasp, and which is nonetheless there, don't forget it - I talk about the symbolic, about the imaginary, but there is also the real. Psychosomatic relations are at the level of the real (Lacan, 1988, p. 96).

Perrier was also differentiating between the relational organ, which has a relation to the outside world, and other organs which are related to 'internal instincts'. Lacan refuses to make this distinction, looking instead at the organs in terms of their place in the narcissistic relation. The narcissistic relation is at the level of the imaginary, as is the object relation.

Narcissism is an important concept here because it marks the point at which the 'second' body is born (see Grosz, 1992 for a summary of the main arguments which relate the body to narcissism and the formation of the ego (Grosz, 1992)). It also raises some important questions about the relation of the bodily organs to the 'actual' neuroses. In this paper *On Narcissism: an Introduction* Freud argues that
hypochondria is one of the ‘actual’ neuroses (an idea which he confirms in his Introductory Lectures (Freud, 1917, p. 437)) (Freud, 1914). In hypochondria the organs of the body become eroticised - but in a very general and possibly indiscriminate manner. This is to be contrasted to the more restrictive notion of the erogenous zones as the oral, anal, genital and mamillary zones (Laplanche, 1973, p. 154). In effect the whole body, or more precisely its components, becomes a generalised erogenous zone. It is also true, of course, that the hypochondrical subject does not consciously experience the excitation of a particular organ as pleasurable - rather it becomes the source of an intense anxiety. Freud explains this as the result of tension which stems from a ‘damming up’ of ego-libido.

One of the important points here is that it seems to confirm Freud’s claim that the symptoms of the ‘actual’ neuroses have no psychical meaning - any organ can become the site of erotic excitation. However, is this an example of a conversion? The answer is surely no - because conversion in the true sense of the word, i.e. following David-Ménard’s concept of conversion through symbolisation as opposed to conversion through association, requires repression and the institution of the imaginary body. In the case of hypochondria, taken as an example of an 'actual' neurosis (and tentatively a psychosomatic symptom), the ego is reacting to an excitation of a real bodily organ. The problem here is that in cases of hypochondria there is apparently nothing physically wrong with the subject - but is this the crux of the matter? In psychosomatic disorders there patently is something wrong if we use examples such as rheumatoid arthritis or cardiac problems (Martin, 1997). However, if psychosomatic disorders can be seen as a form of conversion through association, as suggested above, which means that they are not strictly speaking conversion symptoms at all but rather a correlation between a somatic condition and a psychical one, then the point is not that there should necessarily be something wrong with a particular organ or other part of the body, but rather that it should become a site of eroticisation (or to use Freud’s term, excitation). If there is something wrong with an organ than it is perhaps not surprising that it becomes such a site. However, it does not follow that the disorder is the result of a conversion from psyche to soma - if anything the causal relationship (as much as there is one) would appear to be reversed, with a somatic condition producing a psychical reaction.

The link with narcissism to the actual neuroses, using hypochondria as an example, is that it illustrates for Freud the way object-libido is transformed into ego-libido. Of course this raises the problem that the ego itself is an object - the subject’s first object in fact, which means that strictly speaking all object relations are narcissistic ones - which helps to explain Lacan’s criticism of Perrier’s attempt to differentiate between relational organs, which can be taken as a way of describing organs orientated towards external objects; and organs related to internal instincts. Lacan is surely right to argue that the crucial point is the way some organs are structured through the institution of narcissism - presumably a reference to the erotogenic body. But in what sense, then, are psychosomatic relations at the level of the real? Because they are at the level of the real body, the biological body, the level of the organs, the bones, the (uninscribed) flesh. The ego, at the level of the imaginary, responds to the events in the real, but the events themselves are outside of the imaginary, outside of the narcissistic framework. Although Freud uses hypochondria as an example of the ego turning in on itself, it does not follow that the symptoms are at the level of the imaginary. Rather, the ego is excessively preoccupied with
‘internal’ bodily functions - which in cases other than hypochondria may indeed be bodily *malfunctions*.

In the same seminar Lacan also mentions the concept of the auto-erotic instincts, which Freud argued were there from the birth of the human being (Freud, 1914). Using this concept it is possible to explain how the (real) body can become a site of eroticisation even in the absence of a narcissistic structure. In fact, it is through the institution of narcissism that the auto-erotic instincts become organised and constitute the basis of the erotogenic body.

**Conclusion: towards a theory of the psychosomatic**

By way of a conclusion I would like to put forward the following ‘working hypothesis’ and then to comment on it. ‘Psychosomatic disorders’ is a contemporary term for Freud’s ‘actual’ neuroses. The psychosomatic symptoms are not conversion symptoms in the way the somatic symptoms of the psychoneuroses are. In the latter case there is a disturbance in the imaginary, narcissistic body originating from a repressed trauma in the real. The effects can work back to the real, i.e. there is a somatic response in the sense that the subject faints, vomits, etc. In the former case there is no mediation through the imaginary body - the trauma is re-experienced directly through the real body. The idea of ‘somatic compliance’ or the ‘body joining in the conversation’ needs to be read backwards - the conversation joins the body. In other words, the somatic event occurs and then is associated with a particular event in memory, e.g. Elisabeth von R’s memories which correlated with certain bodily positions (Freud & Breuer, 1893-95, pp. 216-24).

This does not mean that the somatic symptoms in the case of psychosomastics have no signification: on the contrary they represent an eroticisation of certain organs or other aspects of the body. What Freud did not seem to grasp at the time was that the physical discomfort his (hysterical) patients were experiencing was actually pleasurable - or from a more Lacanian position, the subjects experienced jouissance through their physical discomfort. When Freud mapped the bodies of his subjects to ascertain the association between physical pain and memories, his assumption was that something was triggering an existing somatic disposition, i.e. a repressed memory, which was brought into consciousness in the course of analysis. But what if, on the contrary, the physical pain (jouissance) triggered the memory?

Psychosomatic symptoms have no meaning (remember what Freud says about the ‘actual’ neuroses). However, this does not mean they do not evoke memories which are laden with meaning. At the level of the real there is no representation, no meaning - just an unbearable jouissance of the (real) body (see Soler’s comment’s above).

Returning to the person I described at the beginning of this paper, I explained that I was convinced that there was a relationship between his psychical and somatic histories. It is undoubtedly possible to make a case that ulcerative colitis is the somatic representation of something in this person’s sexual history, that what could

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2 Although Fink argues that in fact there is no such thing as autoeroticism: rather the infant child learns from the Other which zones give pleasure (Fink, 1997, p. 226)
not be spoken in words was ‘spoken’ through the bodily organs. I think this would be misplaced. The man certainly had a sexual history, fragments of which were beginning to emerge, and which included a large amount of physical and psychological abuse. But in my view this abuse (trauma) stayed at the level of the real - it was never subject to repression. I say this because this person seemed to have no difficulty at all in recounting the stories of abuse - and perhaps it is important to add that he did not have prior experience of analytically informed counselling or psychotherapy, and thus was unlikely to be acceding to my supposed demand. What also struck me was the pleasure, or rather jouissance, which this man seemed to be experiencing in his suffering. There was a sense of rapture in both his behaviour and his discourse.

I would like to finish by saying that I believe psychosomatics does have a place in psychoanalytic discourse, but stands in a paradoxical position because it is, as Lacan states, at the level of the real, and thus cannot be represented in any meaningful way. Perhaps what it does do, however, is to reopen the whole debate about the relationship of psychoanalysis to biology, for it is at the level of the biological that we need to engage psychosomatics.

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