Day Dreaming and Hypochondria[1]

When day dreaming goes wrong and hypochondria becomes an autistic retreat

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Abstract The lecture attempts to focus on the relation between day dreaming and hypochondria, both theoretically and clinically. The hypochondriac involvement with the body may become so extensive that at its extremity it can induce autistic-like withdrawals into a world of hypertrophied attention to one's sensations, where day dreaming disease and deterioration, and the ensuing flooding anxiety become densely intermingled, creating a very painful and detached existence. It is claimed that an early tendency to be absorbed into excessive day dreaming might enhance hypochondriac anxieties. The developmental roots of such a state are examined and exposed through clinical material and theoretical discussion.

"Since there was nothing at all I was certain of, since I needed to be provided at every instant with a new confirmation of my existence, nothing was in my very own, undoubted, sole possession…naturally I became unsure even [of] the thing nearest to me, my own body...I scarcely dared to move, certainly not to exercise, I remained weakly, I was amazed by everything I could still command as by miracle, for instance, my good digestion; that sufficed to lose it, and now the way was open to every sort of hypochondria"

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[1] Schellekes, A. (2017). Day Dreaming and Hypochondria. In Levine, H. & Power, D.(ed). *Engaging Primitive Anxieties of the Emerging Self. The Legacy of Frances Tustin*. Karnac Books, London. The paper is reprinted now in Psychoanalysis Downunder with kind permission of Karnac Books.

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Kafka, F. (Letter to His Father, 1919, in Kafka, 1966, pp. 89-91)

This short quote from Kafka's letter to his father is most evocative of the experience of loss of contact with one's body and of the ensuing need to achieve control over one's physical existence, through incessant awareness to body's manifestations and to any real or imagined physical dysfunction. Kafka's long-standing mental investment in keeping the body safe culminated in a very special achievement: some claimed (Druker, 2002) that Kafka received the gold medal of the American Safety Society in 1912, because of his outstanding contributions to workplace safety, and in particular the invention of the modern safety helmet, commonly called a hard hat. Slide Because of his innovation, substantially fewer steel workers were killed in industrial accidents. Ironically enough, his invention protected many people's heads, that body organ which Kafka himself could still use even when his body "remained rather short and weak" (Kafka, 1910).

In a letter to Ferenczi written in 1912, Freud mentioned that he had "always felt the obscurity in the question of hypochondria to be a disgraceful gap in our work"(Jones, 1955,p.453). One hundred years later we are not in a much better position, since it seems that the ambiguity and uncertainty inherent in the hypochondriac mode of being contaminate the study surrounding it (Lang, 2007). I think that this state is due to much confusion that exists regarding a clear cut classification of hypochondria, which stems from the fact that it is both a feature in many psychiatric conditions and an entity in itself. Due to this confusion many of the psychoanalytic writings on this topic (Meltzer, 1964; Rosenfeld, 1984; Bronstein, 2011) have attempted, with partial results, to make clearer distinctions between hypochondria, somatic delusion, psychosomatic states and hysteria. For my present focus I would limit myself only to a few remarks regarding this theoretical debate.

The main clinical distinction between hypochondria and psychosomatic states is that in the former a flooding and intense anxiety regarding the body is frequently present, while in the latter, such anxiety is usually absent. Moreover, the psychosomatic's mode of being has been extensively described as suppressing affect to such extent that his affective life has been described as being alexithymic (Syfneos, 1973) or "concrete/operational" (Marty&de M'Uzan, 1963), terms used by the American and French school, respectively, to describe the poverty of affect and fantasy. Since the hypochondriac's flooding, but unsymbolized anxiety, is so prevalent, hypochondria has been historically (Freud, 1892) classified as one of the types of actual neurosis, a term used by Freud to include intense physical and emotional states, apparently lacking psychic conflict, such as neurasthenia, anxiety neurosis and hypochondria. All these states or occurrences are characterized by a high level of excitation that has not been processed, represented and transformed into digestible mentation (Mitrani,1995), as opposed to hysteria, which is considered to be the prototype of the neurotic symptom, that embodies dense symbolism of an underlying psychic conflict, in spite of its physical appearance. Put in simple and phenomenological words, the hypochondriac is flooded by body related anxiety, while the hysteric presents a physical symptom, rich with symbolic connotations, but accompanied by relative emotional indifference.

Though this debate is fascinating, it is much beyond the scope of this paper, since my present interest is to focus on hypochondriac anxiety per se and its relation to excessive day dreaming. {When I speak of anxiety in this context I try to limit myself to conditions in which hypochondria neither achieves the status of a delusion, nor is it part of an organic disease, whether psychosomatic or not, but is nevertheless extremely disabling one's ability to live physically and emotionally.} Even in otherwise relatively well-functioning personalities, the hypochondriac involvement with the body may become so extensive that at its extremity it can induce autistic-like withdrawals into a world of hypertrophied attention to one's sensations, where day dreaming

disease and deterioration, and the ensuing flooding anxiety become densely intermingled, creating a very painful and detached existence.

When working with hypochondriac patients one of the striking clinical features is the extensive mental elaboration and detailed imagination about any possible harm to or disease in one's body, or by proxy, in one's close relatives. One excessively indulges into self observation and overvalues his perception of the body, both of which are accompanied by the conviction of being ill and by disintegrating anxiety (Stolorow,1979), that is not part of a major somatic condition (Nissen, 2000). The hypochondriac imagines how every little sign of physical distress and every minor symptom will lead to catastrophic and lethal consequences. Many times, as I have seen with several patients, the imagined scenario includes almost a trance-like state of mind, in which the hypochondriac gets carried away into an elaborate fantasy of how he (or a very close person) will be diagnosed as gravely sick, how his organs will deteriorate, how days and nights will be spent in pain and anguish, while undergoing medical treatments and prolonged hospitalizations, how lonely and frightful such states will be experienced. These day-dreamed narratives, when employed excessively, acquire autistic features, as the hypochondriac sinks into a world governed by sensations, getting more and more detached from his surroundings and wailing/lamenting his miserable imagined existence that will befall upon him. Though flooding anxiety is often present, in my experience this type of daydreaming disease-related scenarios acquires many times an oneiric quality in which a visible contradiction exists between the frightening content of the hypochondriac fantasy and the affect and tone of voice that accompany the verbalization of this fantasy. In these instances, while imagining the expected somatic catastrophe, the melody of speech and the affect expressed are not always anxiety-laden, but sometimes convey a sense of being carried away into a land of dreaming, full of masochistic painful stimulation. It is important to note that the essence of the hereby described day dream fantasy is not always accompanied by death anxiety

proper, (though apparently one would suspect that, since most imagined diseases are terminal), but rather by a rich imagery of a state of being ill, of suffering, of the body being invaded by malady, pain and medical intrusive practices[2]. The masochistic component is evident in this imagery[3], as the hypochondriac is both terrorized by his conviction of being ill and at the same time fascinated by and immersed into his bodily sensations; he is both anxious about all medical interventions and, at the same time, solicits medical care and procedures for any vague or specific complaint (Barsky & Klerman, 1983). Thus, I propose that the hypochondriac ideation is a mixture of layers, some in which masochistic symbol-laden fantasies prevail and some in which the very sinking into and imagining physical sensations becomes a sort of 'autistic shape' that lacks symbolic activity thus creating an autistic-sensations-related enclave.

This state of excessive detachment from reality, that is part of the hypochondriac ideation, has ancient roots in the history of the individual. Before proceeding to additional theoretical aspects, I would like to relate briefly to a clinical case that portrays some of the main points of my present discussion.

Iris

[2] Of course, this rich imagery of illness details can of course camouflage an underlying extreme death anxiety, which can thus be blurred or even denied. Very intense death anxiety is even more unbearable as it is many times considered to be a result of a failure to internalize the containing/protective functions of the object, so that any disturbing or threatening situation becomes the harbinger of the impending death. The extreme fear of death is thus equated in the internal grammar with the experience of a collapse of defenses and regression to the total, infantile helplessness when the omnipotent parental figures had been emotionally unavailable (Starcevic, 1989).

[3] See also Rosenman, (Rosenman,1981), who conceives hypochondriacal concerns as manifestations of psychic masochism wherein anxiety is a form of punishment for bad wishes and to Aisenstein&Gibeault (1991) who discuss the role that hypercathexis of pain has in the hypochondriac anxiety.

{My relation with Iris has been a very long one with multiple and complex facets. For the purpose of this lecture I will only focus on a few relevant issues that are pertinent to the topic of hypochondria and day dreaming, leaving aside many nuances that are part of Iris's rich personality and of our deep emotional relation over many meaningful years, that could potentially enrich our understanding of her, but all this is beyond my present scope}. Iris, a professionally successful writer in her thirties, married with 3 children, addressed me when her eldest son was a few months old, due to terrible hypochondriac anxieties related to her small baby. She was devastated whenever the baby had any sign of physical distress and moreover so when he had any clear physical symptoms. Both of these were instantly experienced by Iris as grave symptoms heralding an incipient terminal disease or other physical catastrophes. In subsequent years two more babies were born and with all three children, she experienced the same degree of hypochondriac crises, that would make her sink for days and nights into abyssal anxiety, while constructing elaborate day dreams about the imagined physical sensations and catastrophe that would befall upon herself and her children. These day dreams included rich details of future scenarios in which her children would become gravely ill, would suffer immensely, physically and emotionally, would undergo painful medical procedures, would slowly deteriorate until the inevitable end. The imagination was less concerned with the danger of losing the child or with death per se, but much more with all the devitalizing and bodily sensations and states that would precede death. Alternately, Iris reacted to her own physical real or imagined symptoms, with similar anxiety, whose main content was rich imagining of sensations and symptoms and of how her children would become orphans, how much they will suffer; she would calculate various ages at which being an orphan might be more bearable and less devastating, hoping that she would have the chance to live till that age, so that her children would not prematurely experience such a terrible loss.

In parallel to the extensive preoccupation with the seemingly diseased body, it soon struck me that this hypochondriac layer masked a very special relation to her body, from which she seemed completely disconnected. Her physical appearance gave the impression that she had no interest in the way she looked. She was not physically neglected, but it seemed that her body was in a sort of suspended state, not really being experienced, except through possible disease. She showed little interest or pleasure in sex, hardly paid attention to clothes, to her haircut and generally to having any pleasure from her body. Sometimes I had the feeling that she lived in a sort of emotional blindness to her body that I suggest to name '*a negative hypochondria*' (paraphrasing Green's thinking on 'negative hallucination'), so as to emphasize the lack of emotional investment into the details of the living and healthy body, and the lack of experiencing her body as alive and full of vitality. This dual relation to her body became more and more striking, as it seemed to mirror a very deep and old schism in her emotional existence, that gradually unfolded in analysis. On one hand, she functioned relatively well in everything that her life required, though most of the time being tired and lacking energy, on the other hand she lived in a sort of day-dreaming existence, slightly disconnected from the reality of her life, only superficially being involved with her significant others. She kept contact with few social relations, as her emotional energy was deeply caught either in this fantasying existence or in dealing with her extensive hypochondriac anxieties.

During our sessions, a very special presence of Iris began to preoccupy me. She was very devoted to the analytic process, always came to the sessions, talked, brought quite rich material, but there was many times some lack of focus, as if she was not totally present, as if some disconnection from reality kept her in a semi dreamy state. Sometimes she would slightly lose connection with time issues, sometimes she wouldn't notice any changes in my office, that were noticed and reacted to by most of my patients, sometimes she gave the feeling that my presence was a very important

background, but that she was not really in contact with me, on a deeper level. Moreover, for years she continued to be ambivalent towards me, as if never really knowing whether she was in the right place, many times fantasizing that this or other analyst will certainly be a better place to be. She would openly and frequently describe how excited she felt when she imagined herself with another analyst, whom she came to know or heard about, but she never really considered leaving her analysis.

The day dreaming of better places, better families, better analysts alternated in the sessions with the description of her hypochondriac anxieties which attacked her frequently. Gradually I became aware that in spite of the terrifying content of her anxieties, many times there was a day-dreaming quality in the way she described them, as if she was taken away into a world of fantasy, which she would not stop. Her tone of voice also became many times like a dreamy melody, speaking, slightly singing the imagined catastrophes, as if she also found some known, but unthought gratification in the hypochondriac scenarios. At times, as if caught by some contagious disease, I found myself struggling with a sort of day-dreaming state, in which I was slightly losing contact with Iris, bordering the sensation one has in hypnogogic states. The main striking feature of these states of mine was that I became both aware of and observed my day dreaming, while simultaneously I could hardly stop its sharp intensity. It is important in this context to emphasize that such a state has little to do with free association, as the feeling is of being taken away and losing contact with both external and internal reality.

I have detailed these nonverbal transferencial intricacies as they became a tunnel through which we could gradually approach experientially some of the historic roots of Iris's emotional development. From a very early age Iris experienced her parents as living in their own slightly disconnected world, being simultaneously loving towards her and narcissistically and sexually immersed with each other. It seems that her parents had been unaware of

the impact and implications that their stormy involvement with each other, and considerable disconnection from real matters, had for Iris's fragile existence and developmental needs. Iris learned to disconnect herself from her internal reality and from what was experienced as a very invasive and flooding presence of her parents, which was much above her abilities to digest and understand[4]. Though such presence had evident exciting qualities it simultaneously became a haunting presence. It seems that Iris developed all sorts of techniques of shutting out her sensory channels so as to become disconnected both from her parents' flooding presence and from her own internal scene. During these times she oscillated between excitation, anxiety and confusion, all eventually culminating in her need to silence her own senses and to become immersed in a disconnected-from-her-body state. She gradually developed her fantasying abilities which offered her a day-dreaming envelope that protected her from unbearable realities. Whilst growing up, she became exposed to many separations and peregrinations, that created much instability in her life and which, again, were beyond her abilities to contain. Due to her precocious ego development, whose damaging effects have been thoroughly described by many (Klein,1930; Winnicott, 1962; Mitrani, 2007) and due to her high intelligence and wealth of abilities, she could adapt well enough, but she developed more and more strategies of disconnection: she would thoroughly engage in day dreaming, fantasying better parents and homes, she would deny frustrating or traumatic experiences, creating idealizing scenarios or would eventually retreat into her own body, sinking into a world of hypersensitive reactivity to sensations, a sort of autistic shell of auto-sensuality (Tustin, 1990), that ultimately flooded her with hypochondriac anxiety. Thus, her exaggerated day-dreaming and disconnecting abilities, that had been established early in her life, became both the carrier of long standing anxiety and the means to deny it, through projection into the body. Simultaneously, in my understanding,

[4] Though it is not clear to what extent we witness here an "objective memory", or a retroactively fantasized occurring or a mixture of both, what is evident is the invasive quality of this emotional entity. See Spero's (1990) extensive discussion on these topics, that is of great relevance here.

through developing the hypochondriac anxieties and through day-dreaming catastrophic scenarios, she maintained a very faithful relation with her early objects: she was both invaded by unbearable anxiety (as she had been since a very early age in the presence of her parents), in the form of experiencing her body as under the attack of a terminal disease, and, at the same time, she maintained her disconnected emotional existence through day dreaming, both of a catastrophic nature, such as in hypochondriac scenarios, and of an idealized fantasized future, such as when day dreaming of better husbands or better analysts. In addition, I would say that the hypochondriac anxiety also connected her with her formerly denied/suspended body, even if in such a distorted way. Moreover, her hypersensitivity to any physical sign became, in my view, a mimicry of a displaced – unto – the – body longing for attentive care (Granek, 1989), so that the longed-for care by another was substituted by her own concern towards her body.

As it is evident in Iris's case, the early experiences of many hypochondriac patients are, in my view, frequently colored by an object presence which was experienced as either too exciting or too invasive, or a mixture of both, whether in terms of its inconsistency or in terms of flooding the infant with stimuli which were beyond his containing and processing abilities. I will relate shortly to the quality of the invasive object as emphasized by Paul Williams (Williams, 2004). (The invasive object is a term that was introduced by Williams to describe conditions in which the infantile self becomes amalgamated with sequelae of uncontained projections and with the projective activity of the object, that leave the infant in a state of emotional turbulence and confusion, which in turn threat his very sense of self. The individual who has incorporated an invasive object is likely to feel unstable, depleted of personal meaning and occupied or haunted by unidentifiable bodily perceptions. The infant's body is implicated in the trauma in that it carries the status of a primary object to which the infant relates and which can become installed as an internal object, thus bringing one to 'invite' invasion as a sort of identification with invasiveness. Williams also proposed

to distinguish between intrusive and invasive objects. Intrusive objects tend to be motivated by a need to occupy or control the subject for reasons that can include parasitism and sadism. Invasive objects, on the other hand, seek primarily to expel unbearable, infantile conflicts using, for the most part, excessive projective mechanisms. Expulsion is compulsive and violent, but it does not appear to strive to control or become a feature of the subject in the same way, as its aim is to mould a repository for evacuation prior to a retreat to a position of pathological narcissism [Williams, 2004]).

The parent's ability to help the small child in processing and representing the many sensations he experiences, of whose importance Tustin talked so extensively (Tustin, 1981,1990), is thus hindered when an invasive object is internalized, leaving the child in what she called 'an agony of consciousness'. Even when the object's presence seems quite devoted, its possible invasive quality is confusing and overwhelming as it usually lacks any boundaries, so that for a child's mind such an object presence is experienced as frightening and threatening his separate sense of self (Arlow&Brenner, 1969; Nissen, 2000; Williams, 2004; Skogstad, 2013). In such a state of invasion, the normal process of projecting one's unbearable sensations into the object is almost impossible, since the parent's ability to employ his alpha function is rather deficient and the omega function (the reversal of the alpha function: the parental object projecting his emotional needs into the child), which Gianna Williams (1997) speaks about, becomes the dominant one. When one is flooded by internal unbearable and indigestible states of mind and by external confusing and flooding experiences, one develops various emotional tactics, as we all know, but the one I wish to emphasize here, as I tried to illustrate through Iris's case, is the development of a detached, almost dissociative stance, made possible by the construction of a private imaginary world, disconnected from reality and, apparently, from emotional proximity to the invasive object, what Meltzer called a "pseudo-contact barrier of the day dream" (Meltzer, 2009, p.123). The infant thus learns to disconnect through building of imaginary worlds,

wherein he finds comfort and illusionary control. In this context, it is not surprising that many times this excessive day-dreaming quality of which I am talking about generates, in later phases of development, fantastic scenarios of idyllic places, wonderful persons and relationships, all imagined as blissful, conflict free zones of emotional serenity. These scenarios seem to mask a fantasized regressive oneness with the primary object, a “fantasized reversal of a calamity that has occurred and a restitution of an inner homeostasis that was disturbed years ago where a blissful unity with the all good mother of symbiosis” (Akhtar, 1996) and infantile omnipotence would be possible. This fantasized reunion can become an excessive hope, that more often than not, creates heavy demands on real objects to fulfill this reunion. Such a state promotes the quality of keeping reality at a distance, living in the future, while the present becomes a continuous source of masochistic suffering.

One can be mistaken and think of these day dreams as a version of the family romance fantasy, but, in my view, they are of a much more primitive and pervasive nature, as they often become slightly regressive cocoons that enable one to retreat into imagined worlds of better times and better relations. The blissful imagined oneness with an ideal object, that is present in these fantasies, is quite similar to the quality of the timelessness experience (Hagglund, 2001; Levine, 2009; Schellekes, 2010, 2017), in which interpersonal differentiations are blurred, as much as are any distinctions between time dimensions: past, present and future. When past experiences are traumatic and thoughts about future raise the potential of re-traumatization by expected frustrations and losses, the timelessness experience enables one to temporarily live in a state wherein time freezes in a sort of illusionary everlasting present, thus negating the flow of time and the inevitability of losses and death. It is not surprising that many of the patients who tend to negate time dimensions and live in such timeless modalities, achieve this through excessive day dreaming, which becomes an efficient primitive maneuver of denying painful reality. I would suggest to call

such excessive day dreaming, a '*day-dreaming envelope*', functioning, in many ways, in a similar way to the envelopes described by Anzieu (Anzieu, 1985) and Houzel (Houzel, 1990), that is functioning as compensatory envelopes, when basic containing functions are lacking.

{In normal development, though fantasizing is a less mature mode of experiencing, expressing and modulating inner experience than abstract and symbolic thinking, it is an important and creative means on various levels. To name just a few of these levels: it may help processing inner and outer experiences (Sugarman, 2008); it adds one in tolerating object's absence, thus constituting a midpoint in the process of internalization; it enables one to express ambitions and to anticipate important personal events (Lussheimer, 1954).}

However, when fantasizing becomes excessive, it becomes what Winnicott named 'fantasying', a dissociated addictive mental activity, keeping one in a state of distractibility and absentmindedness, absorbing much of one's emotional energy, but not necessarily enriching one's ability to think, to dream and to be actively involved in life or, to put it in Winnicott's humoristic words: "nothing is likely to happen because of the fact that in the dissociated state so much is happening…and immediately, except that it does not happen at all" ((Winniccott, 1971, p.26). The omnipotent satisfaction inherent in the day dream thus becomes an additional obstacle to active involvement in life, as most real experiences face one with one's own and with other's limitations.

The above description portrays a situation in which excessive satisfying day dreaming activity might crystallize an effective defense against invasiveness. However, things are more complicated, as one never totally relinquishes his relation to the object. The repetitive need to stay attached to the object is ever present, even if in disguised form. Thus, when the infant/child's mind is flooded by unbearable excitation or by erratic painful emotional experiences,

many times an ‘attachment to pain’ (Valenstein, 1973; Aisenstein&Gibeault, 1991) develops. Put it differently, rather than separating from the painful quality of the object’s presence and rather than mourning this separation, in the hypochondriac’s development one encounters an adhesive attachment to the painful physical and emotional qualities, that had characterized the object’s presence. In other words, in my opinion, the imagined pain and suffering that the hypochondriac so extensively fears become, through his elaborate attention to physical sensations and imagined scenarios of disease, a sort of psychic retreat (Steiner, 1993) into the body, wherein the imagined pain keeps alive the connection with the frustrating invasive object, who often becomes installed into the fantasy of the sick organ.

Thus, in my understanding, though apparently having been tormented by the object’s confusing and invasive presence, one becomes the unconscious director of the hypochondriac drama in which the object, that has never really been mourned and integrated, is ever kept alive through self-torment, embodied in the rich imagery of suffering and disease (see also Gutwinski, 1997). This imagery echoes the invasive aspects of the original emotional reality, that reality which had been experienced, but never became mentally assimilated. However, in the hypochondriac’s subjective experience he is the passive victim of the feared diseases which act in this scenario as a threatening concrete and somatic reality. In other words, in my view, the hypochondriac subject vicariously aims at distancing himself from unbearable emotional states, of both internal and external origin, by frequently developing, early in his development, excessive, disconnecting day dreaming propensities, which sooner or later also become the venue for day dreaming somatic catastrophes. Thus, the body and the elaborate preoccupation with his somatic states could have potentially become a screen against the possible invasion of the object (Aisenstein&Gibeault,

1991)[5]. However, the hypochondriac's incessant absorption in his body keeps him forever invaded by anxiety, so that he never relinquishes close contact with his invasive-anxiety-provoking-internal objects, with what was meant to be expelled from the emotional sphere. Moreover, the state of being ill may be viewed as a somatic embodiment of an unconscious search for a particular role responsiveness (Sandler, 1976), on the part of the significant other/therapist. Put differently, the hypochondriac's awareness of every slight change in the functioning of the organs mirrors how he wishes the other would tune into him (Rosenman & Handelsman, 1978; Granek, 1989).

Nevertheless, in my view, things are even more complicated since the early object relations of the hypochondriac were never solely frustrating and painful, but many times an admixture of excitement and suffering, so that great confusion became the axis of his experiences. Very relevant here is Rosenfeld's understanding of the genesis of hypochondria, as resulting from confusion related to deficiency in splitting mechanisms (Rosenfeld, H., 1958, 1964). {In Rosenfeld's understanding, it is the hypochondriac's mixture of libidinal and aggressive impulses that intensifies confusional anxieties (confusion between self and object, love and aggression, between pleasure and pain), which in turn generate excessive splitting mechanisms so as to get rid of the confusional anxieties. These are first projected into the external world to be later on re-introjected, but this re-introjection is experienced as a violent and invasive intrusion that threatens to spread everywhere (Nissen, 2000). The absorption of these projections into the body attempts to diminish the emotional threat by attempting to keep emotional threats out of the mental sphere, by displacing them into the body, thus generating the hypochondriac anxiety.}

[7] This is even more relevant in extreme cases, that border somatic delusions, wherein the hypochondriac aims to expel the diseased parts of his body, unto which his unbearable emotional experiences have been deposited (Rosenfeld, D. 1984).

When such confusion prevails, suffering becomes a source of pleasure while erotic life becomes a source of suffering. Many times the hypochondriac becomes addicted to fantasized suffering, while having difficulties in enjoying his real erotic life. The frustrations experienced in his erotic life become an additional venue of suffering and a potential source for additional detachment and retreat into day dreaming, this time, into rich scenarios of sexual arousal and romantic experiences with imaginary partners, who are fantasized as promising to rescue the hypochondriac from his real erotic life, which more often than not, is kept under control and is maintained as a source of suffering. In other words, one can see how the hypochondriac's confused link to the object as both exciting, frustrating and pain inducing is maintained in such a complex and imprisoning matrix of real and imagined relations.

Some clinical implications

The intricate relation between hypochondriac anxiety and excessive day dreaming has in my view important implications for our clinical work. Since this relation is part and parcel of the internal object relations matrix that I have attempted to describe, it goes without saying that the main focus in working with the hypochondriac would necessarily relate to this matrix. However, I would like to make a few more emphases that seem important to me for the present discussion.

First, since the hypochondriac keeps such close contact with his body at the expense of his ability to be involved with objects on a deeper and more intimate level, the therapy/analysis should gradually create a protected space, wherein one can risk relating without feeling invaded and without needing to disconnect and retreat into hypersensitive listening to the body. If enough of the analytic work goes well enough, both analyst and patient can save each other from the danger of plunging into excessive disconnection

that often happens through the day-dreaming envelope and other dissociative modes. This dreaminess and preoccupation with the imagined diseased body keeps one away from what is missing on the interpersonal level. In my analytic work with Iris, it took a long time until Iris could risk engaging on a deeper level with me, without needing to distance herself from intimate and intense contact. In parallel, it required substantial work on my part to reclaim myself back, sometimes with Iris's help, both conscious and veiled, from what seemed to be a partial sinking into contagious day dreaming.

Second, in parallel to the working through of a richer and deeper involvement with the analyst, great effort is needed so that other relations, present and past, can enfold in a more meaningful and creative way. Many times hypochondriac patients have neither emotionally digested the impact that significant others have had on them, nor are they deeply aware of the impact they themselves have on others. Relations are experienced in highly static ways, in which the object has no ability to generate new meanings and new realities, and consequently, the subject's ability to be involved in dynamic and creative relations has been hindered as well[6]. Since the detached, uninvolved relations are largely connected with an underlying need for a perfect and blissed union with the object, wherein one can feel safe and omnipotent, the core of the analytic work becomes the need to both enable regression to primordial states of mind, that have not been experienced enough, in the presence of an involved but neither invasive nor detached object, and, nonetheless, to gradually enable the patient to risk being involved in less than ideal emotional relations, while mourning the ideal object. Though one can say that this is one of the goals in almost any analysis, I wish to put a special emphasis on these dialectics in the present context, because, as said, the hypochondriac's reliance on day dreaming

[6] I am grateful to Neville Symington for the generative dialogue we had on these matters (Symington, 2014).

idealized future scenarios is so strong, that it disconnects him from the reality of his life, which is not necessarily as bad as it is feared.

Third, the hypochondriac anxiety masks a deep seated denial of death and, by extension, of any limitation. The body is expected to be in a perfect state forever, with no weakness or ailment, as if one can experience absolute somatic security, and by proxy, absolute emotional stability. These features, not only become a main part of the excessive day- dreaming activity, but also of the need to live in a timeless modality, wherein limits and terminality are denied. This denial becomes a main issue in analysis, where time and limitations are an intrinsic part of the analytic texture. In other words, repeated attention should be paid to the various tactics employed by the hypochondriac, so as to deny the flow of time and of aging, whether in life or in analysis. Moreover, since the hypochondriac anxiety is also a way of installing an imagined control over the body, there is great need to consolidate the hypochondriac's ability to tolerate uncertainty and specifically to bear a body that does not stand up to his idealized expectations[7], all this without experiencing a complete lack of control, agony and helplessness.

Fourth, if analytic work can progress well enough, it is my understanding that the hypochondriac will gradually substitute his hypersensitive attention to the body with more mature, verbal means, so that his abilities to process emotional experiences will not be channeled into the body, but will become part of his matrix of internal and external relations. This, of course, necessitates a great deal of thinking and verbalizing on the part of the analyst, especially so since the hypochondriac's tendency is to blur and disconnect from his emotional life, via hypochondriac anxiety or the day-dreaming envelope.

Fifth, as said before, the hypochondriac anxiety and intensified attention to various parts of the body, are many times a distorted way to be in contact

[7] See also Starcevic's (1989)discussion on narcissism and hypochondriasis.

with a body that is not experienced as alive. Thus, the feared pain or disease, in this or other organ, becomes a mapping-the-body-device, through imagined pain. To the extent that the hypochondriac can become more connected to his feelings and to his live body, including, needless to say, his sexuality, there is great chance that the contact with the body can be experienced as a source of pleasure, rather than as an imagined disease. Consequently, the more the hypochondriac can be in touch with and contain the vitality of his body, the less prominent will be the need to use hypochondriac anxiety as the main venue for contact with an otherwise suspended body[8], a state which I have called *negative hypochondria*. In the analysis with Iris, an extensive work had to be done so that she could get more and more in touch with her body, with her sexuality, and gradually she became more and more alive and full of vitality. Her ability to experience desire and to enjoy sexual relations increased immensely, even if many times her desires were still part of fantasies about idealized and unachievable partners. The more Iris became connected on a deeper level to me and to her body, the less intense and less frequent were her hypochondriac anxieties.

{**Sixth**, though hypochondria was originally considered a "toxic damming up of libido linked to a narcissistic regression" (Broden&Myers, 1981; Freud, 1914), one can think of unconscious conflictual issues underlying the hypochondriac symptom, such as unconscious beating and torture fantasies, related to denied hostility towards important objects (Broden&Myers, 1981), or to early traumatic auditory primal scene experiences (Niederland, 1958); unconscious fantasies of an internal persecutor playing the function of a concretely repressed superego (Arlow&Brenner, 1969); displacement of

[8] In this context it is relevant to consider Ferrari's (Ferrari,2004) and Lombardi's (Lombardi,2002, 2010) emphasis that in analysis with patients disconnected from their body it is much needed to work on the vertical axis, that is on one's relation to one's body, as opposed to the common emphasis on the horizontal axis, that is, on transference interpretations.

castration anxiety into fears of becoming ill or altered (Fenichel, 1945). It is not my intention to elaborate now on these possible underlying unconscious dynamics, but it is important to note their relevance, since they all raise the idea of the denial of and inability to deal with aggression that is so often part of the deflection that the hypochondriac anxiety enables. Consequently, the need to enable the hypochondriac to be exposed to his aggressive parts without fearing either being destroyed or destroying, is of great relevance. Needless to say, this might have a great impact on lessening the masochistic attachment to pain, that I discussed earlier on}.

Seventh, a great deal of tolerance and self containment, or containment by a significant other, are needed when working with the hypochondriac patient, since his catastrophic anxieties can be of such magnitude as to incur the analyst's need to defend himself from what might sometimes be experienced as a potential physical and emotional deluge. It is my belief that writing this lecture is a vicarious way of maintaining an analytic stance when facing such a deluge, as I have frequently experienced with some of my hypochondriac patients.

Thinking back of Kafka, whose hypochondria was as strong as his creativity, and whose writings have been only partially saved by his close friend, Max Brod, against Kafka's urge to have them destroyed after his death, I would like to conclude with the lines that Freud quotes in his paper On Narcissism (Freud, 1914), from the last stanza of Heine's *Seven Songs of Creation* in which Heine wonders about the act of creation: "Illness was no doubt the final cause of the whole urge to create. By creating, I could recover; by creating, I became healthy". Unfortunately, neither Kafka nor Moliere, who died on scene while taking part in his play, Le Malade Imaginaire (The Imaginary Invalid), were saved, in the concrete sense, by the act of creation. Maybe they could have been saved from a premature death, had they experienced Freud's saying that "a strong egoism is a protection against falling ill, but in the last resort we must begin to love in order to not fall ill, and

we are bound to fall ill if, in consequence of frustration, we are unable to love". But, that is doubtful too since if love or meaningful relations are not experienced "as their own reward, but as a necessary evil, to be swallowed despite its unpleasant taste, like a spoonful of medicinal tonic" (Lang, 2007,p.8), then I doubt to what extent love can have healing propensities. One hundred years after Freud's 'On Narcissism', I think we are still left with a lot to think about when we live the dramas of our patients who fight their dread of becoming ill and, even more, their dread of being fully alive.

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