Body memory and hypochondria: an ever present archaic experience?[1]

Patrícia Paraboni*
Marta Rezende Cardoso
Federal University of Rio de Janeiro, Graduate Program in Psychoanalytic Theory.
Rio de Janeiro, RJ, Brazil

Abstract: The aim of this article is to analyze the uniqueness of the dimension of memory in hypochondria. Its characteristic body distress is one of the most archaic modes of death experience, projecting itself into the concrete and into the immediate of the body. In hypochondria, the persecutory character that affects the subject's body implies an "updating" in the sense of a devilish return of the same, a primary traumatic experience. The imminent danger of death, presented by the serious illness these subjects are convinced to have been affected by, expresses the continuing perception they have of body states. This comes from how long the time made present, an archaic time, stayed in the psychic life, closer to the level of perception. Thus, the ego updates its most basic and primordial mode of existing, paradoxically protecting itself from the effects of trauma.

Keywords: hypochondria, body, memory.

In hypochondria, the persecutory character acting on the subject's body seems to us a kind of *actualization*, a demonic return, the primordial experience, which gives a new perspective on hypochondriac manifestations in which body anguish is one of the most archaic ways of living the experience of death. In hypochondria, it is projected onto the body surface.

Our purpose in this paper is to show that the bodily sensations caused by hypochondria perpetuate an archaic time whose history has been suspended. If time is frozen, suspended, nothing can succeed, there is a refusal of movement. Body overinvestment, in our opinion, is an attempt to freeze time. Therefore, the ego updates its most elemental and primitive mode of existence, protecting itself thus from the effects of traumatic experience.

Which is the memory singularity, however, in these cases, i.e., in which way experienced events may be stored on the mind and always re-experienced on the body without being connected to a past experience as a memory?

Trauma and body memory

In the "Letter 52" (1950/1996e) Freud informed Fliess that he was working in a thesis that memory does not present itself at once, unfolding at different times, for being made of rearrangements, retranscriptions. He proposed a scheme made of different registers, which would be separate according to the neurons, their vehicles. In this scheme, there is a first stage, perception, which does not preserve any trace of the lived experience. After this stage, we have the first record, and this belongs to memory: indexes of perception. The second record corresponds to the inscription of mnemonic traits of the unconscious, the memories. In the following record occurs the third transcription, preconsciousness, related to verbal representations, corresponding to the ego.

Perception, the excitement in the perceptual system leaves marks: the first signs of perception. They are the first transcriptions and in this process the original is lost, little of perception and of the original event is kept. What is preserved as an impression is what will be transposed. The signs of perception are the first record of the excitatory process of perception, therefore being a part of the memory system. However, to become mnemonic traits, integrating the unconscious and therefore liable to memory, it will require another transcription (Lejarraga, 1996).

From the considerations from "Letter 52", Knobloch (1998) draws a distinction between trait and mark regarding inscription. Mnemonic traits are unconscious and may become conscious by assuming an inscription that may be rewritten and transcribed. Its entry in the psychic record is through established links with other traces of impressions, allowing its inscription in the memory. Otherwise, the mark (signs/indexes of perception) supposes a non-inscription. They are "sensations without words", experiences that do not enter into the psychic representation circuit.

The author distinguishes, therefore, two types of memory:

> A memorable form, which, as we already showed, is responsible for the construction of memory,

1 Funding information: National Council for Scientific and Technological Development. Registration number 140259/2011-2.

* Corresponding address: pparaboni@yahoo.com.br

> where the impressions would leave their traces and by their condition would be inscribed as representations within the psychic apparatus and, in their arrangement, are in constant transfer, modified by fantasy and interpretation. There is another form, which some call immemorial, immutable, and not connected. (Knobloch, 1998, p. 91)

Based on Fédida (quoted by Knobloch, 1998), who opposes a narrative memory to the infant memory, the author shows that the infant memory would be made of impressions that would remain unrepresented. Infant here does not mean childhood, but to not able to be released marks, "specific modes of real influence exerted upon pulsional life, during the whole existence and, in this sense, always present" (Knobloch, 1998, p. 92).

The idea of the infant memory is present in the Ferenczi's (1930/2011) formulations, which in "Principle of relaxation and neocatharsis", assumes the existence of "body mnemonic symbols" related to stages of development in which "not being the organ of thought completely developed, only the physical memories were recorded" (p. 74). The "body mnemonic symbols" are "physical memories", as if the body were the place of thought. What acts here and os faced is the pain resulting from a not representable excess (Knobloch, 1998).

According to Knobloch (1998), Ferenczi thinks the trauma from the verification that the patient "would operate the pain" due to the impossibility of representation. What comes up in the clinic in these situations points to a different class, outside the field of representation, and that usually show up because of its allusion to not representable elements. This is an actualization of excess, of the traumatic experience. We must emphasize, however, that the absence of representative content does not mean absence of sensations and emotions. For Ferenczi (1931/2011), *infans* reactions to displeasure are always, and firstly, bodily in nature. There are no conscious memories of the course of events, but just sensations of pleasure or displeasure and also bodily reactions. "*The 'memory' remains immobilized in the body and only there* it can be awakened" (Ferenczi, 1932/2011, p. 304, author's emphasis).

Ferenczi proposed another way of "conservating experiences", distinct from the inscription. For Knobloch (1998), this idea would have been developed from what Freud had made known with the notion of impression to point out that which is not yet an inscription. The traumatic mark, as inappropriate element in the subject's history, tends toward actualization. Therefore, a dimension of psychic functioning outside the field of representation and temporality that characterized it are designed. It is a body memory in which the sensations related to an experience do not function as a memory.

On this matter, Reis (2004) considers that the body memory implies some kind of actualization of scattered marks and sensations of self-erotic experiences—actualization regarding a pre-individual dimension in which the self still does not provide narcissist support for pulsional dynamics. Bodily changes under a autoplastic mode of autoerotic bias are repetitions of the traumatic marks that were kept registered as perception signs.

Fontes (2002) adds that somatization would be a pre-verbal operation, the result of a regression to a period—from the origins of the infant—in which these pre-linguistic communications were part of the baby's relationship with his or her environment.

> There are cases that impression mnemonic traits do not subsist, even in the unconscious, so that the origins of the commotion stay inaccessible to memory. At this point, it is necessary to return to the body, to that we may call the patient's "body memory", to try to reconstruct a story that could not be recollected. (Fontes, 2002, p. 63)

This memory immobilized in the body can only be accessed through the body. Body memory has close relationship with the traumatic event, the field of what cannot be represented, and may only be awakened/accessed through sensations, somatic manifestations, an aspect that we deem essential to hypochondria. These sensations actualize an anguish of death, in which predominates the temporality of despair, as we will see in the following paragraphs.

Anguish of death, time of despair

In hypochondria there is no waiting time, but a temporality of urgency, of the present, despair, automatic anguish. The hypochondriac is taken by anguishes of death because of his/her constant distrust on his/her own body, convinced that some deadly harm is settled. The hypochondriac anguish concerning the sick body, in an alleged imminence of death, configures a situation of despair.

It the words of Roussillon (1999), a "anguish-overflow" that establishes a state of disorder in progress, an undelayed and arbitrary threat. On the other hand, with the anguish-alarm signal, the self allows one to have time to process what would generate internally the disorganizing state, avoiding thus the risk of overflow.

It is worth mentioning that in *Inhibitions, Symptoms and Anxiety* (1926/1996c) Freud reshapes his anguish theory. He considers the ego as the seat of anguish and, as a consequence, repression would be produced by anguish and not by the other way around, as he had stated until that point. He insists on a double origin of anxiety: as a direct consequence of the traumatic moment; and as a sign that threatens with a repetition of that moment (Freud, 1933/1996d).

Roussillon (1999) explains that, faced with anguish, the main task of the self is to organize it as a preventive sign. The signal of anguish has precisely the function

of preventing/anticipating to the self a threat of disorder and operates in the ego in order to transform the previous traumatic experience in a cautionary signal. The signal of anguish presupposes the internalization of the traumatic experience, removing from the self's interior borders the overflow threat. It gives the self enough time for a specific "adapted" action, time to choose and to be opened to conflict.

The transformation of anguish-overflow in the signal of anguish does not come from a simple process of return through which an interiorization would operate, but significantly reduces the intensity in which the signal must be only of displeasure and not of threat to the mind's organization. This intensity reduction presupposes that an operation has been carried out by the self, an operation of igniting pulsional energy.

Given the effraction effects of the para-excitation system, Freud (1920/1996b) shows that the self mobilizes counter-charges to stop disorder, energy counter-investment able to restrain effraction. This counter-investment, however, may not be enough to establish a real alarm signal. The signal of anguish admits connection, establishment of traces that act as an auto-informative system for the self, so that it may anticipate and undertake defense against the possibility of the irruption of pulsional excess.

On this topic, it is worth addressing the Winnicott's contributions, particularly his concept of agony, in his writings on anguish without alarm signal. Agony indicates precisely the failure of representative organization. For Winnicott (1975), such failure would be the result of the self immaturity in the moment of the cataclysmic experience. It would be the case of archaic experiences that affect the subject's rising self in a stage that the psychic organization was not able to deal with the experience, not even to stick to it. For Roussillon (1999), that would prevent later establishment of the alarm signal.

The primitive agony has the following characteristics: it is extreme, endless (temporal organizers are not yet developed), has no limits (it is a consequence of disorder), and has no way out. The ego would have to abstain itself from the experience to survive psychic death. Instead of dominating the trauma, the ego abstain itself from the traumatic experience through cleavage. This withdrawal, according to a protection disinvestment model, is an attempt to build a defense. It is at stake a passive-active axis inversion, peculiar to a withdrawal from the experience (Roussillon, 1999).

Winnicott (1975) underlines the necessity of the self to place the agonistic experience in the present, to actualize it. From this idea, Roussillon (1999) adds that the defense against the agony return through passive-active axis inversion, creates an ever recurring state of agony, but restraining, at the same time, the subjective access to this experience. This defense implies deleting the historicity and causality of trauma, making it difficult to ring the alarm signal.

The belief that undermines the subject's future is related to a past event not symbolized in the moment experienced, nor truly symbolized later (*a posteriori*), because the subject is no longer present to experience it. The presentification/actualization of the "lost trauma" must be, therefore, understood as an appeal to the other, so as to help him or her to find a way out: to put it behind, historicize the trauma that would otherwise stay in the present.

In agony and automatic anguish, we have a time without waiting, a time of despair. Anguish-alarm signal is out of the question here, for it was not possible for the ego to emit the signal of anguish—it does not have an auto-informative system of signs that would forewarn him about the pulsional outburst. Waiting time for completing the connection has not proven itself possible.

For Roussillon (2002), despair happens because the present experience has not been represented as a re-edition of the forgotten past. It stays present, lived "out of time"; it refers to archaic temporality, which does not acknowledge the limit, the relative, time: happens in the eternally recurring present. When reactivated, presents itself again with the same features, with the same absolute character, always present, endless, hopeless, without time. This is not a kind of timelessness proper to the unconscious, but an archaic experience prior to the subject's organization of time. Thus, occurs the historical encystment of the experience.

Time of despair is underlying the compulsion to the repetition logic, an affirmative statement that there is nothing to wait (André, 2002). For Golse (2002), despair is an active reaction, an active struggle, a stage of appeal, but paradoxically placed on the life's side. It is a last struggle before psychic death. We understand despair as an active reaction for psychic survival. According to André (quoted by Golse, 2002, p. 35), "while there is despair, there is life". Acknowledge despair as an active reaction, a fight for psychic survival, even when ruled by the logic of automatism and actualization in the present, implies the reversal of passive axis to active.

In hypochondria, cleavage and projection in the body have an active character, as well as the automatism itself that actualizes the traumatic experience. The self gives up a part of itself to protect the rest. When the body, however, through projection, takes the place of the self, the sign, the agony is not extinguished, it only changes place, namely, from the inside to the outside. The body is constantly threatened by annihilation, diseases, contamination, tumors, and so on. The cause of agony becomes exterior to the self, hindering the subject's access to the experience and the possibility of historicize it.

The hypochondriac complaint is focused on the sensations and on the disease history from which the patient is away, because it would, according to subjective experience, happen against his will, making it impossible to live his life and follow the course of his own history.

These issues can be observed in the Charles case, Gibeault's patient (2002), who felt anguish and

hypochondriac pains for six months. He complained of memory loss, vision disorders, intolerable belly pains. He was convinced he had cancer. He gave countless details about physical problems, about physicians consulted, and countless exams that he was submitted himself to discover the "truth" of his condition. He felt, however, that the doctors did not want to tell him what they knew. In his unrestrained search for doctors and specialists and, moreover, for clinical knowledge in books, Charles felt he was a doctor (more than the doctors themselves), but always being misunderstood.

In psychotherapy he appealed to hypochondriac self-observation, complaining about body pains related to what he called "his dysentery". He attributed the origin of his bellyaches to his father's syphilis that would have contaminated him and he also believed he had acquired a parasitosis due to ingestion of "water contaminated by the Arabs" while he was in Tunisia. At one occasion, Charles arrives 15 minutes late and,

> as usual, he complains about his bellyaches and says he could only came because he took a tranquilizer: "Always my parasitosis, my amebiasis, these things have names impossible to remember, it gives me a bloated belly; I don't like Dr. X... he is not God". (Gibeault, 2002, p. 123)

Faced with the impossibility of remembering, the body is summoned—Charles' bloated stomach. With the evolution of the therapeutic process, however, the patient could evoke, among other things, the feeling of being an unwanted child. He remembers being a baby left crying in his cradle, comforted by his older brother, which in his opinion would attest his mother's absence and inadequacy. Moreover, he could connect his current anguish to what he felt when he was a child, when he was separated from his mother to go to school. Or else, to the fear of being late and be punished, causing "fear in his stomach".

Experiencing the anguish of death in the body, such as occurs in hypochondria, has as a paradigm the baby's feeling of helplessness, who, given the lack of psychological resources to deal with pulsations, experiences the anguish of annihilation in his own body. The hypochondriac body anguish is one of the most archaic ways of experiencing death through the body. When the self is not yet completely developed as psychic instance and temporal marks are not established, all the experiences are printed in the body record, the field of body memory. But how does the body memory make itself present?

Appeal to perception: last resource against overflow of pulsions

In the case of hypochondria, perception is highly important. The feeling of an always sick body, constantly threatened by death make us wonder about the singularity of perception processes that, as we will show, are related to actualization and body memory. We agree with Press (1999) that the impossibility of inscription causes a displacement onto perception.

Hypochondria evidences a super-investment of perception, revealing a constant care with the body, even if it does not present organic damage that justifies this surveillance of organs and bodily functions. Super-investment of the perception system is, in our view, a reaction to the lack of defensive investment capable of protecting the mind from pulsion overflow. When unrepresented elements are projected in the body, it produces a super-investment of perception so as the ego would not submerge by the return of these elements, a threat that in the case of hypochondria menaces the body. For this reason, the body is constantly monitored. Appealing to the body could be the ego last resource to be "in the presence" of these irrepresentable elements.

Super-investment of body perception in hypochondriacs and the continuous state of alert they keep on smallest bodily modifications approximate our views to Forbes (2008) regarding the great capacity of observation in limit conditions and, on the other hand, the ineffectiveness of the transitivity of elements perceived and recorded.

The author explores the concept of "Verleugnung" used by Freud (especially in his works on fetishism and psychosis) and is usually translated as "refusal", but Figueiredo translates it as *disallowing,* because he considers it a term closest to the idea of "stopping a process by eliminating the *transitive effectiveness* from one of its links" (Figueiredo, 2008, p. 59, author's emphasis). What is refused is not a given perception, but what would come after—namely, the effectiveness of its transitive character. The refusal refers to a time and procedure dimension of the psyche, it is the psychic work that is blocked.

In "Neurosis and psychosis" (1924) Freud showed that it is always possible to obtain new perceptions from present perceptions, i.e., a present perception has the capacity to create other perceptions, to renew itself, to transit. In this case, new perceptions are refused: "what is disempowered is the capacity of a given perception to transit to other *perceptions conserving certain continuity*" (Figueiredo, 2008, p. 61, author's emphasis). The perception is disempowered to provide or demand other steps in the psychic chain.

Under the impact of disallowing, the perception does not lose its meaning, but its significance; it was taken from a network of associations to be preserved as "almost-something". Certain elements cannot be integrated into the psychic flow because they lost their metaphorization capacity. That is, in the continuity of what we are developing it is as if the retranscription process of perception signs in psychic traits was blocked. This would be one of the reasons hypochondriacs remain tied to body memory record.

To enlighten the disallowing concept, the abovementioned author emphasizes that a perception involves two moments of synthesis and there would be among them

a moment of undoing. The first is the synthesis, which generates forms, delimits, and gives shape to something, contradicting sensorial dispersion. If this closing cannot be undone, the perception process stops causing serious consequences.

The second moment of the process, opposite to the moment of synthesis, is the undoing, which allows to open enclosed images. It makes perceived images articulate with other images—in the timeline and in a continuous transitive process. In the third moment operates the second synthesis, continuing, giving transitivity and fluency to the perception process. It is in this process that each perception gains significance.

We believe that the problems of hypochondria, with insistent fixation on the conviction that a disease exists and denying anything that contradicts this belief, have roots precisely in the interrupted transition from the first synthesis for the undoing. The hypochondriac remains closed in the disease autocracy and the opening that could change his beliefs require interrupting the second moment of perception (undoing) capable of changing his conviction.

According to Figueiredo (2008), the perception has authorization and effectiveness when it is capable of triggering associative network tracks. In its turn, disallowing blocks perception processual and transitive character—its significance—without destroying, however, the first synthesis (its meaning) and may have a greater power. To interrupt the perception process would already imply in "not perceiving" something essential. Moreover, everything "not perceived" requires the creation of substitutes: the "pseudoperception".

> Contrary to perceptions that are inscribed in chains and circulate in the associative networks, a pseudoperception aims to *interrupt the psychic progress*, freezing itself in a very clear image, intransitive, and defensive. It can, therefore, for being so clear, have the appearance of a "superperception". (Figueiredo, 2008, p. 67, author's emphasis)

With the disallowing of perception until the unconscious, these elements are retained within the senses, attached to the body memory. In the perception disallowing, the impression subjected to this operation isolate itself from perception and its connections with mnemonic processes and symbolization. We believe that the sick body complains and the super-investment of this pseudoperception restrain the transitivity of perception in its retranscription/transformation into psychic traits in the unconscious.

Literal and "ultra-clear" character of hypochondriac sensations

The bodily changes of which hypochondriacs complain are a pseudoperception built from the disallowing of the perception process in a processual sense. The elements that could not be registered in the psyche as mnemonic traits were, however, retained in memory as perception signs. They remain, then, in a layer closer to perception records.

Laplanche (2007) believes that these elements not registered and, therefore, not translated would have remained "in the surface of conscience". They would have been kept in a thin layer of conscious defense, operating as a procedure. Hence the creation of the "medical theories" by hypochondriacs to deal with sensations that haunt them. It is a seemingly logical system of medical description of body conditions.

The complaint that indicates the paralysis of an endless nightmare lived in the waking state and that is not enough to express an affection in an intimate lament translates to non subjective experience of the body (Fédida, 2009), and is in agreement with the lost ability to symbolically represent the body, leaving the subject trapped in a literal logic. Such literality may be perceived in these subjects speech when they talk about their somatic status; this is an "organ-speech", as Freud warned us (1915/1996a).

The literality has an "ultra-clear" character and a relationship with the traumatic experience, with the impossibility of representation. According to Maldonado and Cardoso (2009), literality is the main feature of traumatic experience, making these elements introduce themselves as an unbearable "light", hyper-real, without mediation, and, therefore, cannot be forgotten. The traumatic reveals a hole in the para-excitation system that will show itself "ultra-clearly", without the possibility of concealment. "When the 'para-excitation' system breaks, the protective web of fantasy also breaks, which would cover, enwrap the horror" (Maldonado & Cardoso, 2009, p. 54).

According to Borges (2012), the literal is due to the absence of representation that made it, as well as the fixedness of its elements reveals a past that crystallizes itself as an absolute present. Literality is related to experiences that were not registered as representations, remaining in the psyche as marks, as perception signs. Because of its literality and clarity, these elements constitute a "hiper memory", unlike the concealed memories. They have a tonality closer to affection and perception than to the representation and the symbolic.

Physical and psychic survival is urgent. The body survival is the guarantee of psychic existence, even if it is closely related to a bodily existence, as hypochondria shows us. The hypochondriac's body is loud in its demand for constant care and attention.

In hypochondria, the reality—where attention and perception should always function as radars—is the reality of body modification/change. There is a super-investment of the exterior, since the body may assume the status of exteriority in relation to the self. Through projection on the body of unrepresented elements, the hypervigilance acts to ensure they stay in the outside-body, since they could

not be integrated in the ego and are, moreover, a threat of psychic disorder.

Reality tests: continuous actualization of surveillance

The need to keep distance from traumatic elements that threaten the ego with disorder puts the subject in an exacerbated hypervigilance, through a continuous perception of the body. This aspect leads us to investigate the installation of the reality sense in cases where the body is always fragile and constantly threatened with attacks by some kind of harm.

To accomplish the task we will approach the work by Figueiredo (2004) on reality tests in limit conditions. His hypothesis is that in such cases reality tests are repeated and do not dismay, and may be very frequent. The author starts, then, from what would be at stake in the proves of reality to which the psyche must submit itself in its healthy functioning.

Based on Freud and Ferenczi, he emphasizes the important distinction between "reality test" and "sense of reality". To constitute a "sense of reality" (external and internal) the reality tests would no longer have the function of differentiating fantasy and perception. He uses, among other references, the works of two North-American psychoanalysts, Robbins and Sadow, who differentiate the reality test, with the basic function of differentiating internal and external, of what they call "reality processing". This is a more advanced stage of contact, knowledge, and adaptation to reality. The hypothesis of Figueiredo (2004) is that "when reality processing cannot be made permanently (because it finds obstacles and is interrupted), reality testing gains are lost and they need to be made again continuously, always ineffective, unsatisfactory, and even disturbing" (pp. 509-510).

When the effective establishment of the sense of reality is compromised, the reality tests should be continuously carried out. In the long run, however, they usually fail because an effective sense of reality that could support the tests results has not been constituted, making them tolerable and capable of being assimilated. Disallowing attacks the sense of reality, interrupting reality processing.

According to the Freudian perspective, reality testing comprises a temporality, because it is necessary a long period of suspension of the response so that fantasy and perceived reality could be confronted. Moreover, it is necessary to renounce immediate pleasures, which only occurs when there is hope of future reward. The suspension of discharge and the hope imply time, endure a waiting period to obtain satisfaction later in the future.

When reality testing is required, but at the same time is ineffective, there is interruption of its transformation into continuous reality processing. In the absence of a sense of reality well established, the contact with reality, which would be fostered by reality tests, creates turbulence and oscillation, and its gains lead to suffering. Reality does not find interior space and time to be installed, becoming excessive, traumatic, incomprehensible, harassing, source of constant threat of annihilation.

We consider that in hypochondria there is no proper installation of the sense of reality, since the experience that could not be controled by the self is considered hostile. Thus, reality tests are very important, but at the same time ineffective, for they need to be made again constantly, since they do not produce nor guarantee the proper establishment of reality processing and of the sense of reality. Reality tests are carried out frequently to discern the inside from the outside, keeping threatening elements outside, in a certain distance from the self. As for hypochondria, the exteriority is in the body.

The body is recalled in such cases as narcissistic self-preservation. Hypochondriacs "medical theories" on their body conditions are created as a try to understand, control what is not apprehended by the ego in face of the traumatic excess outbreak. The body becomes a research object, since it "hides" via projection unrepresented elements. Enlarged states of conscience and attention create a state of high perspicuity, allowing a radical knowledge of the body, source of threats to the self. It is a question of knowing, becoming familiar with this stranger who took possession of the body. In this survival strategy, "in which life defends itself from the body", the super-investment of the hypochondriac sick organ maintains an elementary narcissistic resource, in which the self is part of the body, fundamental condition for self-preservation.

Despite the constant reality testing for the traumatic elements remain in the body, even though the lack of effective installation of the sense of reality makes hypochondriacs constantly threatened by the return of traumatic events.

The same eternal actualization

Rethinking the logic of the "present", we saw how hypochondria would be connected to automatic anguish, anguish of death, experienced in the body. In the absence of signal of anguish, which would prepare the self for agitations, the time of despair is installed.

The "present" belongs to a specific temporality of the traumatic event, temporality of a never ending present that does not become the past, and puts compulsively the actualization of unrepresented elements in the present. Summoning the body and the sensations that emanate from it perpetuate that period whose history has been suspended.

The hypochondriac formations put unrepresentable elements in the present. The hypochondriac logic produces desubjectification of symptoms, without symbolization and without connection with the subjective history and memory (Brusset, 2002). Given the lack of historicization, the present sensation remains and also the history of the disease from which the patient is absent. The present would be a denial of a past always present and insurmountable.

What is actualized in the sensations is the anguish of death in relation to the body. The imminent risk of death, *introduced* by the critical illness these patients believe they have been suffering, lead us to the relationship between anguish and trauma. In hypochondria, the disease announces death, but the constant surveillance of the organ—the constant perception of body conditions and the reality tests—makes the patient stay in the present, a survival time. Would it be a "triumph" over death?

The hypochondriac doubts his or her own health, suspecting that the body has been harmed. Combe (2010) points out that such attitude is part of our humanity, of knowing ourselves mortals, i.e., we are living within a vulnerable body. The hypochondriac doubt provides evidence of the sensitivity to human vulnerability. In hypochondria, something on the finitude appears as anguish caused by the body and this causes immobility. Being vulnerable confronts the self with mortality. And this the hypochondriac knows well: "attention: mortality on the horizon" (Combe, 2010, p. 63, our translation). Despite his mortal condition, the hypochondriac seeks for eternity; however, this becomes a punishment, as eternal actualization.

To suspend time, as underlines Bernateau (2010), is a way to avoid what is inevitable in death; narcissistic fantasy of eternity in which underlies a time suspended and dominated by death. To be out of time, freezing all temporality, one refuses the traumatic excitation. If the time is frozen, petrified, then nothing can come from it, nothing will unfold; there is a movement refusal.

Hypochondria is an attempt to freeze time through a super-investment of the organ, of the body. Thus, a feeling remains actualized rather than historicized. Stay at an archaic time. What is more ancient in time is primitive, what is closer to perception. The temporality of the present "carries the trait of *infantia*, of a 'period' prior to time, when time was not yet psychically constituted" (André, 2008, p. 165, author's emphasis). Hypochondria actualizes an archaic mode of operation, triggered on the outbreak of the traumatic event, from which, to survive the ego seems to actualize its basic and primeval mode of existence.

Memória corporal e hipocondria: um vivido arcaico sempre presente?

Resumo: O objetivo deste artigo é analisar a singularidade da dimensão de memória na hipocondria. A angústia corporal que lhe é característica constitui um dos modos mais arcaicos de vivência da experiência de morte, projetando-se na concretude e no imediato do corpo. Na hipocondria, o caráter persecutório que incide sobre o corpo do sujeito implica uma "atualização" no sentido de um retorno demoníaco do mesmo, de um vivido traumático primordial. O perigo iminente de morte, apresentado pela doença grave da qual esses sujeitos estão convencidos de terem sido acometidos, expressa a contínua percepção que eles têm dos estados do corpo. Isso resulta da permanência na vida psíquica de um tempo presentificado, tempo do arcaico, mais próximo do registro da percepção. Desse modo, o ego atualiza seu modo de existência mais elementar e primordial, protegendo-se, paradoxalmente, dos efeitos do traumático.

Palavras-chave: hipocondria, corpo, memória.

Mémoire corporelle et l'hypocondrie: un vécu archaïque toujours présent?

Résumé: L'objectif de cet article est d'analyser le caractère unique de la dimension de la mémoire dans l'hypocondrie. La détresse corporelle caractéristique est l'un des modes les plus archaïques du vécu de l'expérience de la mort, qui se reflète dans la matérialité et l'immédiateté du corps. Dans l' hypocondrie, le caractère de persécution qui se concentre sur le corps du sujet implique une « mise à jour » dans le sens d'un retour démoniaque du même, un vécu traumatique primaire. Le danger imminent de mort, présenté par la maladie grave dont ces sujets sont convaincus qu'ils ont été touchés exprime la percepcion continué qu'ils ont de ses états de corps. Ceci résulte de la permanence dans la vie psychique d'un temps présentifié, temps de l'archaïque, plus proche du champs de la perception. Ainsi, le moi met à jour son mode d'existance le plus primordial et fondamental, tout en se protégeant, paradoxalement, des effets traumatisants.

Mots-clés: hypocondrie, corps, mémoire.

Memoria corporal e hipocondría: ¿Un arcaico vivido siempre presente?

Resumen: El objetivo de este trabajo fue analizar la singularidad de la dimensión de la memoria en la hipocondría. La angustia corporal que es su característica es uno de los modos más arcaicos de la experiencia demuerte, que se proyecta en la concretud y en el inmediato del cuerpo. En la hipocondría, el carácter persecutorio que incide en el cuerpo del sujeto implica una "actualización", en el sentido de un retorno demoníaco de lo mismo, un vivido traumático primario. El riesgo inminente de

muerte, presentado por la enfermedad grave que estos sujetos están convencidos de que les afectan, expresa la continua percepción que tienen de sus estados corporales. Esto resulta la permanencia en la vida psíquica de un tiempo presentificado, tiempo del arcaico, más cerca del registro de la percepción. Así, el ego actualiza su modo de vida más básico y primordial, mientras paradójicamente protege a sí mismo de los efectos del trauma.

Palabras clave: hipocondría, cuerpo, memoria.

References

André, J. (2002). Introduction: présence du désespoir. In J. André (Ed.), *Le temps du désespoir* (pp. 9-24). Paris, França: PUF.

André, J. (2008). O acontecimento e a temporalidade: o après-coup no tratamento. *Ide, Psicanálise e Cultura*, *31*(47), 139-167. Recuperado de http://pepsic.bvsalud.org/pdf/ide/v31n47/v31n47a25.pdf

Bernateau, I. (2010). Le temps suspendu. In J. André, S. Dreyfus-Asséo & F. Hartog (Eds.), *Le récits du temps* (pp. 69-82). Paris, França: PUF.

Borges, G. M. (2012). *Neurose traumática: fundamentos e destinos*. Curitiba, PR: Juruá.

Brusset, B. (2002). L'hypocondrie: thématique ou organization spécifique? *Revue Française de Psychosomatique*, (22), 45-64. Recuperado de www.cairn.info/revue-francaise-de-psychosomatique-2002-2-page-45.htm

Combe, C. (2010). *Corps, mémoire, hypocondrie*. Paris, França: Dunod.

Fédida, P. (2009). L'hypocondrie de l'expérience du corps. In C. Chabert (Ed.), *Traité de psychopathologie de l'adulte. Psychopathologiedes limites* (pp. 89-141). Paris, França: Dunod.

Ferenczi, S. (2011). Princípio de relaxamento e neocatarse. In *Psicanálise IV* (pp. 61-78). São Paulo, SP: Martins Fontes. (Trabalho original publicado em 1930)

Ferenczi, S. (2011). Análises de crianças com adultos. In *Psicanálise IV* (pp. 79-95). São Paulo, SP: Martins Fontes. (Trabalho original publicado em 1931)

Ferenczi, S. (2011). Notas e fragmentos: infantilismo psíquico = histeria. In *Psicanálise IV* (pp. 304-305). São Paulo, SP: Martins Fontes. (Trabalho original publicado em 1932)

Figueiredo, L. C. (2004). Os casos-limite: senso, teste e processamento de realidade. *Revista Brasileira de Psicanálise*, *38*(3), 503-519.

Figueiredo, L. C. (2008). *Verleugnung*. A desautorização do processo perceptivo. In L. C. Figueiredo. *Psicanálise: elementos para a clínica contemporânea* (pp. 57-75). São Paulo, SP: Escuta.

Fontes, I. (2002). *Memória corporal e transferência: fundamentos para uma psicanálise do sensível*. São Paulo, SP: Via Lettera.

Freud, S. (1996a). O inconsciente. In S. Freud, *Edição standard brasileira das obras psicológicas completas de Sigmund Freud* (J. Salomão, trad., Vol. 14, pp. 165-222). Rio de Janeiro, RJ: Imago. (Trabalho original publicado em 1915)

Freud, S. (1996b). Além do princípio de prazer. In S. Freud, *Edição standard brasileira das obras psicológicas completas de Sigmund Freud* (J. Salomão, trad., Vol. 18, pp. 13-75). Rio de Janeiro, RJ: Imago. (Trabalho original publicado em 1920)

Freud, S. (1996c). Inibições, sintomas e ansiedade. In S. Freud, *Edição standard brasileira das obras psicológicas completas de Sigmund Freud* (J. Salomão, trad., Vol. 20, pp. 81-170). Rio de Janeiro, RJ: Imago. (Trabalho original publicado em 1926)

Freud, S. (1996d). Ansiedade e vida instintual. Conferência XXXII. In S. Freud, *Edição standard brasileira das obras psicológicas completas de Sigmund Freud* (J. Salomão, trad., Vol. 22, pp. 85-112). Rio de Janeiro, RJ: Imago. (Trabalho original publicado em 1933)

Freud, S. (1996e). Carta 52. Extratos dos documentos dirigidos a Fliess. In S. Freud, *Edição standard brasileira das obras psicológicas completas de Sigmund Freud.* (J. Salomão, trad., Vol. 1, pp. 281-290). Rio de Janeiro, RJ: Imago. (Trabalho original publicado em 1950)

Gibeault, A. (2002). A solução hipocondríaca. In M. Aisenstein, A. Fine, Alain & G. Pragier (Orgs.), *Hipocondria* (pp. 113-127). São Paulo, SP: Escuta.

Golse, B. (2002). Le désespoir chez les très jeunes enfants ou "tant qu'il y a du désespoir, il y a de la vie". In J. André (Ed.), *Le temps du désespoir* (pp. 25-41). Paris, França: PUF.

Knobloch, F. (1998). *O tempo do traumático.* São Paulo, SP: Educ.

Laplanche, J. (2007). Trois acceptions du mot "inconscient" dans le cadre de la théorie de la séduction généralisée. In J. Laplanche, *Sexual: la sexualité élargi au sens freudienne 2000-2006* (pp. 195-213). Paris, França: PUF.

Lejarraga, A. L. (1996). *O trauma e seus destinos.* Rio de Janeiro, RJ: Revinter.

Maldonado, G., & Cardoso, M. R. (2009). O trauma psíquico e o paradoxo das narrativas impossíveis, mas necessárias. *Psicologia Clínica*, *21*(1), 45-57.

Press, J. (1999). *La perle et le grain de sable. Traumatisme et fonctionnement mental*. Paris: Delachaux et Niestlé.

Reis, E. S. (2004). *Corpo e memória traumática*. Trabalho apresentado no I Congresso Internacional de Psicopatologia Fundamental e VII Congresso Brasileiro de Psicopatologia Fundamental. Rio de Janeiro, RJ.

Recuperado de http://br.geocities.com/memoria_pensante/corpo_mem_traum_ schueler.html

Roussillon, R. (1999). *Agonie, clivage et symbolisation*. Paris, França: PUF.

Roussillon, R. (2002). Agonie et désespoir dans la transfert paradoxal. In J. André (Dir.), *Le temps du désespoir* (pp. 67-95). Paris, França: PUF.

Winnicott, D. W. (1975). La crainte de l'effondrement. *Nouvelle Revue de Psychanalyse*, 11, 35-44.

Received: January 06, 2015
Revised: April 09, 2015
Accepted: May 05, 2015