CHAPTER ONE

Madness and work: from aetiological analysis to theoretical contradictions (a case of *status asthmaticus*)

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Introduction

Whether we like it or not, we must face the fact that the theoretical and clinical questions raised by the impact of the pressures of professional life on mental health remain poorly understood by psychiatrists. We all know, vaguely, that somewhere there is a stream of research going on known as the "psychopathology of work". But few know any more than this. How many of us have heard of Louis Le Guillant (1985), how many can recall the content of studies carried out by the French League of Mental Hygiene, have read the research on work by Claude Veil (1952, 1964), or know of the theorisations of Adolfo Fernandez-Zoïla (1979, 1988) on the experience of work? We have all, in other respects, heard the whispers about research on work-related stress, or "burn-out" (Cherniss, 1980), probably in the media or news weeklies more than through professional journals, as it so happens, but we hardly raise an eyebrow. Because this stream of research unfolds within a behaviourist framework: accessible to the human resources directors and other administrators, certainly, but a little too succinct and simplistic for the practitioner who wishes to explore the psychopathological or aetiological argument.

The subjective relation to work plays a key role in the processes involved both in the construction of health as well as in psychiatric and psychosomatic decompensation. Work cannot be held solely to account for a socially generated discontent, one that lies at the root of all somatic afflictions (medical toxicology) and the most vicious mental afflictions (alienation). The mental damage inflicted by unemployment is there to suggest otherwise. But it would be a mistake to simply make use of this new psychopathology to justify a blissful apologia for labour according to which good health would come only "through toil".

For all that, the conflicting data presented by clinical experience of happy and unhappy relations to work should not discourage the psychopathologist. These contradictions are understandable. For some researchers in psychology, in anthropology, in sociology, and in economics, work occupies a central place in the functioning of society, the production of wealth and national economies, as well as in psychic functioning and the construction of identity. The "centrality of work" is the expression by which, in the scientific community, we refer to the thesis held by these authors (de Bandt et al., 1995).

Psychopathology offers compelling arguments in favour of this thesis. Work is nowhere near to being replaced by substitute investments. Those with plenty of free time are primarily in temporary or precarious work situations, or they are unemployed, and it is not at all clear whether they derive any substantial benefits vis-à-vis the struggle for good health. It would seem, rather, that the scarcity or the deprivation of activity and remunerated employment makes their relation to good health more precarious.

In no way do we share the theories on the end of work, which are of little more use than theorising about the end of history. But we should recognise their powerful impact on the *Zeitgeist* and the formation of perspectives: not only those of the wider population, but of scientists themselves. The widely held social refusal of work filters down to exert its influence upon psychiatrists themselves, who are left somewhat at a loss to explain the discrepancy between the vision of unemployment, poverty, job insecurity, and so on, offered up to them through their day-to-day analytic experience, and what they have been promised by triumphant discourse, heralding the "end of work" as Western civilisation enters into the "age of freedom".

The scant interest afforded by psychopathologists to the centrality of work is due in part, also naturally, to other causes that materialise

before the job crisis. It would be impossible to cover all of these in this chapter. And yet, if the analysis of them was familiar to practitioners, perhaps it would lead to a movement of curiosity for the psychopathology and the psychodynamics of work, which in turn may have significant consequences on the practice of psychiatry. The principal difficulty, however, will not be overcome any time soon. It resides in the fact that work is an enigma that is as opaque as the unconscious. As with the aforementioned unconscious, any psychiatrist has some experience of work. But between the experience of the unconscious and the conceptualisation of this experience, there is a step that can cost several years on the divan. The formulation of the experience of work, which is first and foremost the experience of society to the point of the purpose or function of one's own self and body, is also a difficult matter. And yet each of us has this experience, as suggested by the theory of Ignace Meyerson (1948), which was once again taken up and questioned by Fernandez-Zoïla (1996), for whom work is a psychological function. A clinical mine of inestimable wealth exists, but has not been exploited by ordinary psychiatry.

This chapter is aimed at those who have an intuition of the "centrality of work" and who would like to have an idea of what clinical data on the subjective relation to work may reveal to us.

In order to do so, we shall draw upon one observation. Although this form of decompensation is fairly common, the discussion of its aetiology is complex. To attempt an approach, even schematically, we will first require at our disposal certain conceptual elements of work psychodynamics. Then, we shall move on to the account of the case of Mr A and a discussion of the aetiology of the decompensation from a psychoanalytic and psychosomatic viewpoint. Finally, we shall outline the implications of these two aetiological analyses on the management of the treatment. This will then give us a number of strands in our reflection upon the following question: how is it that two aetiopathogenic theories that are so contrasting, even contradictory, can both be right at the same time?

Work and fear

The example we shall draw upon is taken from the construction industry. One of the characteristics of work in this sector, in relation to other

work situations in industry or the service sector, is the significance of accident risk. While much has been made of the consequences of these working conditions upon the health of the body, less attention has been paid to the impact of exposure to risk on the psychological state of these workers. And yet they adopt behaviours that should arouse our curiosity; particularly in relation to prevention and safety. To this they frequently counter a kind of passive resistance, and at times demonstrate a clear unwillingness to respect safety guidelines and to cooperate with health and safety specialists. Is there not a paradox here? How is it that the community hardest hit by workplace accidents is opposed to measures specifically intended to protect it?

If we take a closer look, we see that, for these same workers, disregard for rules and disorder are not only common practice, but are *positively connoted* as external signs of courage. Over and above the resistance to health and safety, these workers display a certain taste for showy displays of muscle strength, agility, even physical prowess. Worse still, at times they artificially add to the existing site risks by organising kinds of bravery contests, through a variety of tests of strength, skill, and courage. These contests are an integral part of the day-to-day working life. They take on a more dramatic form when, on to the site, comes a new worker. They move on to shows of force, but in doing this they also test the newcomer, going as far as compelling him to take part in what are essentially obstacle courses. Either the applicant conforms to these worksite conventions, or he becomes the subject of taunts, and soon after excluded—even harassed—until he quits the job and leaves the site. The denunciation of the deviant is accompanied by disqualification that often takes the pejorative form of accusations according to which the offender behaves like a woman, even like a "fag" and so on. In the community of these workers, they cultivate a particular penchant for disputes to be settled "man to man", that is to say, by using fists if necessary. *Conserere manus* is a type of behaviour that itself has connotations of virility.

What is more, all of these behaviours are articulated with a sexually specific *discourse*. Courage, strength, recklessness, and rule-breaking are on the side of the *virile*. Conversely, complaining of any kind is prohibited, even when in pain. Showing any interest whatsoever in the health of one's body or mental health is forbidden, as is expressing fear, or for that matter showing too much of a taste for caution, looking a bit too closely at work safety and risk prevention.

Complaining, anxiety, and hesitance—these are attitudes that are denounced as being typically effeminate.

The penchant for alcoholic drinks is easily understood in this context as these facilitate sociability and conviviality between men, and therefore the cohesion of the group. But above all, alcohol possesses a powerful anxiolytic action—an action that furthermore is perfectly *dissimulated*. Alcohol is a substrate that has all of the qualities of a drug to keep virility intact and one that is able to fight fear.

We therefore find ourselves before a system that combines:

1. reticence towards and disregard for health and safety
2. dangerous risk-taking behaviour
3. strict discipline towards the external signs of courage
4. any allusion to fear or pain is strictly forbidden
5. a discourse that calibrates all behaviours, attitudes, and conducts in relation to a virility/femininity grid.

This seemingly paradoxical system reveals its coherence when it becomes clear that these workers are in truth tormented by fear, by very virtue of the fact of their exposure to accident risk.

Now this fear, if experienced without dissimulation, would quite simply be incompatible with the continuation of work as it is organised in a real-life setting, on major construction sites. And for this reason these workers are driven to construct the defensive system as described, the mission of which is precisely to fight against the conscious perception of fear.

The concept of the defensive strategy and the question of normality

I will not enter into the internal mechanisms of functioning of these behaviours here. Instead I shall, for now, confine myself to identifying them as *defensive strategies* (Dejours, 1980), intended to combat the psychic pain brought about by working in a climate of threat.

I shall especially emphasise the *key functional value* of this defensive strategy of construction workers. We see that it has undeniable disadvantages, insofar as it interferes with health and safety campaigns, contributes in some way to a resistance to change, and

may even at times add additional risks to the existing danger, particularly during these collective contests of courage and bravery, occasionally resulting in accidents that are quick to be condemned. And yet, evidently it is vital to grasp the practical necessity of these paradoxical behaviours. Without them, the organisation of the work and the objective pressures of the site would be humanly unsustainable.

The avoidance of the pejorative judgement, so often passed by supervisory staff and the layperson regarding these supposedly aberrant behaviours, does not constitute a difficulty for the psychiatrist accustomed to moving in diverse sectors of society and not conceding to reactive emotional or social reactions.

The difficulty for the psychiatrist lies elsewhere. If he succeeds in suspending judgement, he will not easily manage to keep himself from tending to make psychopathological diagnoses in the face of any human behaviour as soon as it is submitted for his opinion.

These behaviours of bravado, indiscipline, provocation, insolence, risk-taking, and tobacco or alcohol dependence: one would need to be able to recognise them without immediately considering them to be signs of irresponsibility, stupidity, immaturity, an archaic mentality, or of a psychopathological or delinquent personality type. Not that there are not, among construction workers, a few psychopaths, but rather because these diagnoses are based on knowledge referential to *psychopathology* and not to the *psychodynamics* of "normality". It is clearly outside the scope of this chapter to deal with the meaning that may be ascribed to normality, in clinical practice, but it is, however, useful to point out that this concept has occupied a central role in the psychodynamics of work since 1980.

Many psychiatrists, certainly, consider themselves to know what normality is once they have gained some clinical experience and a theoretical understanding of madness. And yet, the psychodynamics of work (the clinical experience and the theory of "normality" in a work situation) cannot be superimposed on to the classic psychopathology of work (the work of Louis Le Guillant (1963) and Jean Bégoin (1957)), in that it is first and foremost a psychological study of *ordinary* situations, where people manage to stave off mental illness, and not the study of extraordinary mental decompensation. Psychoanalysis, which brings into question the conventional departure between mental illness and normality, is surely the royal road to a re-framing of a psychodynamics of normality. But it cannot act as a theory of normality.

Normality is a conquest and the "strategies" deployed to maintain it are unknown both to psychiatry and to psychoanalysis. In medicine just as in psychiatry, there is a tendency to apprehend normality, indeed good health, using *negative concepts*: the absence of illness, the silence of the organs, and so on. This is a flawed conception. The health of the body is the result of the relentless struggle (if we may use this metaphor) between physiological regulations and physicochemical-biological disturbances. It is quite another thing to a negatively characterised passive state of absence of illness. The same is true, it would seem, for mental health. Here also, very sophisticated "regulations" exist, mobilising intersubjective dynamics not only in the affective field (which psychoanalysis recognises) but also in the field of social relationships and civil connections, overlooked by psychoanalysis, which examine in particular the sociology and anthropology of health, but also the psychodynamics of work.

The same behaviour does not have the same meaning depending upon whether it is structured around a sophisticated strategy of struggle for good health or whether is it inscribed within a syndrome of psychopathological decompensation.

This is not a mere technicality, as this is not just a question of analytical perspective. This has to do with two *radically different* functional vocations. In one case, the consumption of alcohol is a powerful, effective, and appropriate means of coping with the pressures of the workplace without going mad. In the other, the consumption of alcohol if anything reveals the overwhelming of the psychoneurotic defences, a sign of the precariousness of the psychosomatic economy, and contributes to the deterioration of the patient's mental and somatic state.

Normality or pathology? The comprehensive approach

How do we know whether this behaviour falls within one dynamic or within the other? There is unfortunately no way to make the distinction, from the outside. Only the subject individually, or workers collectively, may point us in the right direction to follow in our interpretation.

Provided, that is, that the clinicians are able to understand. To do this, they must not only refrain from any judgement, as we have seen above, but must also suspend their knowledge, their understanding,

and their presuppositions. Not that clinicians should renounce these and abandon them entirely—quite the opposite—but they should put them on hold while listening to what the "subject of work" has to say.

Thus the first methodological implication of the psychodynamics of work is to advocate in favour of an *understanding* (*Verstehen*) approach—one that we owe to the social sciences and not to the human sciences practitioners (which remains one of history's incongruities, but one that we must come to terms with all the same!).

According to this approach, any behaviour, any posture, any discourse within work, even when seemingly the most aberrant to the outside observer, even when they are redolent of pathological syndromes to the specialised clinician, are deemed rational in relation to good health, as a first-line treatment, whenever they are not the work of isolated personalities. They possess a rationality, indeed a legitimacy, in the sense that these behaviours generally have a precise function in the economy of the subject (or subjects) vis-à-vis the real pressures of work, in their effort to remain within *normality.*

By "an understanding approach or process" we mean that, as the fundamental aim of investigation, the researcher or clinician seeks to investigate what meaning these behaviours and discourses hold *for the operators* before deciding what meaning they hold for the researcher (Alfred Schütz, 1987).

To access the meaning that a certain type of behaviour holds for the subject presupposes that the researcher or clinician must renounce any role as expert and any pronouncement of a diagnosis from the analysis of objective external signs. The understanding approach is resolutely subjectivist (even if the stage of validity testing of the meaning—uncovered by this procedure—in the *après coup*, endeavours to objectivise the status of it). "Neither judge, nor expert", is therefore the maxim we might advance to the psychiatrist focusing on the "centrality of work".

The notion of the collective: from the collective strategy to the construction of the working collective

Another point I would like to emphasise is the *construction* of these defensive strategies. First of all to underscore that these behaviours are not spontaneously occurring, but undergo symbolic elaboration.

This complex system of defence against fear is the result of a *collective* construction and not an individual one. The strategy we have just described is produced by groups of workers, but it is also stabilised, controlled, and maintained *collectively*. The example of young workers or apprentices is illuminating in this regard. Not only does each have to accept these trials organised by the group, but the newcomer must also have something to bring to the table. Conversely, if someone does not subscribe to the defensive strategy, he single-handedly becomes, through his "timorous" behaviour, a threat to the stability of the defensive strategy and ergo to the psychic equilibrium of the other workers. It is because of this group dimension that these strategies are known as "collective defence strategies".

I will add that not only are these strategies constructed by the group, but beyond this they contribute in an essential, fundamental, indeed a foundational, way to the construction and the stabilisation of the *working collective*. It is because they share the collective defence strategy and the rigour that goes along with it that there is recognition between workers as members of the group, and they are able to establish relationships of trust and solidarity between each other.

Finally, I will note that at times there occurs a kind of perversion, if I may use this term—to be taken here strictly prosaically. A kind of perversion, thus, of the collective defence strategy, which we term "defensive ideology of work practice". This "perversion" appears when workers idealise the defensive strategy, this in turn acquiring an inflexible rigidity such that it may no longer be discussed or criticised. Workers risk becoming the victims of this, insofar as the defensive ideology becomes impregnable and prevents any change—even positive change—to the relation to work, to organisational pressures, and to risks. But we shall leave the "ideologies" and come back to the "strategies".

Accordingly there exists a whole range of collective defence strategies, which is in every instance specific to the work situation. If we go even further into detail, we may show that *pain*, the defensive strategies against which tend to take on the role of mental control, is always closely bound up with the *organisational* constraints of work. Put another way, the entire field of mental health at work refers to the organisation of work, while physical health refers above all to working conditions.

Suffering at work and mental health (in the order of the individual)

What are the consequences of these collective defence strategies on the psychic economy and the mental equilibrium of these workers? It can be shown that suffering with work as its source penetrates the private space and the innermost thoughts of every one of us, and so touches the very "material" offered up to the psychiatrist's clinical investigation.

Mr A is Algerian. He is a little over forty years old. He does not know his exact date of birth. He has worked in construction in France for around fifteen years. His wife must be approximately thirty-eight to forty years old, and he has had six children with her, the oldest of whom is twenty and the youngest eighteen months. The only working member of the family, he must meet the needs of nine people: his six children, his wife, his mother-in-law, and himself. He earns less than €1,000 per month. He leaves the house every morning at 5.45 a.m. and returns in the evenings at around 8.15 p.m.

For approximately the last two years, he has begun to suffer from nocturnal dyspnoea. For the last two months, he has no longer been sleeping at night because of the aggravation of this dyspnoea. A few days ago, on the worksite, he triggered an acute severe asthma exacerbation.

The interview with this patient was somewhat difficult owing to significant difficulties in his command of French. This is a man who to all appearances is rather friendly, with an easy smile, and who seems eager to cooperate. He does not understand what is happening to him; over the last few months he has lost around fifteen kilos. He is deeply upset by this new illness that is stripping him of his ability to work. He says he is not depressed, but he emphasises the fact that he no longer has any courage to work. He no longer has any strength or desire to go out to the building site; he has lost his drive, and his lack of courage is quite clearly, for him, the sign that he "is no longer a man" and that he is unwell.

The issue, from the psychopathological point of view, lies in understanding why this asthma appeared suddenly two years ago. To ask the patient, it would appear that no event, no specific circumstance, no particular condition in his mental, affective, professional, or material life can be pinpointed during the period preceding the first appearance of this illness or concomitant to its onset. For lack of the

patient's associations as our focus, upon the links he does not make, in any case, between somatic events and psychic events, we might be tempted to confine ourselves to seeking an organic aetiology for this asthma: an occupational aetiology for example. It is, therefore, by conducting a relatively directional investigation, in seeking to reconstruct a biography or at least a sequence of events that we gradually find ourselves in a position to advance a construct on the aetiopathogenesis of his affliction.

Since 1971, Mr A had sought to bring his wife and children to France. Without success. It was impossible to get an apartment in an H.L.M. (*Habitation à Loyer Modéré* or low rent housing). For years then, he works doggedly, by himself, saving up. He lives in makeshift premises and makeshift shelters on construction sites with a handful of colleagues who are in the same situation as he is. A community of men. During this period, he does not suffer from a single somatic symptom, or from any psychoneurotic symptom. Two years ago, he finally managed to get accommodation through a "friend". Or rather, by means of a large sum of money to a well-connected compatriot at the S. Town Hall who acquires for him, as if by a miracle, an "F4" (a four-roomed, or two-bedroom, apartment).

He then brings his wife over and she immediately falls pregnant with his child, who is now approximately eighteen months old. The patient makes no connection between the two things and yet the dates match up perfectly: the asthma began during the period in which his wife came to join him in France. It is impossible to find any severe conflict situations with the patient's wife, either because he is concealing them, or simply because there are none. If anything, when he talks of his wife, he clearly shows great tenderness and genuine affection. This marriage is not the result of a parental "inter-family" arrangement. When he first met his wife, they chose each other mutually, and the mere mention of this time in his life has his face aglow with happiness and smiles, accompanied by a certain embarrassment and some shyness in bringing up such thoughts in front of a doctor.

I try, as much as is possible, to get him to talk about his wife and children. Two of his children remained in Algeria, with Mr A's mother-in-law. The youngest four are with their mother and with Mr A. When I talk to him about his children's health, he expresses himself animatedly. Clearly, he shows great deal of focused concern for his children's well-being, unusually so it seems to me, in this context.

When I ask him if his life was easier before or after the arrival of his wife, he immediately replies that life is much more enjoyable now that she is here. Previously, he explains, it was hard for him as he only heard from his wife and children every so often; he did not know if they were healthy or if they were unwell. Since their arrival, he concerns himself over their health, and he finds it reassuring to have them close to him so he can take care of them and his wife. However, it is indeed since their arrival that the patient has been suffering from respiratory impairment.

This is how we can interpret the psychopathological history of this patient. Until the arrival of his family, this man established a relationship of control over fear, illness, and bodily states, which was mediated by the collective defence strategies of his fellow workers on the building site. But during this entire period he only ever lived with other men, in the temporary shelters on the worksites; men who, like him, shared the occupational risks and collective defence strategies. Throughout this phase of his existence, life outside work (that is to say, his private sphere) was concordant and complementary to the defensive economy vis-à-vis the pressures of work.

Investment of the professional sphere vs. *investment of the private sphere*

However, when his wife and children arrive, everything changes. Why? By questioning the patient, I discover a family economy quite different to what clinical experience ordinarily reveals. More often than not, we hear allusions to a life essentially occupied by work, while free time is spent outside the family: in cafes, in male company, playing dominos for example, or some or other political, associative, cultural, or social activity, but always without the spouse and without the children. Time spent at home is therefore reduced to the minimum, and the man pays but a fleeting interest in the lives and in the concerns of his family members. Any matters relating to school, health, running the home, and all the domestic tasks are, generally, entrusted to the wife and the older daughters. So the man often demonstrates a great deal of unawareness, even slight disinterest, in the comings and goings of home life.

This type of economy of intersubjective relations in the affective and familial sphere, and in a broader sense in the private space, is not

the result of a simple "cultural conformism" particular to North Africans for example; we find this just as much in civil construction workers in Brazil as those in construction and civil engineering in France. It is instead the result of a successful articulation between the logic of the collective defence strategy and the defensive virility against fear at the worksite, on the one hand, and the organisation of relationships in the private space, on the other, in such as way as to ensure that continuity is thus established and maintained. Manly, even macho, at the worksite, he also displays his virility in private behaviours, inasmuch as partners in the private space tolerate or are prepared to engage with it (which is not always the case; but then family crisis is inevitable).

In other words, these behaviours of construction workers at home are the result of an alignment, indeed a "technical solidarity" (to borrow here from Nicolas Dodier, 1995), in the man's endeavours to remain within the limits of the collective defence strategies. Anything related to health, illness, suffering, pain, the body, blood, accidents, and so on; he, the man who works, is somehow spared by his entourage.

Thus, through the intervention of defensive dynamics, we find the embodiment of what, in sociological terms, we mean by the expression: the articulation, coordination, and coherence between relations of *production* (work) and relations of *reproduction* (family).

But in the case of Mr A we discover something else entirely. Where I was looking for conflict—even violence—between him and his wife, (or towards his children), which is commonplace, I discover instead that Mr A enjoys a good relationship with his wife, whom he truly loves. I am rather surprised by this, as this is not all that common in North African families, where marriages are often arranged by the parents for social and commercial reasons. I ask him for some clarifications, so discovering that this was not so for him. It was he who made the acquaintance of his wife in his late teens, immediately falling in love with her. They were in love with each other and it was together that they decided to get married—and they love each other still.

Whenever he has a free moment, Mr A returns home to spend time with his family. He loves his children, he cares about their studies even if he is unable to help them, and he is particularly conscious of their health. He keeps a close watch on their health and willingly takes them to the doctor whenever he is able to take a day off work, and so on.

It is this relation to the health, sickness and suffering of his family members that is quite unusual in this type of worker. Indeed, to lavish such attention upon the health of his children, one must, mentally, be in a position to be able to identify with them, with their suffering, their needs, and so on. To identify with them means being able to put himself in their place. Now, putting himself in their place is not very compatible with the collective defence strategy aimed precisely at putting completely out of mind any evocation of the illness and/or suffering of the body.

For Mr A, the arrival of his wife and children constitutes a stark break between the defences against suffering at work and what this brings with it, and the patient's existential choices in his private space and in his domestic life. Now, the affective investment seems to be the stronger. Others would have perhaps coped by generating a situation of conflict in the family and by fleeing the family home, only returning to eat and sleep, even escaping family life entirely or divorcing. But he, Mr A, holds on fast to his family life; it is on the work side that his situation becomes destabilised. All of a sudden, he feels drained, all his courage gone, he can no longer push through, he says. He who, up to then, had been a valued worker, now starts to get into trouble. He can no longer stand himself in this situation. He is no longer well-liked by his bosses. Then he starts to suffer from asthmatiform dyspnoea.

By the time I see him, Mr A is hospitalised in intensive care, with *status asthmaticus*.

Thus I shall stop here to underline this point, which is in my view significant. Namely that the defensive strategies required to withstand the pathogenic pressures of the organisation of work function only at the sites of work. The theoretical cut-off between work space and outside-work space is entirely artificial. By leaving the worksite, the subject is still himself, he cannot change skin nor change his psychic economy. This means that suffering at work, by summoning up specific defensive strategies, will distort the subject's entire mental organisation, its tentacles reaching as far as relationships with children and partners. The economy of love and the erotic economy are in some ways taken over by work relations. If the private space is resistant, if it is not compatible with the defensive demands of work, we should be prepared for decompensation. Thus, from this example, we should keep in mind that there is a *fundamental psychic solidarity*

between work life and outside-work life, or a unity of economy between the two existential modalities.

This problem is not specific to migrant workers in unskilled positions in the construction industry. I have observed exactly the same thing in *fighter pilots*. As long as they are young bachelors, they often bear up well to occupational risks. But marriage, and particularly the birth of children, are one of the most frequent causes of what, in the air force, is termed "unfit for duties as a fighter pilot". They must then be reclassified as instructors in flight schools, as helicopter pilots, or as pilots in military air transport, or even suspend them. That is to say, they must remove them from the risky situations they formerly coped with so well or even prized highly. We meet with exactly the same issues with executives and directors.

The problem is the same with Mr A. If he can be reclassified in an occupation without the routine risks of the construction industry, then he will fare better and perhaps be cured. This is at least what is suggested by the progress made by Mr A who, since that time, has been able to change jobs, becoming an assistant in a small business, and no longer suffers from asthma.

Theoretical-clinical remarks

The next point I should like to emphasise specifically is that a large part of the consequences of mental suffering at work does not always manifest itself at the workplace. In striving to hold on to their position, some workers destroy their family life, and it is not uncommon for the children to ultimately suffer from mental disorders, the connections to the parent's suffering being very easy to elucidate. But rarely is this done in standard psychiatric practice, due to a lack of knowledge among the majority of our psychiatrist colleagues as far as the psychodynamics of work is concerned.

Finally, I would like to touch upon the question of the symptomatic form of Mr A's decompensation. Why asthma? Other subjects, placed in analogous psychological circumstances, would not suffer from asthma but instead a work accident followed by a post-traumatic syndrome, others from depression, and others again from delirious episode (Annie Bensaïd, 1990).

This means only that the semiological form of the decompensation does not depend upon the pressures of work that are at the very

beginning of this crisis. The semiological form depends upon the subject's mental organisation, his or her past, childhood, parental relationships, and so on. Even a person's genetics, some psychiatrists would say. It is therefore important to note that, as long as we stay this side of the decompensation, work inscribes highly specific marks upon the subject's defensive organisation. But once decompensation has occurred, if we take it in isolation from its context, it is impossible to clearly recover the traces of the organisation of work that was nonetheless at the very beginning of the crisis.

With regard to Mr A, decompensation took the form of a life-threatening acute somatisation. The reasons for this vulnerability to somatisation we shall not discuss here, as they would lead us too far into the terrain of psychosomatics. Nevertheless, it is indeed by taking action regarding his work that Mr A's psychosomatic problem could be resolved. Even after it had reached hospitalisation stage! Indeed, it was only because the conventional intensive care technologies were rendered ineffective for several days that the psychiatrist needed to be called. During the course even of the initial investigation, despite the difficult conditions often encountered in "liaison psychiatry", the patient's somatic state improved: his heart rate decreased, his breathing improved, and so on, giving the psychiatric intervention the appearance of a "miracle". In fact, it rather seems that the sedation of the patient's anxiety and the improvement of his biological variables may have been contemporaneous to the intersubjective dynamic mobilised by the elaborative work on his experience of suffering at work.

Conclusion

At the end of this quick excursion into the clinical presentation of a common decompensation, we find ourselves faced with two types of "causalities" or "causal pathways" (Anne Fagot-Largeault, 1986) that are really quite different and contradictory to each other. The decompensation indeed may be described in two ways:

1. Our point of departure can either be the analysis of the processes mobilised in favour of the struggle *for good health* (and their being severely compromised by the arrival of the family) thus enabling

an interpretation of the decompensation in relation to the destabilisation of the economy of health. But this analysis only goes as far as the decompensation. Beyond this, the semiological form of the illness leads us to determinants escaping its functional scope.

2. Or, conversely, we may describe the *bio-* and *psychopathological* processes resulting from the decompensation from the medical/biological data and/or the psychosomatic and infantile characteristics of the patient. But we cannot, then, understand why the decompensation occurred only now nor why the psychosomatic territory, which is fragile and vulnerable to traumatism of all kinds, has thus far *resisted* all the sources of traumatism he would have come up against until the age of thirty-eight to forty years old (i.e., the processes involved in good health).

In this way might the psychosomatic decompensation go by two starkly contrasting "descriptions" (using Elizabeth Anscombe's meaning of the concept). But is this merely a conflict of description, better yet a conflict of interpretation (Paul Ricœur, 1969)? It would appear that the conflict of interpretation here overlays a *duality of substance*. To wit, the initial description would pertain to the processes involved in the construction of health, whereas the second would relate to the processes involved in illness. Herein lies a major contradiction, nonetheless difficult to grasp and accept intellectually: health and sickness may not constitute one and the same process and may not even be contiguous processes, but two qualitatively and objectively divergent sets that do not overlap. Doctors and psychiatrists are familiar with and document illness and the fight against illness. Sociologists and anthropologists have an understanding of the processes involved in the construction of health and in the undermining of this construct.

In this way decompensation can (as much as normality, for that matter) produce two descriptions that do not overlap. Accordingly, a substantial *dualism* would exist between health/illness; not a continuum between the two types of process. This is a dualism which would be reiterated by the scientific dualism between the medical/biological sciences and the social sciences regarding health matters.

Ideally, to render an exhaustive account of a psychosomatic state (normal or pathological) it would be necessary to provide two

descriptions: one with regard to the state of the morbid processes, the other with regard to the state of the beneficial processes.

From the therapeutic point of view, it is clear that the analysis of the two types of processes (illness and health) variously suggests markedly different practical measures. In general, however, the approach via only one of the two access routes may be enough to restore an adequate psychosomatic state. But not always. As the example of Mr A shows, his psychosomatic state resisted the practical measures directed against illness, but was receptive to the practical measures directed towards health.

So must we perhaps conclude that the aetiological contradictions remain, for all that we believe the two competing interpretations to be mutually exclusive. The contradiction is if anything lessened should we apprehend the substantial dualism between sickness/health (which incidentally encompasses in large part the dualism of Freud's later drive theory of 1920) suggesting that the two interpretations can be right simultaneously.

The psychodynamics of work possesses the particular characteristic of providing access to the apprehension of certain processes involved in health and in normality. The ideal, however, would be to harness the knowledge in both the fields of health (the psychodynamics of work) and illness (general psychopathology), because then the therapeutic pathways open to the practitioner would increase dramatically.

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