PRIMITIVE BODILY COMMUNICATIONS IN PSYCHOTHERAPY

Embodied Expressions of a Disembodied Psyche

Edited by Raffaella Hilty

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firing the mind

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Foreword

by Susie Orbach

Abject bodies

When it comes to bodies, psychotherapists, trained within psychoanalytic traditions, can struggle with the hierarchy of a theory which has, since the mid twentieth century, elevated mind, along with the complex intricacies of psychic operations, as primary or of primary interest. Body, has, sometimes inadvertently, sometimes purposefully, become, relegated to the symbolic register. It has been tasked with receiving the distressed and conflicted contents of mind as though body, the body, our bodies were a secondary or bit player to the principal drama of the mind.

Despite the early origins of psychoanalysis which stressed the importance of the body, this notion persists and is embedded in our practice. Outstanding researchers like Beebe (Beebe and Lachmann 2002) and Tronick (Tronick *et al.*, 1975). whose ground-breaking and beautiful work reading babies' faces for signs of connection and disconnection in early attachment, use the language of the body to describe the developments in infancy in almost entirely psychic terms. These developments are not only psychical, they are also developments in the appropriation of a bodily sense. Misattunements in body-to-body relating disturb not just a corporeal sense of the developing infant, they are taken into her or him as an insecure embodiment which is now destabilizing psyche. Analysts talk of holding environment as psychic space as though there were two minds at work. Today, the modern epidemic of disturbed eating and body image issues signals manifestations of body distress and insecure body development which need to be addressed and met in their own terms. Often we encounter these expressions of troubled bodies when we are visited by powerful body-to-body relationships in our consulting rooms.

In these revealing essays, we see the work of clinicians whose analysands have refused to leave the body in second place. We are plunged into accounts of a visceral engagement with the whole person – an engagement which can evoke

difficult feelings in the therapist. As they tell of their encounters, we the reader are attuned to painful encounters which may make us retch, gasp and even revolt against what emerges from the page. And yet, this is so much our work. To hold, to be, to accept what can be so very difficult. We are there to receive the pain, the screeches and excretions; to find ways to make physical utterances – and their somatic impact on us – bearable and comprehensible.

The talking cure is profoundly physical; just as is our reading of these pages. Words enter us physically through what we hear in our ears, observe with our eyes, what we smell with our noses. We notice how breath and speech can be halting, consistent, staccato, screeching or, paradoxically, silent. Through registering how breath and speech are conveyed to us, we know that body is not simply a symbol. Sound, smell, vision are intensely corporeal.

Language itself, both the spoken word and the written word, are not mental constructs. That is too narrow an understanding of psyche-soma. Words are sound waves. Sign language is expressed via the body. The written word is physically transmitted through fingers. Language, in whatever manner it is delivered, is an expression of the psyche-soma struggle for subjectivity. It is not a lower order of subjectivity. Correspondingly – although not necessarily in a complimentary sense – the feelings that are aroused in us as we attend to the people we work with, are intensely physical and create the body-to-body relationship between us.

This body-to-body relationship is integral to the talking cure. Bodies emerge in the room when we are with people or on the phone and on Zoom. Our corporeality is not absent. We register feelings as part of beings. We are aroused physically and if we do not notice our bodies, if we are decidedly comfortable in our bodies working with a particular individual, that is in itself a diagnostic: the communication of what we might consider a Winnicottian good-enough body. If we are distressed when working with a person, the manner in which we experience our body countertransference will be idiosyncratic and unique to that individual. I am not talking of the therapist who falls asleep. That may be her symptom. I am talking of the experience of having an unexpected, enlivened body, a deadened body, a repulsed body, a false body, a misshapen experience. Powerful body countertransferences such as these are useful clues which can prompt us to the distressed embodiment of the people we work with. They can be seen as a glimpse into the disturbing experience of the person we are working with.

Mark Solms's epic work on consciousness (2021) resituates psychoanalysis on the ground of affects. And it very much helps us here. We could summarize this as: *We are because we feel. We feel therefore we are. We know because we feel.* We need no longer be mystified by how countertransference is conveyed to us. Solms sees countertransference as the registering of feelings in the therapist. And the essays

in this fine collection stretch the envelope of feelings to include the abject, the uncomfortable, the disavowed, the screaming states of embodiment that we work with.

Here are the people we work with as they are rarely presented to a general psychotherapy audience. There is nothing tidy. This is messy, gruelling and yet deeply interesting and gratifying work. To encounter people who have so much distress around their corporeality and to describe them with such dignity as all the fine authors in this collection do is the best of what we have to offer. This is a humbling collection, a moving collection and a hopeful collection.

Use of terms

We appreciate that not everyone would use the same term for the person in psychotherapy, analysis or counselling. In this edited book the use of the term patient or client reflects the individual professional choice of each author. Both terms, in the context of this book, indicate a person that is receiving psychotherapeutic treatment either in private practice or in an institutional setting.

Introduction

by Raffaella Hilty

Every clinician will be well too familiar with what it means to experience the verbal expression of one's most vulnerable patients' distress, hatred and despair. But, what about those patients who cannot talk because they never developed the capacity to speak? Or those who are capable of talking but carry a complex range of unprocessed emotions that cannot be verbally expressed? These patients rely on another type of language to communicate their internal distress and, even though this is a topic not frequently discussed, many practitioners in the field of mental health have experienced working with people who communicate through the use of their bodies.

The body in its relation to the psyche has been a long-standing area of interest in psychotherapy. Starting from Freud and his early collaborators, up to contemporary thinkers of various analytic orientations, the topic of an embodied psyche has always attracted great attention and the hypothesis that somatic expressions can be found in place of verbal thoughts and fantasies has been central to psychoanalysis since its inception. In *Studies on Hysteria* (Breuer and Freud, 1895), Freud and his colleague Joseph Breuer used five clinical cases to demonstrate the psychogenic aetiology of the hysterical symptomology, positing that there was a symbolic relation between the physical symptom and the psychogenic causative factor. In their joint chapter 'Preliminary Communication' they write, 'It consists only in what might be called a "symbolic" relation between the precipitating cause and the pathological phenomenon – a relation such as healthy people form in dreams. For instance, a neuralgia may follow upon mental pain or vomiting upon feeling of moral disgust. We have studied patients who used to make the most copious use of this sort of symbolisation' (Breuer and Freud, 1895, p. 5). Among the various symptoms that constituted the diagnostic criteria of a hysterical neuroses they mention: 'neuralgia and anaesthesias of very various kinds,

… contractures and paralyses, … chronic vomiting and anorexia, … etc.' (Breuer and Freud, 1895, p. 4).

Freud's interest in emphasizing the relation between the body and the mind was likely rooted in his wish to provide psychoanalysis with a scientific biological foundation.[1] In his *Project for a Scientific Psychology* he writes, 'The intention is to furnish a psychology that shall be a natural science: that is, to represent psychical processes as quantitatively determinate states of specific material particles.' (Freud, 1895, p. 295). This intention is clearly expressed at least in three main areas of his work: his conceptualization of the instinctual drives, his explanation of the development of the ego and his theory of the aetiology of neuroses.

In *Three Essays on the Theory of Sexuality* Freud describes the instinctual drive as 'the psychical representative of an endosomatic, continuously flowing source of stimulation' (Freud, 1905a, p. 168). Later, in *Instincts and Their Vicissitudes* he refers to the instinct (*Trieb*) as 'a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body.' (Freud, 1915a, pp. 121–122) That same year in his paper 'The Unconscious' he writes, 'An instinct can never become an object of consciousness – only the idea (*Vorstellung*) that represents the instinct can.' (Freud, 1915b, p. 177). From these passages we can see that Freud considers the instinctual drive as the psychical representative of the stimuli originating from the body, as an emergent psychic function which, ultimately, remains unconscious because it is only the fantasy associated with it that comes into consciousness.

This view of the unconscious and of the instinctual drives as an area of contact between the mind and the body is also central to the thinking of Carl Gustav Jung, one of Freud's closest colleagues and 'crown prince' until their split in 1913. Jung refers to the instinctual drives as 'the psychoid' level of the unconscious or 'the psychoid nature of the archetype' (Jung, CW8, para. 419), a level of undifferentiated unity between psyche and soma. Like the instincts, the archetype remains in itself unknowable but it manifests endopsychically giving rise to archetypal images which are experienced as powerful affects. As a consequence, affects are the visible expression of the instincts and the bridge between the psyche and the soma. In *On the Nature of the Psyche* he writes, 'It seems to me probable

that the real nature of the archetype is not capable of being made conscious, that it is transcendent, on which account I call it psychoid …. If so, the position of the archetype would be located beyond the psychic sphere, analogous to the position of physiological instinct, which is immediately rooted in the stuff of the organism and, with its psychoid nature, forms the bridge to matter in general' (Jung, CW 8, para. 417–420).

Another area of Freud's work in which the emphasis on the mind-body relationship is clearly coming through is his theory of the development of the ego where he postulates that somatic processes are the matrix for the development of the sense of self. In 'The Ego and the Id' he writes, 'the ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself the projection of a surface' (Freud, 1923, p. 26), and in the footnote that first appeared in the English translation of 1927, he adds, 'the ego ultimately derives from bodily sensations chiefly from those springing from the surface of the body'. Similarly, his theory of the aetiology of neurosis, which roots all neuroses in the sexual history of the individual, is another area of his thinking that demonstrates the physiological foundation of the mind.

Freud was not the first to become interested in the psychogenic aetiology of hysterical neuroses. As Ellenberger writes, 'The circumstances that brought Freud to devise a new theory of neuroses belong both to the zeitgeist and to specific personal experiences.' (Ellenberger, 1970, p. 480). In the late 1800s it was Jean Martin Charcot who first identified the traumatogenic origin of hysteria and when Freud visited him in Paris at the Salpêtrière between 1885 and 1886 he was deeply impressed by him. Together with Charcot, another influential figure was Pierre Janet whose pioneering work on dissociation has paved the way for what is today known as dissociative disorders. The link between hysteria, trauma and dissociation is something that Freud and Breuer continued to explore. In 'Preliminary Communication' they write about 'the splitting of consciousness' which is 'present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, … is the basic phenomenon of this neurosis.' (Breuer and Freud, 1895, p. 12). They observed that the memories of the traumatic experience, of which the hysterical symptoms were an expression, had become split off from the rest of consciousness. The treatment, at that time, consisted of helping the patient to abreact the 'strangulated affect' (Breuer and Freud, 1895, p. 17) through speech. When the split-off affects could become once again

linked to consciousness there was a reduction of the symptomatology. Breuer's famous patient Bertha Pappenheim, known as Anna O., called this method 'the talking cure'.

Some of Freud's close collaborators, such as Sándor Ferenczi and Wilhelm Reich, made meaningful contributions to the study of the link between psychological trauma and somatic expressions. Ferenczi, for example, developed the concept of patho-neurosis and studied the non-verbal emotional expressions of people affected by trauma, as well as the reactions of people affected by organic diseases (Ferenczi, 1916–1917). Especially late in his career he engaged with the physical bodies of his patients, encouraging them to discharge their unprocessed traumatic experiences by entering altered states of mind. Reich, on the other hand, developed the concept of 'muscular/bodily armouring' or 'character armouring'. He theorized that, as the libido is ultimately a biological and bodily phenomenon so is the repression that opposes it, and he concluded that this mechanism of repression manifests in a pattern of muscular rigidity. This 'muscular armour' is a bodily pattern that expresses the emotional defence behind which lies the patient's trauma, so that there is a functional identity between a muscular rigidity and an emotional block. Both Ferenczi and Reich also introduced bodywork and stressed the critical importance of the therapeutic relationship to access and treat the embodied psychic blockages of their patients.

Another area in which the body in its relation to the psyche has been widely explored is the field of psychosomatic medicine. The Hungarian-American psychoanalyst and physician Franz Alexander, who was the director of the Chicago Institute of Psychoanalysis for almost 25 years, has often been referred to as the father of psychosomatic medicine due to his leading role in this field during the 1930s and until his death in 1964. Born in Budapest in 1881 he moved to Berlin in the 1920s where he became the first student at the Institute of Psychoanalysis and to officially qualify as a psychoanalyst. Overall, the psychosomatic approach acknowledges the contribution of emotions to the onset, course and recurrence of physical illness. As Alexander writes in the foreword to his book *Psychosomatic Medicine*, 'Every bodily process is directly or indirectly influenced by psychological stimuli because the whole organism constitutes a unit with all of its parts interconnected.' (Alexander, 1950, p. 12). Together with Freud, Ferenczi and Reich, Alexander developed the psychoanalytic understanding of the relation between the mind and the body, pushing

the boundaries beyond the classic hysterical symptoms, where the dysfunction usually involves no physiological damage.[2]

From the above it is evident that Freud, his close collaborators and followers made great efforts to conceptualize an embodied psyche, where the body is seen as the matrix from which mental activity can emerge and where, on the other hand, psychological processes influence the physiological ones. Therefore, it is interesting that much of psychoanalytic thinking has often been criticized for its tendency to conceptualize the mind at the expenses of the body. A possible reason for this may be that free association soon became one of the fundamental rules of classic psychoanalytic technique, a method that emphasizes the importance of verbal language which may become implicitly seen as superior to non-verbal communication. In fact, whilst in *Studies on Hysteria* the focus is on the body that 'join[s] the conversation' (Breuer and Freud, 1895a, p. 296), and on the bodily symptoms that could be 'talked away' (p. 35) once verbalized and abreacted, by the time Freud published *Dora* (1905b) the focus seems to have already shifted to the patient's verbal narrative, and by 1913 the psychoanalytic method consisted in the analysis of the transference and of the resistance through free associations. As Jung put it in his paper 'The Theory of Psychoanalysis' published in 1913, at the time of *Studies on Hysteria* analysis was 'more or less closely concerned with the symptoms, that is to say, the symptoms were analyzed – the work of analysis began with the symptoms, a method abandoned today'. In addition, the 1940s and 1950s saw a turning away from the basic premises of Freud's drive theory, the bedrock of his argument for a biological foundation of the mind. Some of the main exponents of this psychoanalytic movement include Harry Stuck Sullivan, Clara Thompson, Karen Horney in the US and W. R. D. Fairbairn in the UK. What they all had in common was a belief that Freud's drive model had underemphasized the interpersonal context. Of course, Freud was aware of the importance of external relations but, to preserve the primacy of the drive, he had explained the role of the object in relation to its function of discharge of the impulse. The drive in this context is the determinant of an object relation. The new theoretical approach that emerged in the 1940s, instead, conceptualized object relatedness as the primary motivator of human behaviour and as the fundamental building block for the formation of the mind, a mind that develops in the context of a relationship. Specifically, Fairbairn criticized both Freud and Klein because, even though Freud's later work

had placed more emphasis on the functioning of the ego and Klein had developed a theory of internal objects' relations, they both maintained that the aim of the impulse was pleasure seeking or discharge and that the object was just a means to an end. Fairbairn argued that the libido is inherently object-seeking and that the goal of the impulse is not pleasure or discharge but the relation to another.

During those years, on a parallel ground, the observational studies on animal behaviour led by the ethologist Konrad Lorenz, the psychologist Harry Harlow and the biologist Nikolaas Tinbergen, provided empirical evidence that the young of the species could become attached also to those adults who did not feed them, thus demonstrating that attachment behaviour is a primary psychobiological need, autonomous from oral satiation and sexual gratification. These discoveries deeply influenced John Bowlby and the development of attachment theory, where the infant is recognized as a human being predisposed to form relational bonds with others from the start. The subsequent studies of Mary Ainsworth (Ainsworth, Blehar, Waters and Wall, 1978) illuminated the importance of those early non-verbal interactions between the infant and the primary caregiver as the foundation for the development of the self, whereas Mary Main (1991) and Peter Fonagy (Fonagy, Steele and Steele, 1991), to mention a few, demonstrated how a reflective stance of the self towards experience develops from attachment security.

What I have tried to briefly outline above is that since Freud's alleged abandonment of trauma theory and the 1940s shift of emphasis from the intrapsychic to the interpersonal, psychoanalytic thinking focused on theories of the development of the mind and of the self in relation to another, paying less attention to the embodied dimension of the psyche. To quote one of the main exponents of contemporary relational psychoanalysis, Jessica Benjamin, 'The crucial area we uncover with intrapsychic theory is the unconscious; the crucial element we explore with inter-subjective theory is the representation of the self and other as distinct but interrelated beings.' (Benjamin, 1988. p. 20). More recently though, the influence of neuroscience on psychoanalytic theory (Damasio, 1994, 1999; Schore, 1994; Solms, 2015, 2021), new findings in infant research (Beebe and Lachmann, 2002) and a renewed interest in trauma theory (Van der Kolk, 2014; Levine, 2015), have brought back the attention to the body as the neurobiological matrix of the mind. The recognition of the reality of trauma and abuse in all its manifestations has prompted

traumatologists and clinicians of various orientations to theorize once again about dissociation and somatization, whereas the influence of neuroscience on contemporary psychoanalytic thinking can be seen as a return to Freud's early mission to root psychological functioning in a biological framework, whilst emphasizing the interpersonal context in which the mind emerges.

Another very important area of influence that I believe is worth mentioning, is the work of contemporary clinicians such as Susie Orbach (1978, 1986, 2009), Gianna Williams (1997) and Jean Petrucelli (2015), in the context of eating disorders, Joyce McDougall (1989), in the context of somatic disorders and Alessandra Lemma (2010), in the context of body modification. These clinicians have made great contributions in bringing back the attention to the relationship between the mind and the body, a body that is often used or manipulated in perverse ways to maintain psychic survival, thus becoming the canvas on which one's story is told. Finally, I would like to mention the pioneering work of Valerie Sinason (1992) in the context of intellectual disability, that has illuminated the importance of bodily communications when working with people with no verbal speech but that can largely benefit from talking therapy.

All these influences, to mention a few, have contributed to rebalance the focus about the mind-body relationship, and contemporary psychoanalytic literature is filled with the efforts to conceptualize and treat the embodied dimension of the psyche. But, whilst relational psychoanalytic theory, mentalization theory, attachment theory and neuroscience all acknowledge the importance of the relationship between mind and body, that the mind develops from the body and that this takes place in the context of a relationship, I wonder if, in practice, once in the consulting room, this embodied dimension is something that is often still neglected today. How much do we truly pay attention to our patients' bodily symptoms or expressions and consider their possible psychogenic contribution and symbolic meaning? And how much do we pay attention to our own body and use it, like our unconscious, as an invaluable 'organ of information' (Jung, CW16, par. 163; Fordham, 1960, p. 247)? And when it comes to non-verbal individuals, do we automatically tend to exclude them from the possibility of talking treatment? Overall, I wonder if there is still an ongoing split in between what we say in theory and what we do in practice. This book wants to contribute to healing this split by providing a spectrum of clinical cases that demonstrate how one can

navigate talking therapy when the patient conveys meaning through the use of the body instead of talking.

Primitive bodily communications can be thought of as embodied expressions of a disembodied psyche. What is expressed through the body are usually not neurotic conflicts but unmentalized affective experiences that, due to early attachment trauma or subsequent traumata, and at times in addition to an impediment of speech, have remained unsymbolized and unverbalized. Often these bodily expressions have been analogically described as *babylike* because, like in infancy, the emotional distress cannot be communicated with words and is expressed behaviourally and somatically. To quote Joyce McDougall, 'the infant's earliest psychic structures are built around nonverbal "signifiers" in which the body's functions and the erogenous zones play a predominant role. We are not surprised when a baby who is suddenly separated from its mother … reacts with gastric hyperfunctioning or colitis. When an adult constantly does the same thing in similar circumstances …, then we are tempted to conclude that we are dealing with an archaic form of mental functioning that does not use language.' (McDougall, 1989, p.10).

We acknowledge that the term *primitive* may convey a derogatory connotation. This is partly due to a long-standing psychoanalytic tradition that has framed bodily expressions as defensive, regressive and, either explicitly or implicitly, *inferior*. On the other hand we are also aware of the historical racist use of the word *primitive* in the context of a colonial Eurocentric tradition. However this book does not refer to bodily communications as *primitive* because we see them as *inferior* to verbal language, but simply because they point to the beginnings of psychological development, to primary ways of being and relating, as well as to enduring aspects of ourselves. Whilst on one side somatic manifestations are the result of a psychic defence organization to maintain psychic survival, on the other hand they are an intelligent and powerful way to communicate emotional distress. We want to highlight the important communicative aspect of these bodily expressions in the context of the therapeutic relationship, as well as their anticipatory role for the development of mentalized affects and, when possible, of their verbal expression.

The book explores the topic of primitive bodily communications in the context of intellectual disability, bodily neglect, somatic countertransference and eating disorders, and it is authored by

contributors from various psychotherapeutic orientations, ranging across contemporary object relations, attachment, relational psychoanalysis and analytical psychology. Specifically, the chapters that refer to intellectual disability explore the additional challenges of working with non-verbal people and highlight the fact that, as much as the psyche affects the body so does the body affect the psyche, as the intellectual disability itself is traumatic.

Some of the chapters in this book include detailed descriptions of very ugly clinical material. Working with patients who communicated through spittle, defecation, urination, ejaculation and other bodily substances to convey unbearable affects, is something that confronts us, as clinicians and human beings, with the ugliest aspects of the work and of the human condition, those aspects that evoke in us horror, repulsion and disgust and that we wished we could avoid naming or dealing with.

In the opening chapter, Brett Kahr provides some historical perspective on the role of 'primitive bodily communications' in psychotherapy to introduce his work with a severely learning-disabled patient who spat compulsively, masturbated and urinated in the consulting room to communicate unthinkable, and unspeakable, emotional distress. Kahr masterfully describes a vast array of clinical material to demonstrate how he was able to engage with this highly tormented and traumatized person, eventually facilitating the remarkable improvements that he could observe after several years of psychotherapeutic treatment. In Chapter 2, Valerie Sinason provides an overview of her work with intellectual disability and extreme trauma. The clinical material shows how she compassionately engages with non-verbal patients who can communicate only through very extreme bodily behaviours, such as bleeding, head banging and defecating. This is followed by Chapter 3, where David O'Driscoll presents ways of working with people with an intellectual disability who self-harm. The first three chapters explore some of the most extreme forms of bodily communication when working with non-verbal patients, thus demonstrating how the 'talking cure' can work also with this population. Chapter 4, authored by Gabrielle Brown, explores the topic of bodily neglect. Brown discusses how individuals who neglect their bodily hygiene repeat scenarios of early abuse and neglect that are still dominating their internal psychic landscapes. She also explores ways of thinking about the meaning of smell and dirt from a socio-historical perspective and questions the long-standing

socio-cultural attitudes that underpin a collective countertransferential resistance to understand this form of bodily communication. In Chapter 5, Raffaella Hilty discusses her clinical work with a patient who presented with a very unpleasant bodily odour, exploring the invasive and aversive aspect of this uncomfortable bodily symptom, together with its defensive and communicative function. Chapter 6, authored by Salvatore Martini, explores how embodied affects, resulting from a mind-body split rooted in early attachment trauma, are conveyed by the patient to the therapist in the form of somatic countertransference, which functions as an *organ* of information for the split-off complexes of the patient. The capacity of the therapist to enter a state of somatic *reverie* by dwelling in this third area as an intersubjective unconscious experience, allows the emergence of healing connections between the psychological event and the body. In this way, far from being seen only in their regressive and defensive function, the somatic symptoms, and our somatic countertransference, become harbingers of meaning. In Chapter 7, Tom Wooldridge explores bodily communications in the context of eating disorders, one of the most evident expressions of the use of the body to communicate unbearable psychic distress. Wooldridge revisits the notion of *the entropic body* (Wooldridge, 2018), a false body (Orbach, 1986, 2002, 2009; Goldberg, 2004) employed by patients with anorexia nervosa in an attempt to regulate catastrophic anxieties rooted in early childhood trauma which become concretized and expressed on their own bodies. In Chapter 8, William Cornell presents the clinical case of a young woman whose bodily symptoms included eating disorders and self-harm. Cornell explores how these somatic expressions narrated on the canvas of her adolescent body the struggle towards establishing a sense of adult personal and sexual identity, as well as anticipating psychic and interpersonal growth. The clinical material sensitively portrays the paramount importance of the therapeutic relationship in facilitating psychological change and interpersonal growth. In the final chapter, Mark Linington reflects on the possible Eurocentric colonial racist connotation implicit in the term 'primitive'. This points to a split of ego and id, rational and emotional, sophistication and uncivilization, and ultimately a split of the opposites which involves the disavowal of the 'other', the shadow, the 'not-me'. This split is central to the concept of trauma, which is a wound in the psyche. Linington refers to 'primitive bodily communications' as 'trauma-based communication', or communication of 'unfelt-feelings', and he presents

two clinical cases, one of which portrays a person with dissociative identity disorder (DID). Here he describes how the dissociated and disembodied parts of the personality (personification of disavowed affects) used the body of the person's main identity as an object on which to express the unbearable affective experience of trauma. Linington discusses the importance of integrating those 'primitive' emotional states and ways of relating by bringing them in a more 'secure' relationship with the other coexisting aspects of oneself.

Notes

1. It is interesting to remember here that Freud's early work with his patients also involved physical engagement with the body (Freud and Breuer, 1895).
2. For example, in a hysterical paralysis the cause of the paralysis is psychogenic and the paralysed organ does not usually carry any physiological damage but is simply hysterically paralysed.

CHAPTER 1

The spitting patient: speaking with sputum and free-associating with saliva

Brett Kahr

'Quod querulum spirat, quod acerbum Naevia tussit,
inque tuos mittit sputa subinde sinus,
iam te rem factam, Bithynice, credis habere?
Erras: blanditur Naevia, non moritur.'

['Because the old lady gasps for breath
And sprays saliva in your eye
And coughs as if she'd caught her death,
Do you suppose you're home and dry?
Miscalculation! Naevia's trying
To flirt, Bithynicus, not dying.']

Marcus Valerius Martialis [Martial], *Epigrammata* [*Epigrams*], XXVI

Communicating with bodily fluids

For those of us who work in the trenches of psychotherapy and psychoanalysis, we very much appreciate that the vast majority of our patients or clients or analysands will comport themselves with considerable dignity and maturity and, of course, with bodily *cleanliness*, during the course of a typical 50-minute session.

Although some of our patients will shout and curse, or rant and rave,

or even bang their fists upon the arm of the chair or upon the surface of the couch, most of the men and women who consult with us will restrict their communications to ordinary verbalizations. Indeed, many speak with such fluidity and intelligence, whether reminiscing about their childhoods, pontificating about their dreams or revealing intimate details of their sexual lives, that I would describe the vast majority of psychoanalytical clients as truly linguistically *sophisticated*.

Needless to say, not all of our patients will free-associate in an unstoppable fashion. Some will experience moments of inhibition or silence. But, for the most part, our analysands speak to us with their mouths and their tongues, articulating word upon word in the privacy of our confidential consulting rooms.

During the 1880s, Dr Josef Breuer, the noted Viennese physician, worked with a young, hysterical woman, Fräulein Bertha Pappenheim, and he discovered, to his shock and delight, that by facilitating a number of ordinary conversations with this troubled patient, her neurotic symptoms gradually began to disappear. Fräulein Pappenheim came to describe her sessions with Breuer (1895, p. 23) as a 'Redecur', known, in English, as the 'talking cure' (quoted in Breuer, 1895, p. 23); and as a result of their frequent verbal interchanges, Fräulein Pappenheim experienced a veritable 'Kaminfegen' (Breuer, 1895, p. 23) or 'chimney sweeping' (quoted in Breuer, 1895, p. 23) of her rather cluttered mind. In 1895, Breuer published his remarkable case history of this hysterical individual, who has since become enshrined in the history of mental health as none other than the iconic 'Anna O'.

Breuer's experiences with Pappenheim exerted an immense impact upon the young Dr Sigmund Freud who, over the course of a lifetime, would elaborate upon Breuer's work and would develop the very foundations of the modern practice of psychotherapy, which we might describe, more accurately, as *talking* psychotherapy.

Nevertheless, in spite of the growing appreciation of the *talking* cure, our professional ancestors certainly came to recognize that not all of their well-educated, verbally competent patients would always free-associate in an unrestricted fashion. For instance, back in 1922, Dr Ernest Jones, one of the founders of the psychoanalytical movement in Great Britain, wrote to Professor Sigmund Freud about a female patient, Mrs Joan Riviere, who had undergone treatment with each of these men in turn and who would eventually become a noted psychoanalyst in her own