The Silent Body and the Body that Speaks: Body, Mind, and Other in the Analytic Field

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ABSTRACT:

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In this paper, I use Thomas Ogden’s concept of the autistic-contiguous position to describe the creation of a sensory floor in ‘normal’ development – which results in the silent body -- through the rhythms of maternal care and attunement, as well as the psychic distress that results from failures in such early bodily care – what Masud Kahn described as ‘cumulative trauma’ and Didier Anzieu as perforations in the skin ego. Such failures create cracks in the sensory floor through which anxiety pours – theorized as unmetabolized and overwhelming sensory stimulation – the noisy body. Through what Winnicott describes as holding and Bion as containment, the patient and analyst create a language for the body’s distress, and thereby (re)inscribe the subject as embodied within the symbolic field. Such a language is necessarily a construction in Freud’s sense, rather than an historical re-construction of an earlier trauma. The distinction between psychosomatic and hypochondriacal illnesses is discussed in terms of the degree to which the patient has lost contact with the signifying dimension of her experience. The role of the analytic field in re-connecting the patient to their emotional experience is described.
The Silent Body: Creating the Sensory Floor

Perhaps the most exciting work in a psychoanalytic understanding of human development in the last thirty years or so has been the exploration of the pre-symbolic realm of experience described by Thomas Ogden (1989) as the autistic-contiguous position. Authors such as Francis Tustin (1986, 1990), Esther Bick (1968), Donald Meltzer (1975), Didier Anzieu (1989), and more recently, Giuseppe Civitarese (2010, 2013), have mapped the speculative territory of our earliest body-based psychological experiences, tracing the origins of the self and of our relationships with others in our earliest sensory experiences of hunger and satiety, frustration and satisfaction, care and deprivation. What I would like to offer in the brief time we have together today is an overly-simplified description of the seemingly miraculous creation of human subjectivity, inextricably embedded as it is in an infinite network of symbolic links to the Other, out of our earliest sensory experiences of the body and its needs. The never-perfectly-synched-up and always changing relationship between the body and the mind was the origin of and remains the contested space for psychoanalysis. From Freud’s first hysterics, descendents of the famous patients of Charcot, to the borderline, addictive, self-mutilating, eating disordered, psychosomatic, body dysmorphic patients in our offices today, psychoanalysis has struggled to help our patients feel at peace in the skins, at home in the bodies. Our understanding of the origins of the self have moved back in time to earlier and earlier periods of development – from the oedipal triangle of a child and two parents, to the dyadic object relations theory of Melanie Klein, Fairbairn, and Winnicott, to the development of a mind out of the sensorial flux of the first body experiences. Far from precluding relations with the other, this earliest stage of development depends upon a stable and consistent embodied presence of another to develop at all.

Winnicott intuited it first, “without maternal care there would be no infant. (1960).” Winnicott’s concepts of the holding environment and the transitional object brought back into the psychoanalytic conversation the critical formative role of the real
external environment, of the physical experience of being held and cared for. Out of the first rhythms of maternal care – feeding, holding, soothing, diapering, cleaning, swaddling, cooing, singing, stroking – the infant comes to experience herself as enclosed within a delimited space – a body which is in some kind of regular and predictable contact with an external world of hard and soft surfaces, sounds, visual stimuli in patterns and shapes, and fluids and solids that flow into and out of the body in regular intervals. Out of this managed swirl of sensory experience, physiological experiences become psychological ones. As Didier Anzieu describes it: “every psychic function develops on the basis of a physical function the operation of which surpasses the mental area (1989).”

In normal development, there emerges a pattern of repetitive experiences that in a relatively stable maternal environment allow for the ‘first thought’ – ‘after this, there will be something else.’ Thinking is made possible not simply by absence, but by the patterned alternation of absence and presence – the rhythmic succession of primitive aggregates of fragments of objects and fragments of experience. The first thought is one of time and succession – the introduction into experience of a caesura or gap that allows for an embryo of intentionality – an anticipation of something else that turns physiological need into psychological wish. This process is founded upon a fundamental tacit agreement that the frustration or period of waiting or absence will not exceed the capacity of the subject to tolerate it.

These early experiences of containment and boundedness – provided by the mothers and caregivers who provide what Winnicott describes as the holding environment and Bion as the container function – allow for the unfolding of a personal self – with sense memories and powerful affective responses to experiences across a broad range. As Ogdon describes the creation of the experience of boundedness in the autistic-contiguous (1989):

In the autistic-contiguous position, the relationship to objects is one in which the organization of a rudimentary sense of “I-ness” arises from relationships of sensory contiguity (i.e. touching) that over time generate the sense of a bounded sensory surface on which one’s experience occurs (the beginnings of a feeling of “a place where one lives”) (53).
This “bounded sensory surface” becomes the sensory floor -- the basis for the silent body. What I mean by the silent body is that the body experiences and the mind processes sensory experience in a way that is consistent with the level of stimulation. Emotions are the ‘appropriate’ expression of the response to stimulation, and they are shared between body and mind. There is a relative homeostatic balance between the two.

Given that the sensory floor is literally propped up on the body of another, there is a two-track experience of being simultaneously joined with and separate from the object. In a pioneering paper on the role of the frame in psychoanalysis, Jose Bleger (1967) describes early development as a two-stage process – first there is the merged body ego -- what he calls the ‘agglutinated nucleus’ or the ‘meta-ego,’ out of which emerges the ego proper. Didier Anzieu describes the way “well-being depends upon the illusion that a being is attached to the other side of the envelope of the skin ego.”

**The Noisy Body**

In healthy development, the body experience, and the environment which provides its stable context, allow for a relatively quiet background, which we can think of as an umbilical link to the world around us. To a greater or lesser degree, however, we all experience moments of excessive stimulation or of not feeling held and contained, which are registered as a basic sense of terror or anxiety. These experiences become encoded in the subject as cracks in the sensory floor, which if excessive – whether in frequency or duration -- will lay the groundwork for later pathological conditions such as panic disorders, hypochondriasis, somaticization, among others. In normal development, these disruptive experiences are more or less contained within a stabilizing framework of mind and other, and at worst are experienced as minor somatic irritations, although under prolonged stress or trauma, this relative stability of the sensory floor can come undone. In more pathological cases, these sensory cracks more or less severely affect the individual’s sense of well-being and ability to function. In these more extreme cases, failures in the mind/body/other alignment that characterize the autistic-contiguous position are complex and overdetermined – contributing factors can include in a dynamic relationship: the innate sensitivity of the infant, the mother’s capacity to be and to stay attuned, the genetic history of the infant and the mother, any unusual extenuating
circumstances such as illnesses to either mother or infant that disrupt the establishment of a regular and stable meta-ego, disruptions to the family and its stability, to name a few.

The experience of coming into contact with the cracks in the sensory floor is disorienting, terrifying, bewildering, and confusing – because by definition these experiences occur at the edge or beyond the edge of our capacity to symbolize them. The body becomes deeply involved as the vehicle for expressing the feelings, which seem purely and undeniably physiological. Often the experience is tied to a catastrophic interpretation – ‘I’m having a heart attack,’ “I’m dying,” – and ERs are filled with patients convinced they are having a heart attack rather than a panic attack.

In his recent account of his personal history of a lifetime wrestling with profound anxiety, Scott Stossel (2014) describes a representative panic attack:

One day I am sitting in my office reading email when vaguely, at the edges of my awareness, I notice I am feeling slightly warm.

*Is it getting hot in here?* Suddenly awareness of the workings of my body move to the center of my consciousness.

*Do I have a fever? Am I getting sick? Will I pass out? Will I vomit? Will I, in one way or another, be incapacitated before I can escape or get help?*

I am writing a book about anxiety. I am steeped in knowledge of the phenomenon of panic. I know as much as any layperson about the neuromechanics of an attack. I have had thousands of them. You would think this knowledge and experience would help. And, to be sure, occasionally it does. By recognizing the symptoms of a panic attack early on, I can sometimes head it off, or at least restrict it to what’s known as a limited-symptom panic attack. But too often my internal dialogue goes something like this:

*You’re just having a panic attack. You’re fine. Relax.*

*But what if it’s not a panic attack? What if I’m really sick this time? What if I’m having a heart attack or a stroke?*

*It’s always a panic attack. Do your breathing exercises. Stay calm. You’re fine.*

*But what if I’m not fine?*

*You’re fine. Every one of the last 782 times when you were having a panic attack and you thought it might not be a panic attack, it was a panic attack.*
Okay. I’m relaxing. Breathing in and out. Thinking the calming thoughts the meditation tapes have taught me. But just because the last 782 instances were panic attacks, that doesn’t mean the 783rd one is too, right? My stomach hurts.

You’re right. Let’s get outta here.

Sitting in my office while something like this sequence of thoughts flows through my head, I go from feeling moderately warm to feeling hot. I begin to perspire. The left side of my face starts to tingle, then goes numb. (See, I say to myself, maybe I am having a stroke!) My chest tightens. I am suddenly aware that the fluorescent lights in my office have a strobelike quality and are flickering dizzingly. I feel a terrible vertiginous teetering, like the furniture in my office is moving around, like I am about to topple forward onto the ground. I grip the sides of my chair for stability. As my dizziness increases and my office swirls around me, my physical surroundings no longer feel quite real; it’s as though a scrim has come between me and the world.

My thoughts race, but the three most prominent are: I’m going to vomit.

I’m about to die. I’ve got to get out of here.

Among the many interesting aspects of this account of a devastating instance of stumbling over a crack in the sensory floor, I am struck by the fact that despite his awareness, at some level of consciousness, that he has lived through this experience many hundreds of times and survived, such knowledge is useless in this moment. In Bion’s terms, he is unable to learn from his experience, which is to say, the experience of the panic attack remains literally ‘unthinkable’, even though he can subsequently narrate it in eloquent and even comic terms.

I would suggest that one way of thinking about his tragi-comic experience in this case is that he is alone with his panic and unable to soothe himself. If as I am arguing, the experience of one’s body is always infused by the experience of the Other, then part of what happens in breakdowns of mind/body attunement like panic attacks is the loss of a comforting presence of an Other. At the deepest and earliest level, this experience of one’s body in fact is one of fusion between subject and object, body and world, self and other. This felt sense of connectedness provides the necessary ground for new and
potentially threatening experiences to be tolerated. In his seminal work, *The Primitive Edge of Experience*, Thomas Ogden (1989) describes three modes of generating experience – the autistic-contiguous, which I have been describing so far, the paranoid-schizoid, which is marked by terror and fear of the Other as hostile and destructive agency, and the depressive position, in which experience can be symbolized and ambiguity tolerated. As Ogden describes the dialectical interplay among these modes of generating experience: “the autistic-contiguous mode, under normal circumstances, can be seen to provide the bounded sensory “floor” (Grotstein, 1987) of experience. It offers sensory enclosure that exists in a dialectical tension with the fragmenting potential of the paranoid-schizoid mode. The danger of psychosis posed by the fragmenting and evacuative processes of the paranoid-schizoid mode are contained in two ways: 1.) “From above” by the binding capacity of symbolic linkages, historicity, and subjectivity of the depressive mode; and 2.) “from below” by the sensory continuity, rhythmicity, and boundedness of the autistic-contiguous mode” (45).

Each mode of experience has its particular anxiety, which is defined by the form that disintegration takes in it. And in each case, that disintegration is directly linked to a particular fear in relation to an object – for the depressive position, it is the breakdown in the whole object relationship -- ie, the fear of having damaged or destroyed the good object and the accompanying unbearable loss of one’s own sense of goodness. In the paranoid-schizoid, the form anxiety takes is the fear of annihilation by a hostile Other. What I would like to focus on, however, is the particular anxiety experienced in the autistic-contiguous mode, which I am describing following Grotstein and Ogden as the experience of cracks in the sensory floor --- a terrible “feeling of leaking, dissolving, disappearing, falling into shapeless unbounded space.” Because these represent cracks, fissures, or gaps in the mind-body integration, they are experienced primarily as bodily distress, the feeling characteristically of not being able to be comfortable in one’s own skin. We lack the words to describe this very embodied sense of dread and discomfort, precisely because it falls between a purely physiological-driven experience of pain or discomfort (a fever, a torn or aching muscle) and a purely psychological state – depression, sadness, rage, elation.
It is as if the body is noisy – loud, symptomatic – but without some clear code with which to translate the signals into meaningful communication. Diffuse, shifting, sudden, and seemingly random outbursts of physical discomfort without a clear and meaningful cause – these are the experiences of the noisy body expressing the pain of cracks in the sensory floor of experience. I would assert that there are few of us who don’t suffer at least momentarily from time to time from the diffuse and discomforting experience of becoming frayed at the edges, which might account for the dramatic upsurge in psychopharmacological use since the development of tranquilizers and anti-anxiety medications which are so effective at quieting this noise at the seam in the mind-body connection.

Depending on the severity and the degree of the damage to the underlying sensory floor, this kind of anxiety can be relieved by sensitive and attuned psychoanalytic therapies, in which the consistency of the setting, the attunement of the therapist, and the stability of the relationship itself can go a long way in stabilizing and repairing sensory cracks. I would argue that this healing is the result of the dynamic interplay of what Jose Bleger describes as the process of psychoanalytic work – the symbolic exchanges within sessions – and what he describes as the non-process element of the frame and the setting – the experience of continuity in time and space, the stable arrangement of physical objects, the body of the analyst, the vocal tones and ambient sounds, the light – all combine to form the texture of the patient’s sensory experience of the session. As such, an essential aspect of the healing in psychotherapy remains necessarily unconscious and non-intentional – part of what Franco de Masi (2009) describes as the ‘unrepressed unconscious.’

Although unintentional and suffused with a high degree of purely sensory experience, the process and non-process interaction is still deeply intersubjective. If psychoanalytic therapy offers a distinct advantage over treatment modalities such as pharmaceuticals or CBT, which target symptoms deliberately and locally, it is that this foundational repair work is allowing for the growth and expansion of the area in the subject’s experience that can be symbolized and made meaningful. And it is doing so necessarily in a way that is driven by a respect for an unconscious and creative process
that is uniquely psychoanalytic, rather than one directed by the intentionality of a therapist or analyst who holds the reins.

**Bodies that Speak**

When the relation between the mind and the body becomes consistently strained by the experience of ruptures in the autistic-contiguous continuity of being, with the attendant strain on the ability of the symbolic to hold one securely in its net, the result is hypochondriasis, which Giuseppe Civitarese (2012) describes as the experience of feeling in exile in a foreign land.

In hypochondria this background changes. The path of subjectification is traced backward in a repeated attempt at sensorial self-containment. The reintegration of the self proceeds like the decryption of a text that has become increasingly obscure and in which the body once again comes to the fore…The conscious ego lives as if it were in exile and feels as though it were inhabiting a body it is impossible to decode, which is experienced as threatening, no longer transparent or natural. (52)

As Civitarese stresses, this breakdown is primarily an intersubjective rather than a physiological one – mind and body have become estranged – and the mind desperately tries to find a meaningful purchase on its experience by casting about for explanations of its distress in a bodily discourse that it can’t link up to the body. Often the patient experiences himself as being persecuted by his body.

A 72 year-old man I saw in analysis routinely began each session with an elaborate and obsessionally detailed catalogue of his bodily complaints. His attitude toward these complaints alternated between insisting they were medical and therefore required the intervention of one of his diverse team of specialists – chiropractors, internists, urologists, ophthalmologists – and asserting that they had to be psychological, or perhaps more accurately, allegorical. For example, when he would complain that his feet were hurting him, he would insist that it had to mean that he was stressed about something – that he couldn’t relax and that clenching himself tightly was creating the pain in his feet. He was convinced his feet were trying to tell him something he needed to know about how he was living his life, but the text was too faint or illegible to be
interpreted properly. In this assumption, I believe he was correct – he lived governed by an unstable combination of omnipotent belief in his mind’s ability to solve his and his client’s problems (and his clients were extremely successful and powerful men) and a deep conviction that he was a fraud and a frightened little boy. His presenting complaint was a lifetime of sexual impotence – his sexual life had consisted primarily of hiring prostitutes and performing oral sex on them while masturbating himself. He had been married for twenty years and had intercourse with his wife only a handful of times – despite having undergone an extensive sex therapy regimen with a sex surrogate. After an intensive period of working through his oedipal issues (his father had humiliated him and his mother seduced him in the bath), he began to confront a core castration anxiety phantasy that a woman’s vagina was a dangerous place, recalling with a shudder a story from the playground he had heard that during WWII American prisoners were forced to have sex with Japanese women who had inserted razor blades in their vaginas.

At some point, he found himself seeing a woman he was interested in having intercourse with, but still unable to sustain an erection. I suggested that there could still be a piece that was simply physical – seventy year old men sometimes need help with the equipment. He reluctantly agreed to see his urologist, who created a serum he could inject that allowed him to achieve and sustain an erection. For a time, he accepted this course of action, but at some point he simply began refusing to use the serum, and was therefore unable to achieve penetration. He complained that he shouldn’t have to use the shot – other men didn’t have to. Or he would claim that he couldn’t take the serum on a trip with his girlfriend because he wouldn’t be able to keep it adequately refrigerated. Or he would let the prescription expire. What we came to understand was that his impotence was an important battleground for the war between his mind and his recalcitrant body.

It was this war between mind and body, rather than the oedipal issues which were merely one particularly tragic battle, that defined our work together. In the treatment, he refused what Freud called ‘the fundamental rule of psychoanalysis,’ which states the patient must surrender to his free associative process during the session and say everything that comes into his mind. This man came to every session with a script – literally a piece of paper with three or four phrases jotted down that would serve as his agenda for the session. Sometimes this was a dream he would bring in – and simply read
verbatim, as if they were notes handed to him by a stranger. Often, he would struggle to decipher his own handwriting, increasing the feeling of estrangement from the material. When I would ask about his associations, he would simply read the notes again – reciting each word as if it were part of a magic spell.

I came to see my role as one of somehow helping him to let go of the omnipotent stranglehold his will and his consciousness had on his feelings and his body. The challenge was how to do so without seeming to impose a method or a technique; in other words, without substituting my omnipotence for his. In short, I saw the challenge as facilitating spontaneity and mutuality in relationships. In the intersubjective analytic field, the experience I felt was standing up to a withering omnipotence – when I would make simple interpretations of what he seemed to be feeling as a way of connecting with his vulnerability and his ‘lost and terrified little boy,’ he would often reply with dismissive sarcasm. Early in the treatment, I struggled with my own feelings of impotence in the work – he was older and much wealthier than I, he had seen several very prominent senior analysts (and had in fact been referred by one who was retiring), and we seemed to be making so little headway.

Over time, his need for control began to drop away, and we made small inroads into his feelings – his actual feelings of his body and his emotions in the room with me. He came to tears and we were both deeply moved that he could feel and express his feelings. He began to use the couch (it was a challenge helping him to see it as something we thought about collaboratively, rather than a directive coming from me). The couch loosened him considerably. What I felt paradoxically was the turning point in the treatment, however, was when he began to let himself nod off to sleep briefly in session. He had struggled with insomnia his entire life – a condition he managed with an obsessive regimen of pills he laid out at the head of the bed each evening. As the work deepened and his obsessive control loosened, he would come to session and announce with surprise that he had ‘forgotten’ to take his second, middle of the night pill.

I found it essential that I feel deeply grounded in my body and resolutely calm during his sessions for him to drop into his body and his feelings. When he slept, at first it I felt like I was watching over a sleeping infant. He would sleep five or ten minutes, then startle awake, and announce that he hadn’t felt that relaxed in a long time.
At a certain point, the phantasy or reverie I experienced while he dozed shifted into a deeper and sadder one – that of remembering the experience of being at my dying father’s bedside in his final moments. At that point, he had lapsed into a coma after the end of a long and painful struggle with leukemia. These were his last moments in his body, and they were painful and anxious ones it seemed, even if he wasn’t conscious for them. His breathing became labored, as he fought for air. I held his hand and urged him to let go – we were ok now – and he could let go. His breathing became fast and shallow, as he gasped for air, then stopped. I was still holding his hand.

On the couch, my patient would snort and gasp, then lurch into being awake. These felt like powerfully shared and transformative moments between us. And linked as they were to my experience of my father’s death, somehow essential to story of the analysis with his man. He had been referred to me by his previous analyst – a supervisor of mine – who had been overcome fairly quickly by dementia, which required him to close his practice within a month. Unfortunately, this was only the latest in a series of abrupt and tragic endings of his analyses. His first analyst, whom he saw for eight years in his late twenties and early thirties, died suddenly of a heart attack at the age of 47. He found out when he came to his session one day and the analyst’s suite-mate informed him of his analyst’s death over the weekend. A few years later he began another analysis with a senior analyst and after five years, received a call while out of town on a business trip that his analyst had died of a sudden illness.

One of his goals when he began seeing me was to terminate an analysis before I died. Early in the work, he would half-jokingly tell me at the end of the week that he hoped he would see me the next week. At times, he would worry that he was cursed and that I should think twice about taking him on, since it had proved the death of all his previous analysts. I must say that in a few anxious and paranoid moments, that thought crossed my mind – would I survive his treatment?

After six years, we reached a natural stopping point – he was in a relationship, he had sold his business and could now ease out of it into retirement on his own terms. I thought in the last few sessions of my reverie with him sleeping of my vigil with my dying father – how now both the patient and I were saying good bye to our dying fathers -
- he mourning his analysts and finally getting to say a good bye in person – me mourning my father and my analyst, who was moving into retirement himself.

**Conclusion**

Our latest understanding of the development of self is that the first ego is a body ego, one that is always already umbilically connected to another. As Winnicott writes, “there is no separation, only the threat of separation” (1971). Early disruptions in this mind/body, self/other unity create cracks in the sensory floor that develop later in pathologies such as insomnia, hypochondriasis, somaticization, anxiety disorders, and body dysmorphia. Psychoanalytic psychotherapy helps repair these cracks both through its non-verbal creation of a holding environment and through its interpretive symbolic process. This understanding of and respect for the shared embodied unconscious field that represents the seam between mind and body, self and other, is what makes psychoanalytic therapy unique and distinct from more directive and ‘intentionalist’ treatment modalities. The assumption we operate under is that a deeply felt subjective life is something both actively created and passively lived, something we consciously will and unconsciously are moved by -- body, mind, and soul connected to an Other. Our theory and technique of clinical practice should reflect this fundamental duality.
References


