Case Reports and Reviews

Short Communication

The Body-Mind Problem in Psychoanalytic Treatment Technique

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Abstract

In recent times, many important publications have emerged that deal with the importance of implicit communication in the therapeutic relationship [1-3]. They assume that success or failure is largely due to the handling of this event. The Saarbrücken research group has shown empirically that this is a valid assumption [4]. Since communication always requires at least two people, the implicit activities of the therapist are also theoretically increasingly given weight. This was done on the one hand under the concept of countertransference [5], projective identification [6] and the bipersonal field [7]. In my own writings and research, I had set up a model of the relationship process in which I had distinguished the channels of hearing, smell, sight, touch and warmth-sensation and had assigned them to the behavioural classes, language, body movements, affect display, illustrator's body movements. What has been neglected so far were the therapist's own body perceptions, such as proprioception, afferents, efferent and efferent copies? Finally, the importance of smells was only dealt with very marginally, although they obviously play a major role in implicit communication. This article aims to show that they make the decisive contributions to countertransference. The integration of the different perceptions is made in this behaviour. In addition, both patients and therapists seem to show extraordinarily large interindividual differences in the ability to perceive such sensory perceptions without them noticing it themselves.

The smell

AWe start with the empirically found differences in odor processing. I deliberately do not speak of perception, because it may very well be that you do not perceive smells, but they can nevertheless have a great influence on the interactive and therapeutic events. Epistemologically, the distinction between conscious and unconscious perception also makes only very limited sense. Bischof [8] distinguishes five levels of inside and outside, which historically played a role in the discussion of the body-soul problem. One of them I want to focus on is me and the other. The process of perception proves to be a dialogic, structured contact, as a merging of being seized and an outreach: the eye, for example, appears to the naïve as a double-sensed transparent window" through which the sensual shell of the world penetrates into my innermost being and through which I at the same time expose my innermost part to the world [8]

This brings us to the clinical findings described under Projective Identification [5,6]. We therefore start with clinical empiricism, which is based on several pillars: on the one hand, the understanding of the individual cases, including ourselves, and on the other hand, attachment research and the effect of the attachment type on the unconscious behaviour and perception of adults.

I take myself as an example because I seem relatively insensitive to the conscious perception of smells and have also worked with patients who smelled to a high degree. In the meantime, I have supervised analysands who could not stand the smells of their patients. Together we had thought about a strategy on how to circumvent this problem. She asked the patient to switch to the phone. I had had a lot of good experience with telephone analysis during the Covid period [9]. This suggestion was not appreciated by the patient. He threw a real tantrum and regarded this intervention as an encroachment on his human rights. Nevertheless, he accepted the offer and the problem seemed to be solved in one fell swoop. My patient, whose smells had not bothered me, nevertheless had to do without these smells because the following people complained massively about them. Ergo, I asked him to come up with something to remedy this. He took note of this without complaint and in fact from that hour on the problem had disappeared. He didn't tell me what he had done until months later. Without going into detail here, I would like to tell you that these were very conscious actions, the production of the odours, but also their elimination. My apparent

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insensitivity corresponded to my self-image that I couldn't do anything with smells. This reaction of mine did not correspond in any way to my ability to identify odours. Because later I was at an olfactory research laboratory at Rutgers University, where I was presented with cotton balls of fear, anger, disgust, contempt, interest and joy. They had arisen in the armpits of persons who had been brought into these emotions. They were then shock-frozen. When sniffing at these waiting legs, I was able to consciously identify perceptions such as dry or damp at best. In terms of affects, however, I had a 100 percent set of hits. I got the nickname superdecoder.

On the other hand, I met a psychoanalyst who was very sensitive to the perception of smell. See in cities that were formerly subject to a dictatorship this very event. In an old castle, in a torture chamber, she also smelled this very event. She was limited in her vision from childhood.

Smells are probably less tied to affects, which are short by definition, than to moods and sensitivities. When affects become chronic, they are always a correlate of a disorder. You have your own smell as well as contempt, pride. A benevolent symbiotic relationship in the first 17 months is carried by a harmony of smells between mother and child. . The feeling of home, but also of foreigners, is demonstrably linked to the correspondence of the spices used by the mother with the food of the toddler.

Other Pre-Representational Experiences

The experiences of the first lifetime are considered pre-representative, i.e. they have no cognitive pictorial correlates, but are nevertheless considered to be highly formative for what are called attachment types in research and clinic. They also remain in adult life. At present, a distinction is made between the following attachment types, which have been empirically well studied. The safe, insecure avoiding, insecurely ambivalent and disorganized type. In the following, an attempt will be made to describe the prerepresentative phase-specific perceptions of the types. .

Secure Attachement

It requires something like an interactive dance between mother and child that is constant, flexible and comforting. The expression of the mother in the face, the voice but also the body movements triggers the same pattern in the child via the ideomotor principle. This event is not bound to the individual sensory areas but is cross-sensory , the visual impression of an effect on the mother's face, for example joy or anger, triggers the associated motor pattern in the child. The processes that carry them are called mirror neurons [10]. They remain until adulthood and are also persistently disturbed in adults in the case of mental disorders. In the implicit behaviour of healthy parents, however, it is sufficiently marked that the answer is different from the child's expression. Without this marking of otherness, the cognitive, non-conducive process of affect contagion occurs, which hinders the construction of self-object boundaries between mother and child [11].

In order to maintain primary autonomy, certain groups of disorders avoid the expression of affects in themselves but also in others, because they have to fear that the effect of the other will set in motion a traumatic event in the patients. A physical correlate of this kind of defence is the renunciation of expressive phenomena of any kind. [12]. These people therefore appear wooden, robot-like and unempathetic. Empirically, this applies to schizophrenia simplex, perversions and psychosomatics who did not arise through conversions, i.e. the suppression of a fantasy. In our culture, about 60% of the population was considered securely bound in 1980. (Strauss and Buchheim 1980). According to my clinical impression, these numbers are no longer tenable today and the insecure attachment types have increased sharply. The implicit behaviour that controls this happening is dyadic. The collapse of this dyadic. What is happening is the visible correlate of the disorder, which is emotionally reflected as loneliness, abandonment or emptiness. As a defensive formation, Krause [13] and Moser [12] speak of occupation defence. In contrast to the neurotic defence mechanisms, they are difficult to change.

Uncertain avoiding attachment type

An implicit behavioural correlate of this type of attachment is the constant effort of the patient or patient to impose the algorithm of his physicality on the other. This seems to be a solution, especially in the case of compulsive personality. This is empirically confirmed for stuttering [13]. If you can keep the disorder under control, they appear immobile and mimic. When the disorder becomes manifest, i.e. they stutter, very violent affects break out in the face, but also in the voice, and the movement behaviour becomes dramatic but uncontrolled. The development of the disorder seems to be classified in a parenting style that is characterized by the effort to comprehensively control the child's behaviour, especially its affective behaviour. If the disorder is maintained in adulthood, it has something of rebellion and struggle against the control compulsion of the environment. We have not investigated other disorders of the insecure attachment type. We are of the opinion that many characteristics of an insecure avoidant attachment also occur in other disorders: It seems to be an attempt to defend oneself against an unpleasant symbiosis and to counteract the world in which it is used.

Insecure ambivalent attachment type

In open behaviour, these people alternate between devotion and joy on the one hand and anger, aggression and contempt on the other. They correspond most closely to what is called a neurosis in psychoanalysis. I.e. behind the friendly, attentive behaviour, an unconscious fantasy of anger and aggression becomes visible and audible. This affect is unconsciously physically suppressed by the consciousness but maintained in expression. But it may also be that unconscious fantasies for love and tenderness are hidden behind the aggressive expressive behaviour.

The general reduction of expression that we have described before is not typical for neurotic patients, they show significantly more facial expression than schizophrenic and psychosomatic patients, including non-manifest stutterers, i.e. those who can keep the speech disorder under control. The affect is not intrapsychically reduced in its occupation, but it is reduced in expression. But there is an excess of different negative and positive effects that alternate or overlap. They are then also visible. There are cognitive representations here, but they are unconscious and can be made conscious by analytical techniques.

The Disorganized Attachment Type

In these individuals, affective behaviour is very pronounced but unpredictable. Rather, it is characterized by extreme changes controlled by the partner. This pattern is most likely

to be found in dissociative disorders [14], borderline disorders [11] and perversions. They have maintained the behaviour they inherited from their parents, who were also severely traumatized, and are now trying to live with this mortgage. The most successful solution seems to be the perverse plot [15]. It functions as a seal and all stages of development are integrated into it, the object becomes a self-object as a fetish, the control of the object is part of the autonomy regulation and the sexual part is neurotic. All of this together prevents psychosis, depressive development or self-destruction and/or destruction of others [4,16].

Transgenerational Aftick

The perception and experiences of previous generations are passed on through dreams and relationships. The dreams use images, but include affects. A patient dreams that he is in a room with his dying brother, who has actually died of cancer.

He can't do anything in his dreams; he has to watch the very painful chemotherapy and is desperate. He wakes up trembling with great fear. Shortly before the death of his brother, he was on vacation and reproaches himself for not having visited him sufficiently shortly before his death and therefore has a very bad conscience. When talking to me, the first association that comes to mind is that his mother, who had also died of cancer, whom he had visited very often, even during the phases of inpatient chemotherapy. The smell of the station is still in his memory today and he tried to eliminate it with disinfectant spray. In the course of the handling of disinfectants during the Corona pandemic, these memory traces were triggered again. The transgenerational transmission of such worlds takes place through relationships, namely those in which the child passes on the cruel experiences to its own children and partners. The traumatic experiences are stored in an implicit memory system, the content of which is dissociated, but leads to a change in the neuronal network that can be passed on epigenetically to the third generation.

Case vigenettes

Mr. Willem was born on October 5, 1942 as the 5th of six children. The war situation was favourable for the Nazi regime at that time. Nevertheless, his father had already predicted defeat at the beginning of the wars, and fathered the children in the expectation of his own death, his mother later recounted. She was a practicing physician with obstetrics from 5 villages. His father was a second lieutenant in a train hospital, from which he deserted when he drove past his home. That was one story, there were others. At that time, the SS was still in power on the eastern side of the river and his wife asked the SS commander for advice. He recommended that the man be on sick leave until the end of the war. 14 days later was the capitulation. In the meantime, a demolition squad of the Wehrmacht had blown up the bridge together with a 4-man guard. At that time, Mr. W. had been with an uncle since the beginning of 43 in order to avoid a tuberculosis infection that his sister already had. After the nanny had delivered him there, however, he was already infected, and according to the uncle and his housekeeper, who was also his lover, he was snatched from death every day for half a year. In the fall of 1945, he was allegedly repatriated against his uncle's will. He would be spoiled by his uncle and would have to get used to the rough life among his siblings. The older siblings were described as unusually violent, and the younger brother, who has since been born, was the narcissistic apple of the mother's eye, and you behaved the same way. His father was depressed and addicted to Pervitin, and his license to practice medicine had been revoked because of his early party membership. He had fallen out with the National Socialist employers at the Reich Court in Leipzig and, with the help of his grandfather, ended up in Gemmrigheim. There he had signed the application for party membership at the mayor's office together with the co-contract. This was concealed from him, and until he was told it by his father, of all people, after the death of his mother. In 1949 he started school with 69 other children

and from then on there would have been a certain normality of life, although above all the school operation remained extraordinarily violent. But nothing happened to him himself, because he would have been under the protection of his mother, who was already feared by the Nazis. From today's perspective, I would describe him as a severely traumatized child who, in a dissociated state, felt neither grief nor anger. Outwardly, he was very friendly and easy to care for. Inside, there was a kind of dissociated horror vacuum. He was able to perfect this attitude thanks to several analyses. It gradually broke out after the serious illness of his woman who had filled in this blank space. During the first two years of the disease, the relationship remained very helpful and loving, until the disturbance of brain functions became very massive, and she developed frontal degeneration. She had become a completely different person, from whom his son also had to separate. For at least 5 years, he was of the opinion that the severe symptoms could and should have been treated psychotherapeutically. He was able to maintain his defence, which was based on his genius, albeit with difficulty. Large research projects, publications, analyses. With the retirement and the departure of his son, he practically had to reinvent himself, which was quite difficult. But the real crisis broke out when the son broke off contact because he described him as selfish and unempathetic. Now the dissociative, warded-off states of childhood appeared with force. He felt abandoned and betrayed. What's wrong with him? He developed very severe physical symptoms, which were diagnosed in the hospital in an emergency and treated in vain. It was only when he was able to make a connection to the traumatization of his parents that things started to look up. The central trauma was that at the age of 17, after her mother's postpartum psychosis, his mother had to take over the education of her 5 siblings, went to high school and university and supported her penniless father with the scholarship she received. She herself had no lustful, regressive activities and only the relationship with her father, who had loved her very much, helped this a little. He had adopted the excellent performance as a prerequisite for love, and apparently his son had figured out that he would function that way, even though the academic world of psychology had always seemed very alien to him when they explained away unconscious processes. The analysts, on the other hand, have no respect for their own perception. Not introspection, but the perception of implicit behavior.

Summary

TIn recent times, many important publications have emerged that deal with the importance of implicit communication in the therapeutic relationship [1-3] to claim that success or failure is largely due to the handling of these events. My research group has empirically proven that this is correct [4]. Since communication always requires at least two people, the implicit activities of the therapist are also theoretically increasingly given weight. On the one hand, this happened under the concept

of countertransference (Klein 1952), projective identification [6] and the bipersonal field [7]. In my own writings and research, I had set up a model of the relationship process following Brunswick's example in which I had distinguished the channels of hearing, smell, sight, touch and warmth-sensation and assigned them to the behavioural classes, language, body movements, affect display, illustrators' body movements. What has been neglected so far were the therapist's own body perceptions, such as proprioception, afferents and efferences and efferent copies? Integration is carried out in these implicit behavioural classes. Finally, the significance of smells was treated only very marginally, although they obviously play a major role in implicit communication. The aim of this article is to show that they make the decisive contributions to countertransference. In addition, both patients and therapists seem to show extraordinarily large interindividual differences in the ability to perceive such perceptions without them noticing it themselves. .

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