IRENE MATTHIS

FINGER-TWISTING & CRACKED VOICES: THE HYSTERICAL SYMPTOM REVISITED

The Psychoanalytic Century

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The Hysterical Symptom Revisited

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Table of Contents

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Iréne Matthis

> [. . .] it still strikes me [. . .] as strange that the case histories I write should read like short stories [. . .]. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. The fact is that [. . .] a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me [. . .] to obtain at least some kind of insight into the course of [hysteria]. Case histories of this kind [. . .] have [. . .] an intimate connection between the story of the patient's sufferings and the symptoms of his illness.

—Freud 1893-1895, *Standard Edition* 2:136

The importance of Freud's early insight into the role of narrative in the patient's history of sickness cannot be overestimated. Several times, in *Studies on Hysteria,* he mentions aspects of a narrative perspective, and he uses metaphors borrowed from literature and drama. However, he does so only in passing, as if he was just noticing something of interest that was a bit perplexing. Freud had not yet fully realized the importance of his discovery.

In the case of Emmy von N., whose treatment he began in the spring of 1888, he remarks on the fact that incidents in her history that were widely

separated in time were told to him "in a single sentence and in such a rapid succession that they might have been a single episode in four acts" (*Standard Edition* 2:57). He points out that "the accounts she gave of traumas arranged like these in groups began with a 'how,' the component traumas being separated by an 'and'" (ibid.). "How," "and"! Actually, he initiates a linguistic analysis of the patient's "text" rather than a medical examination of her bodily symptoms.

Later, in the case of Rosalie, he describes how incidents, collected into groups like this, form "mnemic symbols." The recollected occasions often seem to be of a very ordinary, and even trivial, character, and Freud writes that he "should have been prepared to deny that they could play a part in the etiology of a hysterical symptom." *(Standard Edition* 2:172) But as drops of water, hitting the same spot, slowly will make an impact that each drop by itself cannot, so the collected impetus of all the small incidents, having some element in common, will finally attain a force that, given the right circumstances, will make itself felt. The affects connected with the "mnemic symbol" will again be aroused when a freshly experienced affect—by way of association—will stir anew the dormant forces. "[A] process of this kind is the rule rather than the exception in the genesis of hysterical symptoms. Almost invariably when I have investigated the determinants of such conditions what I have come upon has not been a *single* traumatic cause but a group of similar ones" (ibid.).

DISPLACEMENT AND CONDENSATION

As is well known, Freud worked out the mechanisms of "a process of this kind" in *The Interpretation of Dreams,* published five years later (1900). Through the processes of displacement and condensation a connection is created between otherwise disparate events. In this way meaning is established, where hitherto none could be divined, and an understanding is accomplished, which it seems the patient benefits from—even to the point of getting well.

We generally think of displacement and condensation as linguistic terms applicable to textual material and, in a figurative sense, to matters of body and behavior—as when the concepts are applied to a hysterical bodily symptom or an obsessional conduct in order to make them intelligible. Freud's writings, from the *Studies* onwards, as well as modem psychoanalytical publications, abound with examples of these uses. It is perhaps less well known, or taken into account, that the linguistic terms thus transferred to bodily and behavior spheres in this transposition are actually only returning back to the fields from which they originated.

After Darwin (1872) it can hardly be argued that man's expressions were given from the beginning as they now appear to us (for some as God-given capacities). They originated in specific contexts and were reinforced and slowly developed for specific purposes (for instance, survival). This is

applicable even to those capabilities particular to *Homo Sapiens*—as Carl von Linné christened humans in his system of nature: "the sensible and intelligent man." This judiciousness resides in man's highly developed symbolic functions, which are a prerequisite for spoken and written language, and for using symbols on a theoretical level.

Theoretical concepts like displacement and condensation, so indispensable in all psychoanalytical work, are fruits of this symbolic capacity, but the thought processes to which they generally refer have a deep bodily anchorage: in motor behavior (movements and rhythms) and finally, of course, in the processes of the nervous and humorous systems of the body. This, however, does not reduce thought processes, nor conscious human feelings, to impulses and energies of nervous and muscular tissues. So many other things are involved, that we cannot here venture into.[1] Freud, however, was already wrestling with these problems at the end of last century, and they found an outlet in his

Project for a Scientific Psychology, written in 1895 (Freud 1950). In this venture he was, I believe, on the right track, but neuroscience during his lifetime had not yet evolved sufficiently to give to his arguments an organic foundation. Therefore, Freud never published the *Project* in his own lifetime.

Today, neuroscience has made great advances and, to my mind, modem

neuroscientists have convincingly substantiated psychoanalytical knowledge, even if many of the scientists themselves do not yet like to acknowledge the fact, as they do not want to be connected to Freud. Freud's own thinking in these matters have timely been revitalized, for example, by Mark Solms in London and the New York Psychoanalytical Institute Neuroscience Study Group.

Luckily, despite the miscarriage of the *Project,* Freud did not desert the subject. Instead he developed its implications in an area which was more easily accessible at the time: man's dream life. In *The Interpretation of Dreams* (1900) he explores the dark continents of the unconscious by way of textual analysis of narrative structures. Free association was to become the route to the shadowy quarters where latent and repressed meanings were hidden. Displacement and condensation were the mechanisms unconsciously employed in the process.

FREE ASSOCIATION

Free association is a paradoxical designation of what is going on, as the whole idea with the method is that the thoughts that will appear are not, as a matter of fact, free in the sense that they are under no other influence but chance. Actually, they are determined to the same degree as our conscious thoughts. However, the forces at work are different from those deciding the

course of conscious deliberations. Conscious communication with other people is marked by choices and omissions determined mainly by demands and expectations from the environment as well as from one self. It is exactly this influence that free association is supposed to free us from. But instead, other, unconscious, influences will make themselves felt, as for example the bodily dispositions that constitute the matrix of the unconscious processes of our psyche. It is because of this bodily anchorage that the method of free association is effective in exploring unconscious psychic life.

When analysts talk or write about free association it is usually done in terms of the many difficulties encountered in our efforts to make the patient oblige to the rule of free association; or the opposite is emphasized: the astounding connections revealed in the material by the method and the impact of these moments of "mutative change." But for Freud, free association signified more than a pure method of treatment. It was a step toward a theoretical psychological system:

> With the help of the method of free association and of the related art of interpretation, psycho-analysis succeeded in achieving one thing which appeared to be of no practical importance but which in fact necessarily led to a totally fresh attitude and *a fresh scale of values in scientific thought. [Standard Edition* 20:43; emphasis added]

Thus there are, at least, two aspects of "free association," as Freud formulated it. One having to do with clinical work and the practice of

psychoanalysis, the other with its paradigmatic theoretical impact, which will affect the theories of conscious and unconscious processes, and the issues of body and mind.

In the scientific world at large the theoretical implications of free association is hardly acknowledged at all. But something of the same ignorance in this matter will, I suspect, be found even among psychoanalysts —with a few exceptions. I might be wrong in this and then I hope someone will enlighten me, but if I am correct it is not difficult to understand why this should be. So far, there has been no reliable scientific methods to substantiate the findings of psychoanalysis from a different perspective. Today, advances in the methods of neuroscientific examinations have made Freud's words all the more meaningful, as it is now possible to verify, in the field of neuropsychology, the importance of the psychoanalytical method of free association— as has been shown for example by Mark Solms in his recent work *The Neuropsychology of Dreams* (1997a).

The importance of free association as a step forward in understanding the human psyche can also be illustrated with the result it showed when transferred to the field of the interpretation of dreams. If dreams are formed through influences from those layers of our mental structure to which consciousness does not have access, they will compare to material produced in free association. In "On the History of the Psycho-Analytical Movement"

Freud writes: “I need say little about the interpretation of dreams. It came as the first-fruits of the technical innovation I had adopted when, following a dim presentiment, I decided to replace hypnosis by free association” *(Standard Edition* 14:19).

It would be tempting to probe more deeply into this subject, but the clinical material that I am soon going to present (a Freud case) is not adequate to such an endeavor and therefore I will content myself with trying to point to a way in which the two aspects of free association here mentioned could be related.

For this purpose we will start with the concrete clinical situation, in which the method of free association is applied. If free association is the means of getting to the unconscious wishes and fears that lie behind a patient’s symptom, then it must be important for the analyst to know what factors could obstruct and what circumstances could facilitate the process.

In his work with Frau Emmy, Freud had discovered early on that his suggestions to the patient did not give the expected result if the patient had not first been permitted to tell her whole story without being interrupted. Even when under hypnosis, Frau Emmy kept a watching eye on Freud’s proceedings, and he writes: “I now saw that I had gained nothing by this interruption and that I cannot evade listening to her stories in every detail to

the very end" *(Standard Edition* 2:61).

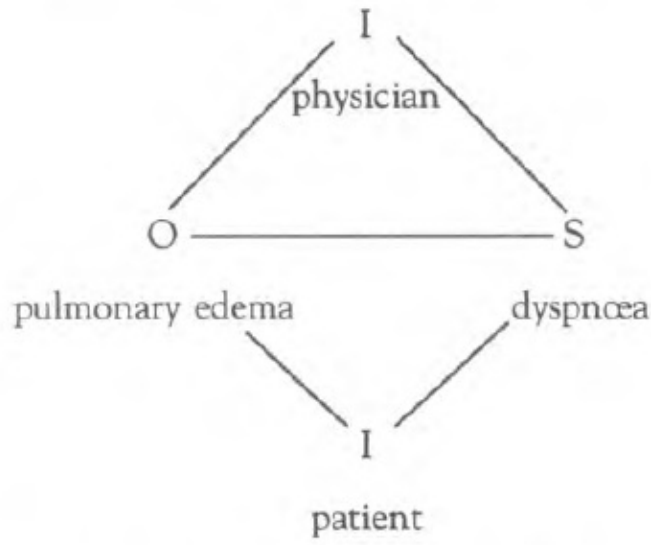
In the psychoanalytical method of free association it is, however, not only important to listen to the story told spontaneously, but equally, or even more significantly, the stories forgotten or actively withheld by the patient. Through the associative pattern slowly established by way of mechanisms like displacement and condensation, the analyst will eventually discern forms and contents that reveal the conflictual basis for the symptoms in question. This constitutes the material which the analysand and the analyst together elaborate in the day-to-day process of analysis.

I have found a semiotic model helpful in illustrating these processes.

A SEMIOTIC MODEL

A basic assumption in a semiotic model is that we know every object in the world by way of some sort of sign.[2] The sign stands as a symbol for the object to which it refers. This means that all our experiences and all our knowledge of the world are mediated: we know what we know only by way of something else, which has a referring function. This is apparent, for example, in the case when a patient comes to the hospital with a symptom, let's say a breathing difficulty. The physician on duty might easily decide on the cause behind the dyspnoea: heart failure with pulmonary edema. He acts accordingly, not on the presented symptom, but on the cause; acts not on the

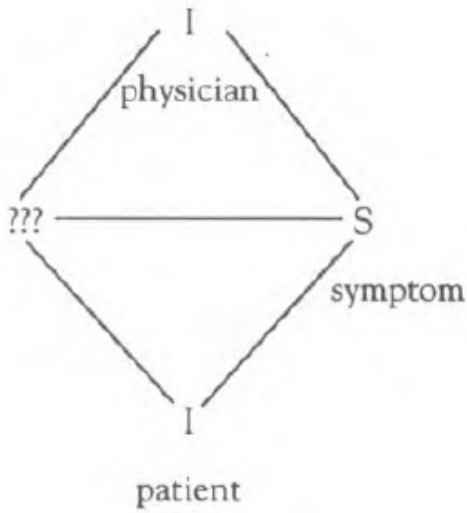
sign, but on that to which the sign refers: the pulmonary edema. The physician reads the sign and remedies the cause:



Everybody is satisfied.

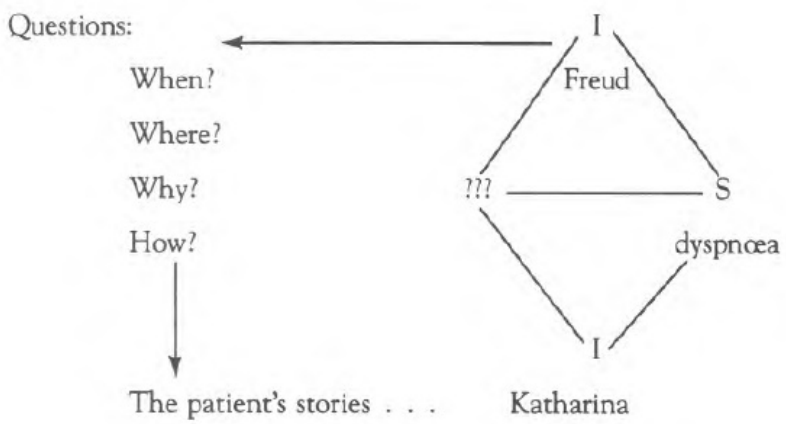
But often enough the object to which the sign refers is not easily detected. So was, for example, the case with the hysterical patients Freud treated a hundred years ago, and so is the case with the new psychosomatic disorders confronting the medical-care system of today; chronic fatigue syndrome, environmental illness, fibromyalgia, and other pain syndromes. The bodily symptoms in these cases can often not be related to any known organic cause. Thus the sign is invalidated, and the question of what the

symptom signifies remains unanswered:



In the hysterical patients Freud met and worked with at the end of the last century, this question was central. Trying to solve the enigma of the hysterical symptom, Freud—together with his patients—invented the genial method of free association. When "the object" cannot be found, the sign will instead give rise to a series of questions, such as: When? Where? Why? and How? In turn, these questions will initiate a process of storytelling: the talking cure. Katharina, for example, a young girl Freud treated in 1893 for breathing difficulties, and whose case is reported in *Studies on Hysteria* (Breuer and Freud, 1893-1895), was in this way cured from her attacks. Telling the stories, revealing their interconnections, and expressing their dammed up

emotions proved to be an effective treatment:



As we know from Freud, the symptoms in this process are looked upon as signs that refer to emotional states that occurred *in the past.* The famous statement: "hysterics suffer mainly from reminiscences" epitomizes Freud's view on the etiology of the hysterical symptom as presented in *Studies on Hysteria (Standard Edition* 2:7). The symptom arises due to a trauma, which in the case of hysteria usually is psychical and related to sexuality (in the case of Katharina, for example, the father's sexual seduction of herself and her cousin). The trauma has stirred up distressing affects that were not, for different reasons, allowed adequate expression. Instead the trauma—or rather the memory of it—remains in an unconscious form: it acts as a "foreign body which long after its entry must continue to be regarded as an agent that is still at work" *(Standard Edition* 2:6).

The hysterical symptom is thus based on and finds its affective matrix in a strongly cathected situation, where the details of the drama will provide the material for what later—*nachträglich*—and by way of conversion, will provide the bodily symptom-signs used to give expression to affects and sufferings felt but not known. To this well-known theory I would like to make an addition by reintroducing the concept of disposition for the corporeal matrix to which these affective "reminiscences" are attached. Our experience teaches us that psychic and mental phenomena (affects and thoughts) influence the physical, and, vice versa, physical disorders give rise to psychic disturbances. My assumption is that these exchanges work by way of a disposition.[3]

We shall shortly return to this issue, but first let me—as material for my argument—present the case of Rosalie, which Freud uses to illustrate the process of symptom-formation in hysteria *(Standard Edition* 2:169-173).

ROSALIE H

Fräulein Rosalie FI. was 23 years old when she came to see Freud in Vienna, because of some difficulties with her voice. She was a good singer and had for some years been undergoing training. But, she complained to Freud:

> In certain parts of its compass [her voice] was not under her control. She had a feeling of choking and constriction in her throat so that her voice sounded tight. [. . .] At times the disturbance was completely absent and

> her teacher expressed great satisfaction; at other times, if she was in the least agitated, and sometimes without any apparent cause, the constricted feeling would reappear and the production of her voice was impeded. *[Standard Edition* 2:169]

The difficulties could not be attributed to a defect in the organ itself, and besides, they only affected the middle register of her voice. Therefore we start out with the realization that there are no organic causes to be found behind the disorder. We might be mistaken, but so far we have no way to find out. This, of course, not only puts special demands on the doctor who is to treat the case, but also makes the situation for the patient more difficult by putting the blame on her. Fraulein Rosalie's guilt would thus be much greater, as it seemed she was the sole cause of the disorder. But if that was the case, she still could not by an act of will do anything about it.

Thus we can conclude: first, that the causal mechanism is not to be found in the physiology of the muscles and the organs of the throat. And second, that the reasons are not to be found among her conscious wishes, nor can she change the situation by simple willpower.

Where then are the causes to be found? "In the unconscious," would be Freud's conclusion. This realm of mental processes and psychic realities Freud explored by way of the cathartic method first introduced by Breuer in his work with Anna O. In this treatment the stories told by the patients, and the expression of affects related to these, were of fundamental importance.

This will become clear, for example, in the case of Rosalie.

She was the eldest child in a family of many children. The father was an abusive and violent man, both towards the mother and the children. Especially distressing for the family was the fact that he openly showed his sexual interest in and preference for the servants and the nursemaids in the house.

Then the mother died and Rosalie had to take over her responsibilities, defending herself and her siblings against the father's assaults. In order not to provoke him even more she had to keep back her disgust and hatred for him:

> It was at this time that the feeling of constriction in her throat started. Every time she had to keep back a reply, or forced herself to remain quiet in the face of some outrageous accusation, she felt a scratching in her throat, a sense of constriction, a loss of voice—all the sensations localized in her larynx and pharynx which now interfered with her singing. [*Standard Edition* 2:170]

A singing teacher came to her assistance and gave her lessons, to which she had to sneak in secret, often directly from an emotional scene at home. So a connection was established between a threatening situation, an emotional state, her throat, and singing. "The apparatus over which she ought to have had full control when she was singing turned out to be cathected with residues of innervations left over from the numerous scenes of suppressed emotion" *(Standard Edition* 2:171).

The Traumatic Process

In this description we recognize most of the elements that constitute a traumatic situation: violence, psychical or physical; strong emotions of fright or anger that have to be suppressed; in all, an overwhelming situation of too much anxiety and too little understanding. If we add to this the fact of the loss of the mother, we have a scenario designed for a traumatic impact on Rosalie's further development.

We can now give a first, simple model for the traumatic process, from which we can develop our argument:

External situation	**Psychical and physical reaction**	**Aftereffect**
physical or psychical	affective states	symptoms
violence or threat	and	and
(traumatic situation)	bodily reactions	dispositions

Whenever an external situation of traumatic effect occurs, internal reactions will take place that imply affective states as well as bodily reactions. We might feel angry and irritated, or afraid and desperate. These emotional states will always be accompanied by somatic reactions, whether we are conscious of them or not.[4] The heart will race or the eyes fill with tears, the hair on our arms will stand on end or our skin blush. Beside these easily

detected reactions, a whole series of physiological and chemical reactions will also take place: signal substances are released and hormones and enzymes rush into the bloodstream. Emotional signs are in this way primarily linked to the body.

In Rosalie's case, Freud described some of the traumatic external situations and her emotional reactions to them. When, in our analytical practice, we are faced with situations like these, we tend to concentrate on the object relationships at the time and the affective links between the actors of the drama. We take the symptom to refer back to the psychological phenomena, with which we are generally concerned. This technique usually proves itself to be effective. But we tend to overlook, and even forget, the bodily reactions that took place at the moment of the event. However, these reactions are, I want to stress, important. In the case of Rosalie, for example, the bodily signs were related to her throat. "It was at this time that the feeling of constriction in her throat started" (*Standard Edition* 2:170).

The external traumatic situation results in a symptom, based on the specific emotional and bodily reactions at the time (and they are always individually determined and context-bound). In Rosalie's case, her throat problems and vocal difficulties. The original reactions, however, did not only —in due time—give rise to symptoms which we can observe and analyze. Of equal importance is the fact that they created a disposition, a tendency to

react in one way or another in the future. A disposition functions as a kind of anticipation: it is an *acquired expectation* founded on, and interacting with, an *innate condition.* The disposition cannot be investigated in the same manner as the symptom. The latter is obvious, something to be seen or heard by the subject himself or by an observer. The disposition, however, we can only make assumptions about. Only in the course of events will these show themselves to be true or false.

Rosalie's conversion symptom can thus be looked upon as both a symptom in the ordinary sense of the word, and as an indicator of the presence—in the unconscious, in the body—of a disposition, established on the same ground as that which caused the symptom. When we follow the course of treatment in Freud's presentation we will be able to see how this disposition will come to make itself known. Let us therefore return to the case history.

Rosalie's Treatment

Rosalie was soon to leave her family and move to Vienna. There she stayed with an uncle and aunt, while she continued her singing lessons. She was, however, not happy with her relatives. The uncle, a nice man—but old—took a liking to her. This made the aunt suspicious and she then made it her habit to spy on them. This made Rosalie avoid playing and singing when the

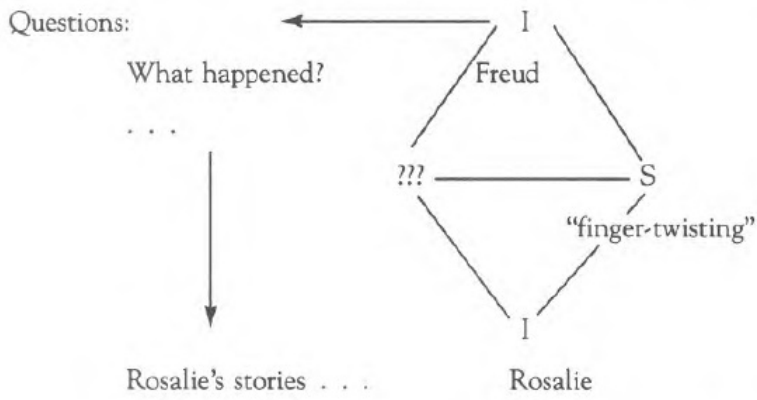
aunt was around.

This was the situation when she came to see Freud because of her throat symptoms. Freud's treatment at the time included hypnosis as a part of the cathartic abreactive model. Thus he proceeded to hypnotize the young lady, in order to have her experience, once again and in his presence, the emotional states of the traumatic situations in her family of origin. But now, instead of holding back her emotions, she was encouraged to vent them freely, to "abuse her [father],[5] lecture him, tell him the unvarnished truth, and so on, and this did her good" *(Standard Edition* 2:171).

To begin with, Rosalie did get better. But the tensions in her host family in Vienna worked against Freud's therapeutic efforts, and finally brought them to a premature end. But before this happened, Freud got a chance to observe the creation of a completely new symptom. One day Rosalie came to her session with a symptom that was scarcely 24 hours old.

Because of a disagreeable pricking sensation in the tips of her fingers, she made compulsory movements with her fingers. These movements came on as a kind of attack, that is, they could not be started by pure force of will. We can draw this conclusion because Freud first complains that he could not observe an attack, which he would have liked, as an aid to solving the puzzle. Well, in due time he would.

A semiotic model for this situation could look like this:



Freud now hypnotized Rosalie in the hope of finding out what had happened 24-hours previously—something, he guessed, that had precipitated the attacks. Instead he was astonished to find her starting to tell him about incidents dating from long before, and situations from far back in her childhood. One theme ran through all the narratives Rosalie now presented to Freud. It had to do with her having had some injury done to her, against which she had not been able to defend herself. For example, a schoolteacher had once hit her on the fingers with a ruler. But all the stories seemed to relate to very simple and ordinary occasions and, Freud writes:

> I should have been prepared to deny that they could play a part in the etiology of a hysterical symptom. But it was otherwise with one scene from her girlhood which followed. Her bad [father], who was suffering from rheumatism, had asked her to massage his back and she did not dare to refuse. He was lying in bed at the time, and suddenly threw off the bed-

> clothes, sprang up and tried to catch hold of her and throw her down. Massage, of course, was at an end, and a moment later she had escaped and locked herself in her room. She was clearly loath to remember this and was unwilling to say whether she had seen anything when he suddenly uncovered himself. [Standard *Edition* 2:172]

The Details of Bodily Involvement

So here again we find a traumatic situation, giving rise to an emotional state and to bodily reactions. Here too the sexual element is introduced, which was so decisive for Freud's argument concerning the traumatic process. To this I would like to add the importance of the details of the bodily involvement, in this case the fingers: they are being hit by the schoolteacher; they are being used to massage the father's body, and so forth.

Only after relating the scene with the father does Rosalie come to the one of the day before, which had precipitated the new symptom "as a recurrent mnemic symbol" *(Standard Edition* 2:172).

> The uncle with whom she was now living had asked her to play him something. She sat down to the piano and accompanied herself in a song, thinking that her aunt had gone out; but suddenly she appeared in the door. Rosalie jumped up, slammed the lid of the piano and threw the music away. We can guess what the memory was that rose in her mind and what the train of thought was that she was fending off at that moment: it was the feeling of violent resentment at the unjust suspicion to which she was subjected [. . .] The movement of her fingers which I saw her make while she *was reproducing this scene* was one of twitching something away, in the way in which one literally and figuratively brushes something aside—tosses away a piece of paper or rejects a suggestion. *[Standard Edition*

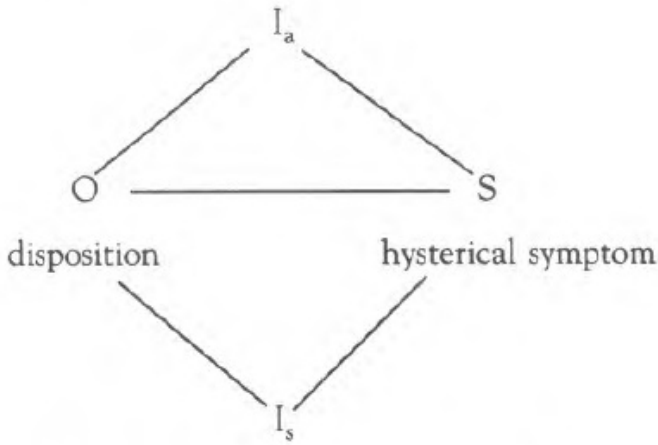
2:172-173, emphasis added]

The body reacts: it *reproduces* a scene, that is, it is what Freud sometimes calls a *Darstellung,* a putting on the scene, as it were, concretely: an embodiment. It creates a situation where the sign (S) coalesces with the object (O). The symptom in this situation is therefore not the creation of a *Vorstellung,* an idea of the thing, but the "thing" itself manifested. The quality of sign is in this case only ascribed to it from the position of the observer. Rosalie's body acts as if it was again at the father's bedside, where his body is demanding to be touched by her fingers. As the filings assemble around a piece of iron and thus it discloses its magnetic disposition, Rosalie's finger-twisting now reveals her bodily disposition. The finger-twisting is here not only a symptom in the narrow sense, but it reproduces a sign of a bodily inscription: a disposition to react in a certain way. Rosalie's finger-twisting symptom—that suddenly presented itself during the ongoing treatment—was not only related to the fingers that, at the request of the uncle, were playing the piano, but also to the bodily memory of the fingers that had massaged the father.

Freud believed "that a process of this kind is the rule rather than the exception in the genesis of hysterical symptoms." There is "not a *single* traumatic cause but a group of similar ones" (*Standard Edition* 2:173). Thus, we have a cluster of experiences that create a disposition. A few years later, in

the *Project,* Freud will call it *Bahnungen*—a stimulation of certain synaptic connections and not others. Some of the traumatic scenes as reported by the patients seem rather harmless, but when they join forces with more dramatic instances, all this will work together to over-determine the resulting symptoms. The symptoms arise, as Freud said, *from reminiscences.*

Given this evidence we have the right to ask whether it is the case that a bodily disposition (innate or acquired) is a prerequisite for the formation of a hysterical symptom? If the answer is "yes," a general model could look like this:



where O stands for an acquired disposition based on memories of traumatic situations—always connected to *bodily reactions* and *affective states* (sexuality), as described earlier; S is the presenting symptom (in this

case the cracked voice and the finger-twisting); I_a an agent that in some way or other partakes of the interaction (the father, the uncle/aunt, Freud, and so forth); and I_s is the subject (Rosalie).

In the beginning of this paper I stressed the importance of the role of narrative in the patient's history of illness. The case of Rosalie, I hope, has illustrated this process, where the patient's stories are shown to constitute a kind of narrative of a bodily disposition. They actualize an anticipation by linking traumatic situations to perceptions and bodily movements, in which one or several elements are shared.

I also emphasized the often overlooked fact that free association is not only a psychological method to set this process going, but that it also has important theoretical and scientific implications, in that it reveals the intimate relation between the patient's words (conscious thoughts) and feelings (conscious emotions) on the one hand side and her bodily symptoms (signs of unconscious dispositions) and brain processes (unconscious mental states) on the other. The hysterical and psychosomatic symptoms cannot, to begin with, be controlled by the will; neither produced, nor stopped. The causative mechanism belongs to the unconscious and is constituted by a whole series of incidents which combine to create a bodily disposition. This disposition will give structure and form to our lived experience—in health and illness alike.

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Notes

1 For a discussion on some of the issues related to this interface between neuroscience and psychoanalysis, see, for example, Mark Solms' article "What Is Consciousness" in *Journal of the American Psychoanalytic Association* (1997) 45:3, and the discussion that followed, in the journal as well as on the Internet. For an excellent survey of the field, see Pally (1997, 1998a b), and for further information, see Damasio (1994), Edelman (1992), Freeman (1995), Johnson (1987), Lakoff (1987), Penrose (1994), Schachter (1996), Searle (1997), and Shevrin (1996). For a metapsychological model of the role of affect in this interaction, see Mathis (2000).

2 I have used the semiotic model of C. S. Peirce, but adopted it for my special purposes. C. S. Peirce (1839-1914)— a physicist, mathematician, and philosopher—created a model for human interaction which he labeled semiotic. He is regarded as the founding father of pragmatism in the United States, and he played an important role for William James and his work. I also think his influence on Lacan's writings (not only thinking but style) was great.

The semiotic model here presented goes beyond the Saussurian dual-sign theory. It introduces a triadic conception which, to my mind, makes a much better fit with our experience in the psychoanalytic situation. It can also be extended— as I do here— to a model of intersubjective interaction which takes place by way of some kind of sign (neurotic, psychotic or somatic symptoms, dreams, parapraxis, acting-out behavior, yes, even the lack of a "sign"— that ought to be there — is a sign). Space does not allow me to present a full semiotic model in this context, nor define the meaning given to symptom, symbol, and sign respectively in this connection. A reader familiar with Swedish will find a full account of this in Matthis (1997). In English, and related to the work of Bion, Alfred Silver has presented a somewhat different semiotic model based on Peirce (Silver 1983).

3 In Studies on Hysteria Freud and Breuer talk about "dispositional hysteria" (Standard Edition 2:12) to designate a "liability to dissociation" so characteristic of the disease. And section 6 of Breuer's theoretical contribution is titled: "Innate Disposition— Development of Hysteria." He uses the term to replace the phrase "abnormal excitability of the nervous system" (Standard Edition 2:241). For both Breuer and Freud disposition is not only innate but acquired. "It is possible and perhaps probable that further observations will prove the psychical origin of one or other of these stigmata and so explain the symptom; but this has not yet happened" (Standard Edition 2:242).

The term disposition is a concept also used in the latest developments of cognitive theory (Johnson 1987, Lakoff 1987) as well as in the neuroscience dealing with the

brain and its "brain states" (Damasio 1994, Freeman 1995). Thus here we have a point where, at least in theory, the different perspectives of cognitive science, neuroscience, and psychoanalysis meet.

Within analytical philosophy the term includes properties of inorganic matter as well: a piece of iron will, for example, have a magnetic disposition. This cannot be judged by the exterior, but will show itself only when the iron is put in a certain context: among iron filings that will— if the iron is magnetic — arrange themselves in a certain pattern around the centerpiece.

The concept of disposition is thus a generally accepted one within many different sciences. Besides, it is a word of everyday use, and nobody has difficulties in understanding what is meant, when someone, for example, says that he has a disposition for a special illness or to certain acts. This does not imply, however, that it is possible to explain how a disposition is established or how it works. And when it comes to the type of psycho-physiological disposition with which we are dealing here, the explanation will of course be speculative and the models hypothetical. But in order to be able to even ask the question: why "words work wonders" on body and soul in the therapeutic process, we have to start by describing the clinical experience of it. This knowledge (which Aristotle called phronesis) precedes the question of why the word has effect, and even more so the answers to how (episteme) (Toulmin 1994).

4 It is a long-known fact that emotions and bodily reactions go together. William James wrote: "Instinctive reactions and emotional expressions thus shade imperceptibly into each other. Every object that excites an instinct excites an emotion as well" (1890 p. 1058). According to him, the bodily changes precede the feeling state, and the feeling actually "is our feeling of the same changes" (ibid. p. 1065). We do not run from the bear because we feel afraid; we feel afraid because we run from the bear. The relation between bodily reactions (having to do with objectively verifiable facts of physiology, chemistry, behavior, etc.) and emotional states (referring to subjectively experienced states of affect) is a complex issue. At this level of inquiry it is, however, enough for us to know that they always "go together" and all the time— in various ways— interact. I have elaborated this further in Matthis (2000).

5 In the original text, Freud presented the offender as an uncle, while, in reality, it was the father. The reason was, as always, to cover up the identities of the persons involved.