

Toward a Semantics of the Symptom: The World of Frau D¹

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Frau D is strong looking woman with pitch-black hair and silver studs in her ears, five in one and one in the other. She is tall and has a penetrating yet open glance. Originally thin, she shows signs of having added weight over the past several years, as is common among working class women. Now thirty years of age, she has been married for about ten years and has two children, 6 and 4.

This is the fourth time she has been treated for a failure in her hearing and the second time she has been treated psychosomatically, which is itself a source of concern for her. The first three times there was a temporary loss of hearing for which the examining physicians found no ear infections. After the third collapses, she spent several weeks in a psychosomatic course of treatment in another clinic. This fourth time her hearing remains but she complains of an unremitting sound persisting in both ears. The sound is uniform and no voices of any kind are heard, she reports. If the *tinnitus*, as it is called, was present in earlier cases, this time it has increased and become so loud that she needs strong sleeping pills at night. She has been wearing an ear device that she believes helps diminish the volume of the tone. Her one prior stay in the hospital did not work, as she puts it. She returned to the same living situation as before and now finds herself back in the clinic. My observations of her were in a group, with two other women, led by Dr. Schueffel. This paper grows out of my collaboration with him in the Department of Psychosomatic Medicine at the University of Marburg. I have also been greatly helped by discussions with Dr. Dr. Neraal, who was the primary physician, and Dr. Kolb-Niemann, who also offered valuable insight into this case.

A case like Frau D's tinnitus suggests that this illness is a complex that cannot be sufficiently explained by physical causality alone and that a complementary notion of *motivation* must be included as well. Indeed, it even suggests that neuro-physical causes (micro-level) run their

course within complexes (macro-level) having essentially functional and existential significance. To truly understand the illness, larger questions must be asked. Why did Frau D develop this *particular* illness and not another? If one invokes stress then why does it affect her hearing and not her taste or smell, as in the case of Frau A, another patient? How is this symptom connected to her efforts to navigate her “all too human” environment?

In an effort to understand the case of Frau D, I have divided this paper into five parts. The first part works with the assumption that to understand the case of Frau D is to understand the *world* of Frau D. I will use the concept of significance (*Bedeutsamkeit*) as my point of entry to a notion of world appropriate to psychosomatic medicine. The second part will suggest that various types of significance can be correlated to differences within the concept of world between setting, context and background. The third part will further specify the formation of background. The final two parts will focus on the way the case of Frau D sheds light on what I will call the truth-bearing function of her symptoms.²

A. World as Horizon

For the class of psychosomatic illnesses that are forged out of conflict, such as we find in the case of Frau D, we readily say that symptoms arise because a person's involvement with her or his world has become overwhelmingly stressful. But what do we mean by world? Or, better put, what is the notion of world that allows us to understand both the etiology and what I will call the teleology of psychosomatic symptoms? Let me step back from psychosomatic medicine for a moment and go at this question with an approach shaped by phenomenology.³

The phenomenological problem of the world arises in reaction to the natural scientific attempt to reduce it to a certain type of natural complex. This reduction is a result of a certain stance or attitude, what Husserl calls the natural attitude. According to him, the sciences do not apprehend the world falsely but "objectivistically", i.e.; they are capable of approaching the world only as something having the character of an object. Unfortunately, in psychiatry and psychology as well, Blankenberg complains, “objectifiability [*Objektiveirbarkeit*]” also reigns.⁴ What confirms this apprehension is that, given a certain attitude (*Einstellung*)

the world can appear in this way. In the natural attitude the world can be treated as the set of all facts or as the totality of all things. Sets and totalities are not things, of course, but they are nevertheless objects, *Gegen-stände*. But what allows the world to appear in this way is not itself an appearance. The structure of the world can never be manifest as something having the character of an object and, therefore, never as the field of an object-oriented investigation.

In an effort to capture this difference between an objectivistic and a phenomenological concept of the world, Husserl and then Heidegger characterized the world as *horizon* and horizon as a nexus of *significance* that situates not only our multiple discourses about different regions of the world but also the regions themselves.

But what does this mean? What do we mean by nexus of significance? As someone asked in one of the workshops, what is the meaning of meaning? Does it have an internal structure? In some of the philosophical work that I have done I have attempted to get at the concept of the horizon by distinguishing between field, context and background. Does the distinction between background and context have any relevance for clinical understanding in general and the case of Frau D in particular? This paper is an attempt to *begin* to give a few answers. Let us look at the polymorphic world of Frau D.

B. The Polymorphic World of Frau D

1. Setting

The illness that Frau D has is, first of all, situated in a particular environment. The environments that psychosomatic medicine study might better be called settings since they are particular human places in which persons work out their relationships with each other. A setting can, indeed, be given a rather straightforward description. There are a number of facts that Frau D reported using what we philosophers call claims or proposition. Propositions are sentences that have the standard form of S is p, that refer or fail to refer to facts, and thus can be true or false. The *meaning* of a proposition is carried by the concept(s) expressed by the predicate term(s); concepts, in turn, are publicly shared and *rule-regulated distinctions*. Propositions can be grouped according to the different fields or "regions" to which they belong, with the rules governing meaningful claims in one region overlapping and differing to

various degrees from the rules of another region. Logical coherence and consequences define the relationship between propositions. This is the language of textbooks; textbooks are what transform regions into academic disciplines. But this is also the sort of third person reporting we find in everyday life whenever a speaker offers an objective account of the facts or, lacking sincerity, whenever he or she chooses to deliberately conceal the facts. Much of what Frau D offered were straightforward propositions; taken together they "set the stage" of her own illness. Summarizing we can say that in addition to *general* rules that set formal conditions for meaningful propositions, there are also *regional* rules regulating psychosomatic discourse in contrast to other types, and then *particular* rules that are in play in the case of Frau D's situation. The *setting* is the set of these particular conditions.

Over time the picture of her home situation fell in place. She and her husband have been living in what was originally a pub (*Gaststätte*) owned by his father and mother. The father became a drinker and sent the pub into bankruptcy. In an effort to save the home, the son, Frau D's husband, took out a mortgage, bought the building and converted the downstairs into living space. To help with the expense of carrying the expenses, his father and mother, his sister and family, then Herr D and Frau D with their two children all lived there. The home was located in A, which is a strict Catholic village, open only to those born there. A Passion Play is staged periodically, along the lines of the one found in Oberabergau. This is the town from which Frau D's mother stems but Frau D was never really received by her in-laws. She gets along with some individual members but not all and certainly not the whole group, she claims. Her father-in-law in particular would constantly demean and verbally abuse her. The husband promised to move the family on several occasions but this never happened. At one point during the ten years she did leave in frustration for a year and moved some 100 km back to her parent's house. But she returned and was living with her family in the unbearable and stressful situation in the old *Gaststätte* at the time she was admitted to the hospital.

2. Context

In addition to making different claims *about* various facts in her home setting, Frau D also revealed segments or samples of dialogues that took place *in* that setting. Discussions with her father-in-law and, later, with her husband would be reenacted. Or she would freely talk about her

feelings and reactions to her situation as if she were still in the Gaststätte.⁵ What we are interested in are the various ways she acts out and "sorts out" her situation. Here we turn our attention not to her third person *reflective* account *about* her situation, as we just did, but to the grammar of her first person *reflexive* discourse *in* her situation.⁶ Indeed, the value of transference, as Dr. Schüffel emphasizes, is that it allows the therapist to stand in for a significant person to whom the patient's discourse is addressed. As the patient places the therapist in his or her situation, the therapist gains access to it. This discourse is meaningful but in a way different from propositions. The meaning of the sentences here consists of various *schemata of differentiation* that allow the speaker not so much to reflectively describe but to directly articulate and engage her situation. Here the element of performance prevails. The schemata of differentiation are different (possible) ways of "taking-up" or "taking-on" various persons and facets of the environment. Speech here is not the product of well-formed thoughts seeking words. Rather the "thought" or intention is itself first shaped in the process of speaking.⁷ Meaningful terms, in turn, are related not by logical entailment but by *differential implication* or what goes by the unfortunate name of association.⁸ The meaning of terms is determined by their relationship to yet other contrasting and opposing signs that can or cannot be used as a speaker engages his or her environment. We could say that the *unity* or identity of a term's meaning is a function of these *differences*. The set of all such relationships of identity and difference give us the system of implications; the set of differential implications is what we mean by *context*.

Notice also that a corresponding change in the referents of the sentences is in play. The facts become *affairs* in which we are entangled and our speech captures the style of that active participation. This is the kind of talk⁹ that carries our practical and emotional involvement in situations. Like farmwomen, we "sing" as we harvest the golden wheat; in periods of drought our songs become sad.

Therapy begins with the setting but is mainly interested in context, for to understand a patient is to grasp the relationships of implication and exclusion in the language that the patient uses. The therapist is interested not so much in the logic of what is said, for she or he has been trained to view that with suspicion, but in its illogic its bending of the rules, its *Unrechtmässigkeit*. Along with many others, we

found two forms of semantic deviation in Frau D's discourse about and with her father-in-law that were especially telling.

Frau D reported feeling very secure in the group session with two other female patients, did not hesitate to speak about her feelings, and offered good insights into the other two patients. Yet even charged group sessions, in which the other two wept deeply and where she talked about her own frustrations, never saw her moved to tears. This seemed related to an important feature of her descriptions. When asked about her feelings and thoughts at the present time she had great difficulty using the indexical pronoun "I" (*ich*). For example, her frustrations with her father-in-law, who continues to drink, were put like this: "One cannot cope with him at all," which works a little better in German, i.e., "Man kommt mit ihm überhaupt nicht zurecht." She also said that she feels guilty and sad because she had to leave her children and reenter the hospital but expressed this impersonally as well: "one is guilty" "man ist schuldig," not "I feel guilty." The I, the "ich," is lost behind the One, behind "das Man."¹⁰

There is another striking form of grammatical displacement in the case of Frau D. At one point, when talking about the way "du" (familiar form of "you") and "Sie" (formal or polite form) were being used in the group, she candidly admitted that she had never been able to call her father-in-law, even after ten years of living under the same roof as part of the family, "du" but always addressed him as "Sie." I was astonished, as were the others in group. Of course, a "Sie" implies only a neutral "man sagt," a "one says." It was not she that was speaking but the community of voices. This was a way not of dealing with him but of refusing to deal with him, of being absent, of not being affected. But here it is also the case that a "du" implies a contrasting "ich," a delimited "I" that is sufficiently different from the father-in-law that she can be angry with him without herself becoming the object of her rage. This, we find, is what is missing in her case.

3. Background

The analysis of both stage and context has taken its guiding thread from language, as well it should. Therapists begin by talking to patients and most of what therapists know about patients comes from interpreting both their reflective claims about their lives and the pattern of their unreflective discourses and dialogues in their situations. Yet patients also act or fail to act, work or fail to work, move freely in their

environments or remain locked in their houses. Thus far we have made no connection to the body and the actions that carry our involvement in various situations. Doing so allows us to discover another type of significance and yet a third type of horizon, what I am calling background. Being rooted in the body, it is preverbal and preconceptual in nature. We must dwell on this for a few moments as the prevailing tendency is to confuse background and context or, in the case of strict social constructionist theories, to collapse background into context.¹¹

Context does not stand alone. In addition to our speaking about matters in an environment we are also engaged with them bodily. There are not only acts of speaking but also *actions* in which we take what is spoken about to hand and use it practically. Taking to hand and using objects generates a kind of significance different in kind from what we found in speech. In place of that distance that allows the speech-act to refer to an object, we grasp the object and bring it within the circuit of our body. Indeed, actions can "constitute" the determinations of things apart from or before speech: placing a rock in front of an open door "unfolds" its significance as a door stop; the action of taking the round stick in hand and using it to hit a ball is what determines it as a bat.¹²

It is in this relationship between action and what is ready-to-hand, *zuhandenes*, that we discover what we can call primary perception. Primary perception itself is never a mental act of interpreting data or sensations according to concepts, for it is controlled by action, on the one hand, and need or desire, on the other. In primary perception objects appear according to what Kurt Lewin called their "Aufforderungscharaktere," K. Koffka their "demand character" and J.J. Gibson their "affordances."¹³ "A handle wants to be turned, a step invites a two-year-old infant to climb it and jump down from it, chocolate wants to be eaten, a mountain to be climbed."¹⁴ In primary perception, moreover, the way the object is present for action is internally connected to our *affects*. Needs and drives motivate actions. The desire for or an aversion to something calling us to action frames the way it is perceived. Perception, we can say, employs schemata of *discrimination* facilitating action that are not or not yet the schemata of differentiation animating speech. Let us follow both Husserl and Heidegger and call this kind of significance *sense (Sinn)* and let us at the outset not confuse it with *meaning (Bedeutung)*, which was the focus of our analysis of propositions and everyday talk.

The senses of things, I am suggesting, arise in the course of our bodily actions upon them. While action is often directed by conceptual content expressible in speech, it does not require this nor is the significance of things ready-to-hand itself produced by the way they are referred to in descriptions. Rather than looking to differential schemata, which we have linked to our speaking about the world, there is another level of organization, schemata of *discrimination*, that is in play, one suggested by the actions of the body and the way perception itself is organized affectively. In contrast to context we have *background*. World as background is a nexus of indicative implications (*Verweisungszusammenhang*).

C. The Formation of Background

Let us give up one of the restrictions that we have imposed on the analysis thus far. We have spoken only of actions but actions are generally forms of *interaction*: we work with others, we play soccer together, we dance with a partner or, in more turbulent times, we strike others in anger. It is crucial to see that our interactions are not always the product of prior thoughts or ready-made intentions. Often intentions arise in the course of an interaction and are shaped by it. Striking another person is often a case of intention-in-action.¹⁵ The body, pushed beyond a certain threshold, reacts. And when she says afterwards "I did not mean to hit you," we should interpret this precisely: there was not a prior act-intention formed before the action and motivating it. Yet, in fact, she did mean to hit him, i.e., her body and its actions formed the intention for her, not her deliberative thinking. Background takes shape, first of all, through forms of intentionality that are rooted in the body and that arise during the course of our actions and interactions.

We also need to root background in affectivity. Well before all of our developed forms of interaction, rich with speech, we find the triadic relationship between child, mother and father, rich with affects. This is the first and most basic field of interaction.¹⁶ This relationship is governed by the dynamics of touch, not vision. Here touching is structured in a way that not only provides an awareness of the physiognomy of the body of the other but also establishes an exchange of feelings that necessarily involves both the parent and the child. The parent touched is also touching which allows the child doing the touching

to sense itself as touching and touched at the same time. Touching, as Husserl also pointed out, "localizes" experience in the body.¹⁷ Here the feelings of the mother or father are directly given in the exchange of touch. Thus to touch the other (mother or father) is simultaneously to experience the affects of the other. Touch introduces a singular type of bodily reflexivity, in play well before there is a developed difference between inner and outer, subject and object, that is missing from vision and even further removed from speech. An analysis of touch leads us to something deeper than intersubjectivity here: we discover the intercorporeal nature of affectivity.

The triadic relationship between child and parents is governed by an economy of needs and gratification, of desires and affection, in short, of an economy of binding.¹⁸ Touch developed over time is what produces holding and holding that becomes constant leads to what Erikson and Winnicott calls "basic trust," its failure to that terrible opposite, basic fault. To fix this terminologically, let us say that at this level the primary mode of the child being related to the significant persons in its environment is clinging (*Anfassen*¹⁹), the mode of significant persons experiencing the child is embracing (*Umfassen*²⁰).²¹ The horizon in play here can be thought of as an emerging nexus of senses defined by primary attachments. It is the organization of primary attachments that gives us the deep structure of background.

D. The Origins of the Symptom

Breaking out the notion of world in terms of setting, context and background, and then deepening the account of background in terms of action and affectivity allows us to return to the question of the origin and function of symptoms. We will attempt to show that the symptom²² has not only an etiology but also a teleology, i.e., not only formative features, *Gestaltungselemente*, but also purposive features, a certain *Zweckmässigkeit*. The analysis of both formative and purposive achievements in terms of context and background will give us the key to the constitution of symptoms.

The context sustaining our everyday talk is essentially a social horizon of meanings consisting of shared schemata of expressible differentiations. It allows a subject to articulate not only the matters with which she is engaged but also the feelings and concerns that she has,

sometimes directly, sometime indirectly. Wishes and desires are cast in an ideational form that allows them to meet the conventions and expectations of others. If strong wishes and especially the core need for basic affection are emphatically rejected, they do not die of their own accord but seek to find fulfillment in surrogate objects or people. And if these surrogates fail or are also rejected, tension is redoubled. Once certain thresholds are crossed, the tension is manifest as bodily symptoms. This conversion model, of course, was the one that Freud introduced.²³ As is well known, his notions of wish, censorship, repression, sublimation and substitution provided a workable account of the oblique and dense nature of the ideational content of symptoms. This account has been modified and extended by Dr. Schüffel's discussion of wishing, warding off, suspending and solving.²⁴ Approached from the side of content, what is striking is the way that the symptom and, with it, the speech of the subject introduces a certain *impropriety* into relationships with others that plays off manifest meaning against the underlying sense. The impropriety is found in the fact that collusion with, protest against and protection from significant others are all in play. Indeed, the manifest meaning as understood by others stands in tension with what they accepted as normal or healthy and, in being rejected or judged by others, thereby conceals its sense. But this point already carries us into background, into the domain of affects and interaction. Because the symptom is formed by what Freud called primary and not secondary processes, background is inextricably interwoven with context: the processes of condensation (*Verdichtungsarbeit*) and displacement (*Verschiebungsarbeit*)²⁵ generating the manifest meaning of the symptom are driven by the vicissitudes of basic drives or affects. Barriers in the way of acting on the basis of needs, wants and/or desires create a conflict of affects that are *converted* into a symptom to which the body, for its part, lends itself and finds at least a momentary resolution. Yet the fact that that the conflicted desires generating the sense is also unknown to and not in control of the subject turns protest into a pathology from which she cannot escape.

The meaning of the symptom is found in its ideational context; the sense of the symptom is found in its affective content. By means of primary processes they form a single whole. The implications of this for therapy are quite clear. It is only by (re)establishing an affective sense of basic trust, reactivating the affects associated with the underlying

conflicts, and tracking the way that they come to expression in the symptom that the therapist and subject will be able to get at the origins of the illness. “Hysterics suffer mainly from reminiscences,” Freud and Breuer tell us in their early 1893 *Preliminary Communication*.²⁶ Mutually discovering and, to some extent, recreating the context and background generating the symptom opens up the *retrospective* significance of her symptom(s).

While the distinction between context and background might be new, the notion of conversion and its “mechanisms” are already familiar. What might be novel in our account is the claim that symptoms also have a teleology co-constitutive of their formation.

E. The Teleology of the Symptom

Time does not permit me to deal with Frau D’s relationship to her father-in-law and, thus, the way this seems to involve unresolved Oedipal issues with her own father. And we can only mentioned her suppressed resentment toward her husband and the way this involves a symbiotic dependence upon him. He has dominated the relationship and determined its space. Conflict based psychosomatic symptoms are a form of *withdrawal* that allows a subject to process the conflicting desires and affects connected to significant others, yet we can also understand them as forms of *engagement* that grant one enough space to navigate the coming day. They reflect as they deflect a past but they also make possible action in the future, I want to suggest.

However one decides to interpret the Oedipal dynamics²⁷, we are now in a good position to return to the tinnitus. Connecting the sense of the symptom to its generation out of action and interaction is simultaneously to understand how the meaning of the symptom is connected to way the subject *navigates* her all-too-human relationships. In short, the symptom is purpose-driven, though it is not a purpose located in a conscious intention but one shaped by the way its ideational content stands in for the unconscious wishes and desires sustaining the symptom and “works” their “will” on significant others.

If it is the background that dominates the etiology of the symptom, it is the context that dominates its teleology. Symptoms are more than indicators, they are signs: the subject knows, at least tacitly, that the symptom has a certain meaning that in being understood

(superficially) by others also moves them in one way or another. The subject's acquaintance with the context allows for a restructuring of the space of her actions and, thereby, the background. The symptom is not only reactive but proactive, not only retrospective but prospective, not only a form of memory but also of anticipation.²⁸ In *marking* the impossibilities it also *intimates* the possibilities of acting in the environment in which Frau D lives. The symptom, I am suggesting, not only projects a past onto a present; it also protects the present in view of a future. Taken in this way, the tinnitus is rich with significance. It contributes toward a certain "spatialization" of the "I" in at least four interlocking ways.

1. Delimiting, *Abgrenzung*. The tinnitus both draws a line and establishes a difference. On the one hand, it separates the space that belongs to others and that belongs to her. The contrast is in ownership. Her space is not to be touched by other hands. This space is open only to her. She alone has access. She hears the sounds, no one else does, not even the examining physician.
2. Threshold, *Schwelle*. The border between inner and outer is also a threshold between the two. Unlike certain cases of schizophrenia, where the connection to the world has been inverted and the sounds have become internal voices, this is a uniform tone that both blocks what she hears and yet allows her to understand everything. The threshold as well as the intensity of the sound are determined by the affective quality of the relationship with the other. Significantly, when Dr. Schüffel, whom she trusted, deliberately lowered his voice in a group session, which he did without her realizing it, there was no loss in comprehension.
3. Gatekeeper, *Schleusenwärter*. The threshold is also a gate that can be open or closed to others. The symptom causes others to hesitate and sometimes repels them. The element of control is there. During her stay in the hospital she even cut her hair, which otherwise concealed the small device she was wearing to help with her hearing disorder. Now it is open for all to see. It functions like a small, stern gatekeeper that simultaneously assists her even as it obstructs others.
4. Attaching, *Verbindung*. Symptoms of this type are not just ways of gaining control, however imperfectly, over fields of action, but are also ways of reaching out. They communicate, though they are more like icons than words, more like gestures than symbols. They even invite

help. She does not want to divorce. The tinnitus keeps the husband connected, if at a distance, by shared issues that they have to come to grips with together. If the gatekeeper usually functions to push away, this invites connection, invites him to enter respectfully what is now becoming her own space.

It is this last function of reattaching---in the face of lost or frustrated primary attachments---that opens up the hope of a new relationship to significant others and gives both the patient and the therapist a future toward which they can work. The fact that symptoms have not just a etiology but also a teleology has clear implications for therapy and points to the importance of rebuilding narratives and developing new *rhythms*, i.e., new ways of integrating affects and styles of action that ground such narratives.

Footnotes

¹ A lecture as given at the 19th World Congress on Psychosomatic Medicine, Quebec City, Canada on August 30, 2007. This is the abridged version of a larger paper with the same title, which is itself a work in progress. Critical comments are welcome and can be addressed to: donn.welton@sunysb.edu.

² Let me say in advance that I am frightfully aware of how laconic and incomplete this account will be. Each section that follows is easily a chapter, if not several, in itself. I expect to devote considerable attention to them in a forthcoming book tentatively titled *Bodies of Flesh: The Dialectics of Desire*.

³ What follows is adapted from "World as Horizon," Welton 2003.

⁴ Blankenberg, 183.

⁵ What makes the distinction between claims and first person descriptions subtle and hard to grasp is that there need not be any surface difference in the form of the sentences (they can both have the form of S is p) and the fact that even the most straightforward claim always has the implicit operator "I think that," "I believe that," "I feel that," etc., and thus a certain indexicality or occasionality that allows one, especially a skilled therapist, to interpret the claim as expressive not of a fact but of how the speaker is coming to grips with his or her situation.

⁶ On the difference between reflective and reflexive see Welton 2003.

⁷ When that speech repeats or mimics the voice of "man sagt," the schemata of differentiation are simply what a culture teaches us to say and think. Our way of taking-up and taking-on are the product of our society.

⁸ If this is the case, then the very notion of association must be freed from the emphasis upon contiguity (Hume) and pairing (behaviorism) that prevails in empiricists accounts.

⁹ It is what Husserl called "occasional" and what we today think of as "indexical" speech.

¹⁰ Of course, these are also excuses or justifications, which also have the effect of removing the I (the ich) from the stage.

¹¹ If one collapses background into context we end up with a strict social constructionism in which the body is only a blank tablet on which culture inscribes its structures.

¹² "Door stop" and "bat" are, of course, concepts. But we use each here only as placeholder for a sense-structure or what Husserl called a "type," which would have to be characterized in terms appropriate to it.

¹³ Koffka 1935, 355-357; Gibson 1986, chapter 8.

¹⁴ Koffka 1935, 553.

¹⁵ We need to contrast what we can call intention-before-action to intention-in-action. There obviously are cases where one decides what needs to be done and then does about doing it. The dishes have been sitting in the sink for a week; I decide that it is time to clean them, from which follows the action of filling the sink with water and washing them. But to get at the concept of action of particular interest to psychosomatic medicine, we need to think about cases where my behavior does not follow from a previous conscious decision but occurs without such, thoughtlessly or automatically, as we often say. The skilled cyclist swerves to the left to avoid touching the wheel of the competitor in front of him. The experienced cabinetmaker moves without hesitation from sawing the leg of the table to chiseling out a mortise and to sanding its surfaces. The sleepy student does not hesitate to put her books on the table and sink into the chair. These forms of action, in which there are no "prior" intentions, are the more interesting to look at for us as they might eventually give us insight into their neurotic sisters, as we find in obsessive-compulsive disorders, and perhaps even more distant relatives, such as the symptom of Frau D.

¹⁶ It is central to the account we are offering that we place interaction first at this level, both structurally and genetically, and not the level of verbal exchange.

¹⁷ Husserl 1952, 144-156 ; Husserl 1989, 152-163. For an analysis of Husserl's notion of the body see Welton 1999b.

¹⁸ On the notion of affection and a critique of Freud's emphasis upon eros see Welton 1998b.

¹⁹ I am playing on the sense in which "an" can mean "up against," "in," "at," and "on." This is the view of the child on the mother's breast, in the father's arms, etc.

²⁰ Not in the sense of "comprehend," as if this is a mental act, but in the sense of "contain" or "cover" or "embrace."

²¹ Umfassen stands in contrast to the Umsicht that Heidegger takes as basic to action.

²² Keep in mind that we are focusing on conversion-type symptoms, what Freud called hysterical symptoms, leaving open the question of whether this scheme applies to yet other classes.

²³ For a recent discussion of conversion that has been of help in our study see Casey 1998.

²⁴ See Schüffel 2007, section 3.4.

²⁵ See Freud 1900/ 1972 for these notions.

²⁶ Breuer & Freud 1957, 7. Italics dropped. After Casey 1998, 217.

²⁷ If time allowed we would go on to speak about the way that the Oedipal story is situated between context and background. It must be located there because it is not just needs or desire of the child but the actions of the child that meet the culture of the parents, shaped by language (context). Background and context always work together in the "history" of illness. But here I am after the transference of sense between father and father-in-law

²⁸ As the dominant temporal dimension shifts from the past (memory) to the future (anticipation), spatialization achieves a certain priority. I will take this up in a forthcoming book, *The Spatiality of Consciousness*.

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