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Fabricated bodies:

A model for the somatic false self

PETER GOLDBERG
909 Ordway Avenue, Albany, CA 94706, USA — plgoldberg@excite.com

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This paper draws attention to a particular use of the body, one in which basic psychical security is achieved through a radical detachment from body vitality, necessitating the creation of a coercive regime of psychosomatic control and auto-stimulation for purposes of artificial enlivenment of the self. When the personality is organized predominantly along the lines of a systematic dissociation (and then pseudo-integration) of the mental and the somatic realms of psychical life, the psyche-soma undergoes a far-reaching transmutation: the desiring body is eclipsed and replaced with a fabricated body. Clinical observation of this set-up is obscured by the fact that, in these cases, the body is deployed in a 'realistic' manner, rather than in a recognizably symptomatic way. It is, indeed, the hallmark of a successful somatic false-self organization that the colonization of the body is disguised as natural, ego-syntonic and compatible with social norms. The treatment approach requires a broadening of analytic attention to apprehend shifts in states of consciousness and psychophysical cues.

Keywords: body, psychosomatic dissociation, hypnoid states, somatic false self, pseudo-vitality, dissociation, false self

I wish to draw attention to a specific type of defensive use of the body, one that serves the function of a somatic false self. Always well disguised and therefore peculiarly difficult to recognize, the effects are nevertheless far reaching. The desiring body is transformed into a defensive body, in which somatic phenomena are deployed first and foremost to secure an unassailable psychical refuge. The clinical picture is one in which libidinal vitality is replaced by tactics of pseudo-aliveness: somatic phenomena are latched on to so as to achieve an omnipotent sense of psychical containment.

Activating the psyche-soma—getting the body to react on cue in order to contrive a sense of predictable pseudo-vitality—is the key to the false-self deployment of the body. The deciding factor in these cases is the degree to which, in order to secure absolute and impermeable boundaries for the self, a culture of habitual auto-stimulation of the sensorium becomes so ingrained that it leads to a change in the psychical quality of the body itself: it becomes a fabricated body, in so far as the natural impulsive rhythms of the libidinal body have had to be subdued and then brought under total control, to be replaced by coerced and regimented forms of body-aliveness.

This colonization of the body is meant to create a psychical buffer for the individual against perceived external sources of dangerous impingement, but also

against internalized libidinal objects, which are themselves felt to threaten upheaval, excess or chaos. Where it is successful, this strategy affords a sense of sanity through mastery of the psychical interior, and thoroughly orients the self toward social adaptation. But subduing the impulsive body and the internal libidinal objects has a crippling effect: the self, cut off from vital sources of eros, is left constantly struggling under a threatening cloud of encroaching deadness and meaninglessness. This means that, in order to avoid devitalization and even catastrophic depersonalization, these patients must exploit their own body-aliveness by means of eliciting tension or pain or excitement in the sensorium and the musculature. Such artificial activation of body vitality is, however, inimical to any real satisfaction of appetite or need, and therefore is always accompanied by an underlying sense of futility and exhaustion.

Dislocation from body-aliveness means that passion tends toward atrophy, and along with it all imaginative connection to unconscious life is gradually lost. Yet, because these patients rely so much on normal social adaptation, it is necessary to disguise the underlying futility and threat of deadness. Economic and cultural conditions furnish a variety of masks that may be adopted to provide legitimacy for the fabrication of a well-regulated false body, and currently this appears most often to take place under the auspices of the ideology of health, self-improvement and self-determination.

When somatic experience is under coercive control, we come up against insincere passion, artificial emotion and a contrived imagination. Behind the pseudo-normal persona of such patients we will find a cruel paradox: a convincing sense of authentic body-aliveness is sought in vain, and yet is traumatizing when it comes close to being found. All that remains possible is a highly controlled life of pseudo-vitality.

I want to document this particular phenomenon, namely the way in which the desiring body, having been deposed from its position as the source of eros, is replaced by the fabricated body, in which sensations and feelings are coercively activated in predictable ways (through the introduction of stimulants, ritual behaviors, compulsive activities, auto-stimulation, auto-hypnosis). I also wish to highlight its often elusive clinical presentation, which confronts our method with a number of peculiar problems, not the least of which is the absence of genuine associative processes linking the thinking self to the unconscious and the body.

Overadaptation of the ego and falsification of the body

Are we in a position to trace the etiology of this type of defensive fabrication of a somatic false self? At the very least, we can conceive of a juncture at which a newly competent ego, already strongly oriented to the external world but still dependent on maternal functions, is confronted with an overwhelming and systematic threat to its existence. It should be emphasized that, in this phase of concrete dependency, a failure of the holding environment amounts to a threat of annihilation. Faced with imminent collapse of the framework of psychical life, the ego has no choice but to shift focus and redeploy its talents and capacities, thus relinquishing its essentially experimental orientation (imaginative play) and its fundamental function of exploring inner and outer worlds (emotional growth). Now, instead, the ego must

preoccupy itself with a new and urgent task of rescuing the self from annihilation by omnipotently fabricating a reliable framework for the self, from the outside in, as it were.[1]

The new task that now preoccupies the ego is twofold: through great expenditure of attention, the ego must attain mastery over the workings of the outside world, so that the surface of the self can be adapted to external reality as expertly as possible; and, at the same time, the ego must remain on guard at all times to repudiate—and then dominate and control—the entire range of expression of the internal world of personal desire.

The necessity of emergency reconstruction of a psychical holding environment leaves a fateful mark on the ego: its function is henceforth perverted, in so far as skills (attention, perceptual discrimination, memory, reality sense, judgment) that were meant for the discovery of suitable new libidinal objects and activities (Freud, 1923) are now doomed to be used predominantly for another purpose, namely control, mastery and vigilance over libidinal objects in all its forms (both external and internal). The body's wishful vigor can no longer be accepted as a source of aliveness, and is experienced instead as a source of traumatic disruption, threatening to undermine or explode the containment of the self. Winnicott described the emergence of the intellectual false self as a refuge from the disruptions of the desiring body (1960). I wish to extend this conception to include the ways in which the body itself can be deployed to control the disruptive and even traumatizing potential of the volatile body-libido. Just as omniscience secures an unshakable framework for the self by contriving a sovereign position of control for the mind, we find something quite comparable in the fabrication of an unassailable false body through omnipotent activation of somatic states. This transmutation of the flexible wishful body into a rigid fortification for the self is achieved by bringing the entire sphere of wishes under control. This amounts to a colonization of the body's impulsive nature, and hence of unconscious desire, for the purposes of psychical self-preservation.

Clinical manifestation of false bodies: The problem of pseudo-normality

How does this false body become manifest in the clinical situation? In contrast to the more familiar outbreaks of somatic symptoms and of somatic delusions in the neuroses and in psychotic illness, this omnipotent use of the body typically takes place unnoticed. Indeed, this type of defensive organization relies for its effectiveness on its approximation to normality.

Illustration: Ms Q

Ms Q was a communicative patient who presented material that lent itself readily to a conventional exploration of defense and transference. She had already undergone one analysis, but felt unaffected by it, and she entered into the new analytic treatment

[1] Where the ego is less competent, the same systematic threat will be met by a different defensive strategy, for example, by phantasmatic fragmenting or splitting of the self, as described by Klein (1946), which, if extreme, leads to evacuation of functions of the mind, and hence delusion, as described by Bion (1962), or the autistic dismantling of the psychological sense of self (Meltzer et al., 1976).

without much question or pause. Her discourse was one of incessant longings for pleasure, intimacy, engagement and the accompanying themes of jealousy, rivalry, social and moral obstacles to fulfillment of wishes, and so on. My attention was drawn to several sources of data that gradually led me to expand the parameters of the analytic investigation. First, the patient's material seemed a little too amenable to transferential analysis and interpretation, almost inviting it. Second, while the material was consistently intellectually engaging, anxiety and discomfort in the countertransference were notably absent. A dimension of bodily based emotional impact was missing. Third, I became aware of a peculiar pattern of physical response in the patient: normally a physically stiff and constrained person, Ms Q would begin almost imperceptibly to twitch or rock back and forth the moment that I spoke. In light of these observations, a question began to take shape: Was this apparently engaged and engaging patient actually an unreachable emotional recluse, retreating unnoticed into a barely visible, twitching kinesthetic capsule?

These observations had the cumulative effect of altering my analytic awareness: my clinical attention broadened and adjusted to a different wavelength, hovering somewhere near the edge of verbal meanings, more awake to qualities of aliveness and pseudo-aliveness, and to shifts in state of consciousness and bodily states. This also meant not being drawn too narrowly into the patient's rendition of her emotional conflicts, jealousies, wishes etc. At this point, a new interpretation began to coalesce, namely that the patient's discourse, while appearing to express conflicts over desire, actually expressed a profound futility over the very possibility of desire. This new idea, which emerged along with the alteration in analytic consciousness that had taken place over the course of several sessions, elicited an entirely unforeseen reaction: Ms Q now despondently reported the appearance of binge eating ('to stop the hollow crazy hunger'). Suddenly, a palpable disturbance had broken out in the clinical field: she felt incipient panic, and then persecutory anxiety and paranoid mistrust. In this newly turbulent context, Ms Q revealed in passing, in a matter-of-fact way, the details of an elaborately constructed, high-maintenance somatic false self, one that had been in place more or less unaltered throughout her adult years, but had nevertheless remained heretofore invisible to the analytic eye. The patient's omnipotent body, I learned to my great surprise, operated according to the following principles:

- A daily regime of physical exercise, morning and evening, to the point of exhaustion.
- Food consumption on a strict schedule of calorie dosage at fixed times of the day.
- An extended daily ritual of skin-care activities, with extensive application of creams and ointments.
- A strict laxative-controlled regimentation of bowel movements.

This compulsive, ritualized activation of the false body was remarkably effective in providing a viable framework for successful everyday life, counteracting the ever-present threat of psychic devitalization and deadness, and masking the effects of

grave interpersonal difficulties (by allowing her to avoid any substantial emotional exchange with others).

It now seemed reasonable to suppose that Ms Q's capacity to enter so readily into analytic exchanges and arrangements was, in large measure, an overadaptation to the analytic method, and to the analyst's therapeutic (as well as personal) hopes and wishes—wishes that the patient frequently seemed able to discern with more alacrity than could the analyst.

Regarding this material, the following points seem germane to the clinical presentation of this and other cases of somatic false-self illness:

a) One is often taken by surprise, in otherwise high-functioning cases, by the sudden appearance of psychotic anxiety and near-breakdown brought on by a moderate physical illness or injury. This is due to the utter reliance on the smooth functioning of the false body, disruption of which literally splinters the psychical framework. Thus, Ms Q revealed that she had previously experienced transient episodes of binge eating, panic and paranoia when—due to physical injury or being on vacation—she was unable to complete the combination of activities and rituals necessary for activation of the required somatic states.

b) Such patients have difficulty differentiating authentic body vitality from the pseudo-vitality that comes from regimented stimulation of the soma. For this reason, the insistent appearance of themes of desire and longing in a patient's discourse might actually mask the fact that access to the desiring body has been completely lost. Recognizing this confusion (of pseudo-vitality with actual body-aliveness) is crucial and will allow for clarification of the true dilemma, which is that the pursuit of one or another object of desire is fruitless. At heart, these patients desire the experience of desire, which has been lost to them in the establishment of a false body.

c) The operation of the somatic false self pre-empts the possibility of the development of any actual bodily based appetite. Evolving a personal idiom of appetites is of great importance for the possibility of any degree of satisfaction in life; whereas the narrow demands of a specific need can be met by momentary or immediate satiation, developing something like an appetite transforms the nature of satisfaction into something more far reaching (Boris, 1994). Appetite entails the linking of a need with a broad array of subjective experiences and memories, and, through aesthetics, to a range of possibilities for meaning and fulfillment represented by cultural and symbolic objects in the world. In this way, the developing appetite greatly enhances the potential for more complete satisfactions (body, mind and soul). However, this process of elaboration of needs toward wish and appetite is forestalled, and even reversed, wherever the body has begun to be colonized for false-self purposes. The constant barrage of defensive stimulation of the soma makes it impossible for body and mind to be sufficiently at rest, so that a wish (impulse, memory, relational need) might actually be experienced. This inability to discover an authentic source of vitality (what Winnicott referred to as the 'spontaneous gesture') was all too evident in the case of Ms Q: her unrelenting preoccupation with somatic regulation and auto-stimulation pre-empted any useful experience of actually being hungry—for

food, for touch, for free movement of the body, even for movement of the bowels. This illustrates a characteristic and poignant irony: for all the incessant catering to bodily needs, these patients are constantly and woefully deprived of the opportunity of experiencing authentic desire based in body-vitality. It is further characteristic of these cases that, when one is unable to develop an appetite, all that is left is the urgency of stanching the need. This naturally perpetuates a sense of pervasive helplessness and inadequacy in the patient, and often leads to the appearance of an addiction to instant gratification.

d) It is a remarkable feature of the somatic false self that it can persist unnoticed, even in the clinical situation. I will return to a consideration of this problem below. Even when it dominates psychical life, the false body tends toward obscurity. It will not manifest itself in the shape of a conflict over guilt, pleasure, rivalry etc. It is meant to operate smoothly, not call attention to itself. The fact that so many of the methods employed in maintaining a false body find social, economic and ideological support, and are even promoted as healthy cultural ideals, adds greatly to the normalization and effective disguise of this kind of pathological defensive organization. Of all the compulsive activities and rituals employed by Ms Q, only the laxative use occasionally gave her reason to wonder if there was something amiss. All else—the eating and exercise fanaticism, the compulsive self-grooming—conveniently matched high lifestyle ideals.

e) Because it seems like the natural order of things, the activation and maintenance of the false body is not so much kept secret as merely taken for granted; it is just the way the patient lives. Therapeutic unmasking of the existence and function of the false body opens the patient up to the return of deep anxieties concerning the viability of the self. As illustrated by Ms Q, the discovery of the false body (which threatens its inscrutable status and power) will typically result in the appearance of severe anxiety, defensive regression and primitive defenses. Over the course of treatment, once omnipotent somatization is relinquished in favor of a more flexible and robust form of containment, the patient will have to reckon with a newfound vulnerability, and will have to work through the gamut of mournful reactions to having lived within the confines of a false body. Perhaps foremost is shame; in Ms Q's case, as the false-self system gradually gave way to the presence of a live, desiring body, she developed a sense of regret, sadness, guilt and depression about a lifetime of omnipotent use of her body.

Clinical obscurity of the phenomenon

Somatic false-self illness, like other narcissistic disorders that involve omnipotent self-formations, can place severe difficulties in the path of the clinician. The often extraordinary obscurity of its presentation throws up a particular challenge in finding a suitable clinical approach. The false body does not flaunt itself. Not only is there a marked absence of delusional quality in the illness, but also, more generally, a paucity of phantasmatic elaboration. Instead, the somatic false self relies on a 'realistic' apprehension—if not an accurate perception—of the somatic phenomenon being activated. What counts here is not the imaginary, flamboyant or

dramatic distortion of a body part that we expect to find in hysteria and delusional illnesses or in hypochondria, but the apparently prosaic functionality of the somatic event—pleasurable and painful muscle tension, head and stomach aches, skin eroticism, all attributable to the demands of everyday life. While this terrain of constant somatic arousal is to some degree invariably unpleasant, it nevertheless remains oddly ego-syntonic: rather like the more successful totalitarian forms of government, these rigid and coercive somatic regimes are inevitably dressed up in such a way as to appear natural and inevitable, and are provided with a conventional social framework that justifies their persistence. The aches and pains of the body are not viewed as anomalies, to be given up as would symptoms of an illness; instead, the pains and tensions of the false body are rationalized as the normal hallmarks of one's way of life.

If somatic false-self illness involves the masking of the way the body is used, it is equally characteristic that these patients have developed a facility for establishing patterns of behavior that induce mildly druglike states before every analytic session. This may be achieved, for example, by ritual consumption of foodstuffs (coffee and donuts particularly frequently); by trance-inducing activities, including subtly auto-hypnotic activities like blasting loud music in the car; or by activating bodily tension, for instance through strenuous physical activity or arranging to run late for sessions. Management of the false body between sessions is carried out in myriad ways; contemporary lifestyles make it commonplace to find the false body attended to by an array of body therapists (chiropractic, osteopathic, yoga, massage, meditative, personal training etc.). But it is in the sessions themselves that the false body is often most difficult to apprehend, because patients rarely think to report what are long-standing, unarticulated patterns of habitual auto-stimulation and mind–body control. Additional difficulty in apprehending these phenomena arises from the disorienting impact of the patient's deployment of hypnoid techniques upon the analyst's own perceptions and states of mind.

Because of this tendency to appear clothed in rationalizations, in the guise of normality and sanctioned by social convention, somatic false-self illness is inherently difficult to recognize for what it is. This may account also for its obscurity in psychoanalytic clinical theory.[2] But why is it that the false body tends to disguise itself as realistic and normal? Why is the patient constrained to be so pragmatic about what particular parts of the soma can be made to do? If one is seeking a discreet somatic locale for a symptom, the ordinary body certainly provides a range of possibilities to choose from: the skin can readily become itchy or flaky, the joints stiff, the muscles weak or tight, the neck and head tense and aching. Ears are prone to ring; eyes will trace visual patterns. But why is there such an avoidance of the imagination in these cases, such an absence of phantasmatic elaboration or of delusional incursion?

[2]Valuable insight into pathological normality comes from McDougall's (1985) conception of the 'normopath', and Bollas's idea of the 'normotic' (1987). The false self constructed in the mind has been described not only by Winnicott (1960), and in a different way by Hélène Deutsch (1942), but also by many subsequent commentators (see Corrigan and Gordon's 1994 collection on the 'mind-object'). However, of the false use of the body itself, very little has been theorized.

Compare this blending-in tendency to the exhibitionism of neurotic symptoms. A fundamental feature of somatic symptoms as deployed in the neuroses is that they must more or less stand out, if not to others then certainly to the sufferer himself. For, unless distinctly noticeable—and quite consciously so—the symptom will not fulfill its essential purpose, namely that of representing elements of psychical conflict, while at the same time disguising the unconscious significance of the conflicted wishes. If a painful swelling is meant to express an unconscious sexual wish, as well as the punitive rejection of that wish, one had better notice that swelling, or else the wish might turn up in a more revealing or less convenient form, perhaps in a dream or in an unwelcome acting out. The symptom must obtrude (without revealing too much) in order to do its work.

We are familiar also with the idiosyncratic—not to say bizarre—types of containment that can be obtained through somatic delusions. In seeking a framework that will cohere a fragile psyche, nothing matches the immediate power of hallucination. But this, of course, is a tragic solution: the delusional organization is both inflexible and unstable, and is inherently at odds with the social organization of consciousness. Delusional somatic events are obtrusive in a far more disturbing way than in the neuroses, for here an unthinkable aspect of mind has entirely split off and lodged somewhere in the soma, resulting typically in a sense of alien possession or intrusion in that part of the body. Delusions about the body frequently remain a well-kept and even paranoid secret, out of the sight of others (in contrast to hysterical or melancholic somatizations, for example, which are usually telegraphed as an insistent communication of distress); but within the idiosyncratic confines of the psychotic system, somatic delusions loom large as dystonic and disturbing presences. Hallucinating a gaping hole in the bottom part of the body, or hallucinating the presence of a sinister alien device installed, perhaps, during routine surgery, ensures that these defective processes are definitely located somewhere other than in psychic reality. If the only way to protect the psyche is by keeping evacuated bits of mind lodged in the body, unobtrusive somatic events will not do; bizarre and extreme somatic creations are far more convincing.

The somatic false self, on the other hand, does not announce itself in symptomatic or ego-dystonic form. Its purpose, after all, is to secure a bulwark against dissension and dissolution within the personality; consequently, unlike these other psychosomatic phenomena, where the body acts up in order to express one or another aspect of a psychical conflict or else to evacuate something from the mind, the somatic false self is meant to function smoothly, without attracting attention. In this way it mimics the facilitating functions of the unobtrusive holding environment: in the security of her embrace, we do not have to notice or concern ourselves with mother's arms, but can delight in the light of her countenance. The false body carries in its structure something of this illusion of safety, of the security of a parent's strong, unfailing physical hold, of an omnipotent physical presence—except that, in this case, the painful irony is that this enabling physical presence must perpetually be fabricated anew, requiring never-ending stimulation of the body to emulate the function of the maternal enveloping embrace, thus resurrecting the lost environmental provision.

A further important distinction: whereas somatic delusions—and to a lesser extent symptomatic compromise formations—always entail a degree of impairment of social functioning, the false-self organization allows the individual to retain his or her designated social identity, and maintain connection to social modes of thinking and coherence, despite the fact that the false body affects a radical emotional withdrawal from the world.

In summary, in so far as the soma is being used specifically for the purposes of providing an unassailable container for the self (as opposed to other uses, such as symptomatic displacement or delusional evacuation of psychical conflict), it is precisely the actual, predictable physical functions of the soma that are of value.

Questions of clinical method

Approaching the phenomenon of psychosomatic dissociation

I have described how, in these instances of the omnipotent fabrication of the body container, somatization occurs as a literal concrete activation of the sensorium, non-specifically invested with meaning. Used in this way, the soma is brought into compliance with the dictates of a narcissistic organization designed to control the internal world: the entire disruptive potential of unconscious desire must be mastered and turned to the purposes of psychical survival. But what are the implications of this for clinical method? Any thorough discussion of questions of technique will take us far beyond the limits of this paper; a few scattered comments will therefore have to suffice.

The standard framework of psychoanalytic technique affords the patient an opportunity to relinquish conventional states of mind and body, so that we might glimpse the emergence of troublesome wishes, viewed through layers of disguise and defense. But the false body is inured to this clinical approach. Perpetually under the duress of defensive activation, the overstimulated soma is never at rest long enough for an impulse or an unconscious wish to show up in a noticeable way in psychological space, so as to allow a reaction to unfold in the personality (activation of representational processes, opening up possibilities for action and gratification). If the effective function of the false body is to pre-empt and appropriate the wishful impulsivity of the self, then we can hope to find no genuine wish emerging from its precincts. We are thus deprived of a cornerstone of our method, namely the availability of associations (derivatives of unconscious desire) for analysis and interpretation.

In seeking a clinical approach to this false body that cannot wish, it is therefore preferable not to stay too narrowly focused on the derivatives of unconscious wishes. I have found it more fruitful to head in the direction of broadening one's analytic attention in such a way as to possibly capture more of what goes on closer to the psychology of the body. The presence of the false body is usually more readily grasped by means of perceptual clues and observations of states of mind and body than it is through decoding the patient's verbal discourse, dreams or transference enactments. Already, in the case of Ms Q, I have hinted at the importance of shifts in bodily, perceptual and attention states, all of which are

pertinent to the problem of apprehending the workings of an omnipotent system based in the body. Shifts in bodily state (stillness, shiftiness, breathing patterns), even of the subtlest kind, warrant attention, as do shifts in consciousness (degree of wakefulness, distractedness).

How is it that the analyst's consciousness might expand to capture data pertaining to the false body and the alive body? For a number of reasons, there can be no set technique designed to accomplish a therapeutic shift in analytic attention; rather, it is accomplished through surrendering oneself as much as possible to an immediate observation of what is going on, as well as through trial and error. I have frequently found it fruitful, in these cases, to refrain, temporarily but deliberately, from focusing attention on the patient's associational processes, transferences and affective communications. This kind of experimentation with altered states of attention may encourage increased intuition of pre-verbal states, so that gradually one may begin to discern the patterns of a more somatically based type of psychical experience.[3] Here, emerging from a primary body–mind matrix, we encounter pictographic proto-thoughts and sensate meanings, 'primitive' thought elements that have not yet organized into phantasies, representations or dream thoughts (Bion, 1962), and hence have not as yet been appropriated for false-self usage. These temporary periodic reorientations of analytic attention may place us somewhat closer to the possibility of apprehending signs of dispersed or lost elements of psychical vitality; and then, in turn, allow us to return to the associational realm of words and symbolic meanings with a newfound sense of the dimension of body-aliveness—and false aliveness—in the clinical encounter.

Need for a theory of psychosomatic dissociation

It is important to recognize that the false-self organization of the body is premised upon a type of defensive organization that revolves around psychosomatic dissociation. In this set-up, anxiety and danger are dealt with primarily by means of detachment of mind from psyche-soma (Winnicott, 1949). I have suggested that this strategy of psychosomatic dissociation results not only in an omniscient mind, as Winnicott described, but also in an omnipotent false body. Of particular clinical significance is the fact that dissociative organizations are not primarily regulated and maintained phantasmatically, nor by compromise formations, nor indeed by means of projective identifications or fusional attachments to objects. Rather, systematic dissociation is regulated by means of alterations of states of consciousness, through the use of hypnoid techniques. I have described 'successful' dissociative organizations (Goldberg, 1995) as those defensive systems in which systematic detachment from bodily vitality is

[3]By advocating the relinquishment of memory and desire in the analyst, Bion (1970) pointed the way to a disciplined use of the analyst's consciousness in the service of analytic enquiry. But it was Milner (1960) who most explicitly brought the analyst's bodily based awareness into the field of analytic technique. She emphasized the importance of the natural oscillation between differentiated mental states and undifferentiated (fusional) states, and she explored the clinical efficacy of the analyst's heightened awareness and experimentation with states of attention, thereby bringing bodily states more fully into the clinical encounter.

masked by body-control techniques (auto-stimulation, auto-suggestion) that serve to maintain a regime of pseudo-vitality, and by consciousness-altering techniques (distraction, auto-hypnosis) that serve to shift the focus of attention so as to regulate severe anxiety and threats to psychic stability. These hypnoid techniques, which depend upon alterations in attention and consciousness, operate quite differently from the defensive techniques that we encounter in both neurotic and psychotic organizations, which in one way or another rely for their effectiveness on the power of phantasy or mental representations.[4]

Characteristic of the structure of 'successful' dissociation is a subtle form of semi-detached consciousness, one that escapes notice because it does not present itself as conspicuously removed or trancelike, as we find in poorly organized and unstable dissociated personalities. This semi-detached state, when effective, creates a disguise that masks an emotional withdrawal behind impenetrable somatic (and/or intellectual) fortress walls; yet all the while the ego remains successfully adapted and in busy contact with the external world. In the clinical encounter, this often means a patient who is perceptually and interpersonally engaged, in some cases hyper-vigilant, in others hyper-related, but always simultaneously withdrawn beyond reach in terms of deeply personal emotion and vitality. Frequently this produces the ironic—or comical—situation of the patient being superficially alert and engaged, while the analyst, being shut out from emotional contact, is distracted and gets lost in a trance of one kind or another.

For all of these reasons, I suggest that the clinical approach fitting to the treatment of the false body requires an experimental approach by the analyst in order to discover states of consciousness that can enliven the contact with authentic body-aliveness, and hence with unconscious psychical qualities. It entails not so much the unearthing of—or creation of—meanings that have found mute or vexed expression in somatic symptoms, but involves therapeutic regression to a bodily state of libidinal aliveness, which includes periodic entry into partly undifferentiated states in the transference (see Milner, 1969).

Intellectual and somatic false selves

It should be emphasized that, theoretically speaking, the function of a false self is to fortify the framework of the psyche, to prevent not only impingement from outside, but also impingement from inside, from the id, from desire and impulse and primitivity. This is easy to grasp in the case of the intellectual false self, who distances his mature (or pseudo-mature) mental functions from his bodily based experience: despite being accomplished in the outside world, he simply does not

[4]In a number of respects, the phenomenology of psychosomatic dissociation resembles that of the autistic processes, in so far as the latter also eschew phantasy-elaboration and representational thought, and operate on the terrain of sensory/somatic self-regulation. The difference lies in the quite opposite functional goals of the two defensive systems: the latter seeks to preserve an inviolable self in a world of separated psychical entities, while autistic defenses employ sensory experience to obliterate the sense of psychic separateness (see Meltzer et al., 1976). However, Tustin (1986), Rosenfeld (1986) and Ogden (1989) each give accounts of certain autistic phenomena that appear to conform closely to the picture I have given of the somatic false self.

know what is going on inside. But how can we imagine the soma serving a similar false-self function? Surely stirring up the bodily dimension of psychical experience must bring us closer to the realm of the instincts, of the emotions? Observation shows, however, that these individuals, who are so excessively wrapped up with bodily preoccupations, are nevertheless just as removed from discovering the sincere expression of their emotional and instinctual needs as are those individuals who take refuge in an intellectual citadel.[5] Are these patients who suffer psychosomatically, who rely so emphatically on the concreteness of their somatic organization (and who, as I have already noted, therefore invariably fail psychologically when physical illness or impairment occurs), any closer to being able to tolerate their own desire—or to appreciate the unfolding of a wish or the seeking of an object—than is the obsessional who lives in his head?

To the degree that somatization is put to the service of fabricating a false body, it invariably obstructs the evolution of learning about the world through the body; it pre-empts the ordinary way a body expresses itself, learns to find mental correlates, waits for an appropriate opportunity to link up with an object. It would seem that the false body, once established, cannot tolerate these ordinary developments, and instead sets itself up as a narcissistic bulwark against the passions unleashed whenever one discovers something new. Against the disruptive impact of a new encounter with the unconscious and the live body, the false body champions the certainty of old patterns of gratification. A further characteristic of the dominance of the false body is the artificiality of emotion that accompanies it.

Adapting the container by refabricating the false body

Mr P

There is a type of cooperative patient who is interested in analytic discoveries, and even quick to begin interacting, but who remains somehow unaffected by the analytic process. I was surprised to learn, in the case of one such patient, that his analytic sessions, all of which took place in the early morning, were preceded by his masturbating. This young man arrived for his sessions in a kind of somatic bath, his very quick mind on auto-pilot. Many interesting things were said, but nothing ever hit home and the analysis gathered no momentum. The picture changed when our meetings were rescheduled to later in the day, so that he would arrive directly from work. He now appeared nervous and out of sorts, his mind alarmingly jumbled. Threat of depersonalization and panic attacks hovered constantly; fleeting occurrences of out-of-body experiences pointed to the existence of dissociative defenses that I had not previously noticed. It was not long, however, before Mr P settled down into a newfound equilibrium, albeit one that had quite a different feel to it. Some of the elements of this new set-up included:

[5] It is worth noting the frequency with which both intellectual and somatic false-self organizations coexist. In some cases, it becomes possible to observe a pattern of moving defensively between mentalizing and somatizing. This oscillation is often obscured by the patient's strong tendency to activate trancelike altered states of consciousness.

- Fatigue arising from chronic sleep deprivation (Mr P now slept no more than a few hours a night).
- Lightheadedness consequent upon adoption of a radical vegetarian diet, resulting in minimal food consumption.
- Chewing of the inside of the mouth, leading to persistent sores.
- Exacerbation of tendon inflammation in the hands, associated with excessive computer keyboard use.

All of these elements, taken together, seemed to constitute evidence of a newly fabricated somatic refuge. Mr P accepted his newly fatigued and inflamed body with equanimity, even with relief. No longer troubled by acute dissociative and fragmentary reactions, Mr P seemed to have successfully reconstituted himself within the framework of a new false-body arrangement, and the analysis resumed its previous unrewarding course of superficial interactive engagement. Now, however, the make-up of the false body was more apparent, and my focus of attention shifted to the ways in which Mr P was able to activate a sensory cocoon to prevent even the smallest hint of psychical pain or incipient body hunger. Analysis of this false-self use of his body led once again to a phase of disequilibrium and momentary threats of fragmentation. And again, after a disturbing period of fairly acute anxiety, including fears of crazy things inside and dangerous persecution from without, Mr P unexpectedly calmed down, resuming the now familiar partially removed way of busying himself in the sessions, with an even more encapsulated cast to it. This stifling regime of pseudo-normality was eventually interrupted after I became aware of a discoloration on the wall beside the couch, and then noticed that Mr P had developed a habit of rubbing the wall as I spoke to him; in this way he conjured up a sensory barrier that kept me—and his disturbing internal objects—at bay. Immediately upon having his attention drawn to his habit of rubbing the wall, he began displaying signs of acute anxiety and paranoia. This time he settled down rather more quickly, and now quite independently he noticed another set of bodily and mental constructions that had emerged, including a new habit of quietly humming tunes in his head during the sessions.

Multiple uses of the body

It should be emphasized that the static use of the body as a false-self organization does not exclude other possible uses of the body. It is probably the case that the body is always serving more than one function simultaneously, and that these different functions might even be at odds with each other. A male patient, apparently the picture of temperate emotional stability but unable to engage in anything other than the most impersonal and rote sexual encounter, unexpectedly became very agitated and quite disorganized soon after becoming sexually interested in a woman he had come to like very much. This sudden erotic hunger evidently was fueled by an increased object love kindled transferentially in the analysis and then subject to repression. The severity of the disturbance, however, was not primarily due to guilt or anxiety over the emergence of sexual interest in the analyst or the potential girlfriend, but due to the fact that the outbreak of

genital longing in the patient interfered with a long-standing pattern of auto-erotic regulation of his body: the impulsion to use his genital to express a wish, to unleash libidinal desire, ran counter to the essentially anti-libidinal false-self use of his body, which took the form of regimented, twice-daily doses of a formulaic and joyless masturbation. This attractive, lonely man, who spent his life longing for a seduction into sexual and emotional intimacy, was forced to reject each and every willing partner because of the imperative of maintaining psychical equilibrium through omnipotent regulation of a false body.

Any somatic event may potentially be used in any number of ways. A physical illness may elicit despair, or just as readily bring a sense of comfort and reassurance. The suffering of a degree of organ pain can serve as a signifier of an encounter with a loved one, or as harbinger of abandonment and lonely isolation. Eczema may mark the attempt to recoup a dissolving psychical boundary, or it may concretize, on the skin's surface, a primitive fusion with the mother's body, or it may do both. We cannot decide at first glance how to interpret this drama of what Anzieu (1989) called the skin ego. Similarly, we are not in a position peremptorily to decide the psychological status of a body that has been pierced in 100 places, or has been entirely covered with tattoos, or surgically transformed. Is the refashioning of a body through extreme exercise a realization of vital body eroticism? Or is it—quite the opposite—a regime designed to repudiate libido and colonize body-aliveness through ritual stimulation and control? Once we notice that these contradictory motives might coexist side-by-side, we are forced to recognize that judgments on these matters cannot be made on the basis of observable patterns of behavior. Rather, grasping the severity of a somatic false-self illness will depend upon an extensive analytic (including countertransferential) evaluation of the individual's libidinal and emotional vitality.

Social legitimation of the false body: Invisibility of the illness

On the level of generalizations, we can say that, at any given time, certain communal and cultural materials will be psychologically available for fabrication of false bodies. These will depend upon shifting social and economic forces as well as cultural practices and sanctions concerning the body. While eczema may in some cases serve a psychical boundary function, it is unlikely to serve the unobtrusive, 'normalized' purposes of the somatic false self. This is not only because, when serious, it is a potentially dangerous and agonizing illness, but also because it has no legitimizing communal status, and cannot easily be made ego-syntonic. Less extreme forms of anorexia, on the other hand, traverse the line between an illness and a legitimized practice normalized within a subculture. As such, over time its practices become increasingly ego-syntonic, and hence available for false-self use. Body scarring has only recently migrated from a symptom of mental illness to its new status as a legitimized subculture practice amongst suburban youth. Activities suitable to the fabrication of false bodies are those that can also be carried out without raising widespread suspicion of psychiatric disturbance. This cloak of legitimacy ensures the successful perpetuation of false-self illness, making it unlikely that it will be recognized as an illness.[6] Mainstream fanaticism (health, exercise, food) proves

especially effective in representing somatic false-self formations as if they are the very antithesis of psychiatric illness: indeed, the bodily sufferings of the neurotic or psychosomatic patient, which seem out of control and inexplicable, stand in contrast to the preoccupations of the somatic false self, which insists that the body can be known, controlled and 'understood'.

False bodies and illegitimate organic illnesses

While fabricated bodies are most frequently clothed in ideological rationales of health fanaticism and self-improvement, it is not uncommon for the somatic false self to insinuate itself in another guise, in this instance under the auspices of an organic illness. Certain long-standing organic illnesses—typically 'new' or hard-to-diagnose maladies that may elicit medical skepticism—seem to lend themselves particularly well to the purposes of maintaining a false body. But why should this be the case? It is often tempting to imagine that these illnesses lack an organic basis and are merely psychosomatic creations. This assumption, however, is difficult to substantiate and may be inaccurate. As I have pointed out, hysterical, hypochondriacal and delusional formations tend to rely on dramatic or imaginary bodily symptoms. On the other hand, actual—rather than exotic or intrusive—bodily aches and pains seem to better fit the requirements of the somatic false self. What makes a real and chronic physical illness specifically amenable to false-self usage may be not its intractability, but its diagnostic obscurity. Chronic fatigue conditions and the like, as well as organic conditions that go undiagnosed for a long time, lack symbolic recognition (that is, medical legitimacy): the symptoms cannot be authorized in the mind of the patient.[7] The very fact that the organic physical symptoms persist, however, creates a situation of ever-present physical discomfort, a pattern of pain that, due to its chronicity, becomes an enveloping psychophysical presence. Here—in the existence of chronic physical distress that nevertheless remains unnamed—lies the potential for false-self usage. Unlike 'elective' somatic constructions (for example, food and exercise compulsions), symptoms of these unrecognized (that is, unsymbolized) illnesses will be experienced dystonically, yet will remain peculiarly unreal, unlocatable, and thus—even though there exists an organic illness—will function in the mind like a false-self creation.

Conclusion

In recognizing the existence of the intellectual false self, Winnicott outlined the way in which the devastating effects of traumatic impingement may be ameliorated by means of the ego's precocious ability to adapt to external reality, while systematically dissociating itself from the body-based, wishful level of psychical life. I have attempted

[6] It has been brought to my attention that my description of the social legitimation of the somatic false self closely resembles certain ideas proposed by writers of the French psychosomatic school in the 1970s, for example, Marty's (1980) conception of the 'legalized ego' found in psychosomatic patients.

[7] A subjective experience that remains symbolically unrecognized persists as part of the Real (Lacan, 1977), i.e. something that disturbingly exists but cannot be signified, and thus cannot be transformed through thinking processes (Bion, 1963).

to extend this conception to describe the phenomenon of an omnipotent bodily refuge, a somatic false self that usurps the role of the alive, desiring body, appropriating its vitality for the purposes of fabricating a reliably on-call, controllable false body. The goal of fabricating a false body would seem to be the installation of an infallible body container for the psyche, a bastion designed not only to protect against impingement from outside, but also above all to forestall the threat of depersonalization arising from the divorce from the vital interior of the self.

False-self organizations arise in reaction to a specific failure of internalization. It is the environmental ('holding' or 'selfobject') functions of the mother that are inadequately internalized, thus requiring the child to construct in their place a self-made set of functions. Where a functional framework can be constructed 'realistically' (thanks to precocious ego capacities, and especially a talent for psychosomatic dissociation and social adaptation), the more drastic delusional solution can be postponed, perhaps indefinitely, and a pseudo-normal life secured. Under these circumstances, the ego no longer serves its evolutionary function of finding appropriate objects and conditions for the fulfillment of organic somato-psychic needs, but now envisions survival only in terms of controlling the disruptive potential of libido. The body must be colonized for the purposes of attaining hegemony over emotional turbulence and desire. Omnipotence is enhanced under this regime by the ability to arouse the soma in a realistic and socially acceptable fashion, providing a reliable physical envelope to provide the self, unfailingly, with a fortress against dissolution.

The fabricated body, when deployed extensively as a dimension of pathological narcissism, produces futility, resignation and blank depression. This is its principal irony: that a regime relying so exclusively on stimulating the body should so completely obstruct the experience of vitality within the self. There results a vicious cycle of chronic depletion and compulsory auto-stimulation: the subject is left with no choice but to continue depending on the false-body regime and its coercive strategies of awakening the self from its near-deadness. Yet, for all of this, the false body and its strategies remain obscure, even to the clinical eye, because of the inherent pseudo-normalizing function built into this type of illness. In contrast to phantasmatic recreation of bodily experience in hysteria and delusional illness, a successful false self is founded upon reliable activation of actual body processes, and these patients will commonly invent a private science of their bodily processes. The entire process of dissociation from libidinal vitality, and the accompanying omnipotent activation of the sensorium and musculature, is carried out under the auspices of subtly altered states of consciousness, and disguised by legitimizing ideologies. Currently, the reigning ideologies of improved health and mastery of the self provide ideal discourses for the camouflaging of the somatic false self. Indeed, the proliferation of body fetishism in our culture would appear to provide the false body with innovative opportunities to remain unobtrusive, thus obscuring the workings of psychosomatic dissociation in a cloak of pseudo-normality. Certainly, the clinical picture remains opaque, and we should not expect the false body to be brought deliberately for treatment; rather, it will have to be discovered first in the clinical setting before it can receive therapeutic attention. The false self strives

to present itself not as a sick body, but as functional, running very smoothly, like clockwork, albeit requiring a lot of maintenance. Behind this facade we find a hypo-manically controlled, incessantly stimulated, emotionally artificial body, incapable of relaxation and authentic libidinal vitality.

Since somatic false-self functions are maintained and regulated by means of specific techniques—auto-hypnosis, distraction, auto-stimulation, auto-suggestion—all of which operate as attention-shifting devices, unearthing the structure of the somatic false self requires rather particular clinical attention to these mechanisms. It is useful to broaden our analytic attention in an attempt to capture the peculiar ways in which omnipotent body states are activated and used in the clinical situation. This entails making observations of a range of phenomena that usually lie beyond our analytic focus of attention, including subtle shifts in bodily and mental states.

Translations of summary

Fabrizierte Körper: Ein Modell für das somatische falsche Selbst. Dieser Beitrag lenkt die Aufmerksamkeit auf einen spezifischen Gebrauch des Körpers, bei dem eine basale psychische Sicherheit durch eine radikale Abtrennung von körperlicher Vitalität erreicht wird. Diese erfordert die Herstellung einer Zwangsherrschaft durch psychosamtische Kontrolle und Autostimulation, damit das Selbst auf eine künstliche Weise belebt werden kann. Wenn die Persönlichkeit in erster Linie im Sinne einer systematischen Dissoziation (und anschließenden Pseudo-Integration) des mentalen und des somatischen Bereichs der psychischen Lebens organisiert ist, unterliegt das Psyche-Soma einer weit reichenden Transformation: der begehrende Körper wird durch einen fabrizierten Körper in den Hintergrund gedrängt und ersetzt. Die klinische Beobachtung dieser Konstellation wird durch die Tatsache erschwert, dass in diesen Fällen der Körper eben nicht auf eine erkennbar symptomatische, sondern auf eine „realistische" Weise benutzt wird. Es ist sogar ein charakteristisches Merkmal einer erfolgreichen Organisation des somatischen falschen Selbst, dass die Kolonisierung des Körpers maskiert wird und natürlich, ich-synton und mit sozialen Norman vereinbar erscheint. Der Behandlungsansatz erfordert eine Erweiterung der analytischen Aufmerksamkeit, damit Veränderungen von Bewusstseinszuständen und psycho-physische Signale wahrgenommen werden können.

Cuerpos fabricados: un modelo de falso self somático. Este artículo llama la atención sobre un uso particular del cuerpo, en el cual se logra una seguridad psíquica básica mediante la desconexión radical de la vitalidad del cuerpo. Esto exige crear un régimen coercitivo de control y autoestimulación psicosomáticos con el propósito de vitalizar artificialmente al self. Cuando la personalidad está organizada sobre todo en términos de una disociación sistemática (y por lo tanto de una pseudointegración) de los campos mental y somático de la vida psíquica, la estructura psicosomática experimenta una transformación de grandes dimensiones: el cuerpo deseante es excluido y reemplazado por un cuerpo fabricado. Dificulta la observación clínica el que, en estos casos, el cuerpo esté desplegado de una manera "realista", en lugar de una manera sintomática reconocible. En efecto, el sello distintivo de la organización exitosa de un falso self somático es que la colonización del cuerpo está disfrazada de algo natural, egosintónico y compatible con las normas sociales. El enfoque terapéutico exige una ampliación de la atención analítica para percibir cambios en los estados de conciencia y señales psicofísicas.

Les corps fabriqués: un modèle pour le faux self somatique. Cet article attire l'attention sur une utilisation particulière du corps dans laquelle la sécurité psychique de base est obtenue grâce à un détachement radical de la vitalité du corps, nécessitant la création d'un régime coercitif de contrôle et d'autostimulation psychosomatiques dans le but d'une animation artificielle du self. Lorsque la personnalité est organisée de façon prédominante selon les lignes d'une dissociation systématique (suivie de pseudo-intégration) de l'univers mental et de l'univers somatique de la vie psychique, le psyché-soma subit une transmutation de grande portée : le corps désirant est éclipsé et remplacé par un corps fabriqué. L'observation clinique de ce montage est obscurcie par le fait que, dans ces cas, le corps est déployé de façon « réaliste », plutôt que d'une façon symptomatique reconnaissable comme telle. C'est en réalité le signe d'une organisation somatique en faux self réussie lorsque la colonisation du corps apparaît comme naturelle, ego-syntone, et

compatible avec les normes sociales. L'approche thérapeutique nécessite un élargissement de l'attention analytique pour appréhender les changements dans les états de conscience et les signaux psychocorporels.

Corpi fabbricati ad arte: un modello di falso Sé somatico. Quest'articolo mette a fuoco un uso particolare del corpo, quello in cui la sicurezza psichica di base è ottenuta attraverso un radicale distacco dalla vitalità corporea, con la necessaria creazione di un regime coercitivo di controllo psicosomatico e di autostimolazione per dare artificialmente vita al Sé. Quando la personalità si organizza prevalentemente lungo le linee della dissociazione sistematica (e poi della pseudo integrazione) della sfera mentale e di quella somatica della vita psichica, lo psicosoma subisce una trasformazione di vasta portata: il corpo desiderante è messo da parte e sostituito con un corpo fabbricato ad arte. L'osservazione clinica di questo assetto è resa difficile dal fatto che, in questi casi, il corpo si dispiega in maniera "realistica" anziché secondo modalità sintomatiche riconoscibili. Segno caratteristico dell'organizzazione ben riuscita di un falso Sé somatico è la colonizzazione del corpo, camuffata come naturale, egosintonica e compatibile con le norme sociali. L'approccio terapeutico impone un allargamento del fulcro dell'attenzione analitica per comprendere i mutamenti degli stati di coscienza ed i segnali di natura psicofisica.

References

Anzieu D (1989). *The skin ego*. New Haven, CT: Yale Univ. Press.

Bion W (1962). *Learning from experience*. In: *Seven servants*. Northvale, NJ: Jason Aronson, 1977.

Bion W (1963). *Elements of psycho-analysis*. In: *Seven servants*. Northvale, NJ: Jason Aronson, 1977.

Bion W (1970). *Attention and interpretation*. In: *Seven servants*. Northvale, NJ: Jason Aronson, 1977.

Bollas C (1987). Normotic illness. In: *The shadow of the object: Psychoanalysis of the unthought known*, p. 135–55. New York: Columbia Univ. Press.

Boris H (1994). *Envy*. Northvale, NJ: Jason Aronson.

Corrigan E, Gordon P, editors (1994). *The mind object: Precocity and pathology of self-sufficiency*. Northvale, NJ: Jason Aronson.

Deutsch H (1942). Some forms of emotional disturbance and their relationship to schizophrenia. *Psychoanal Q* **11**:301–21.

Freud S (1923). *The ego and the id*. SE **19**.

Goldberg P (1995). Successful dissociation, pseudo-vitality and inauthentic use of the senses. *Psychoanal Dialogues* **5**:493–510.

Klein M (1946) Notes on some schizoid mechanisms. In: *Envy and gratitude and other works, 1946–1963*, p. 1–24. New York: Delacorte, 1975.

Lacan J (1977). *Ecrits: A selection*. London: Tavistock Press.

Marty P (1980). *L'ordre psychosomatique* [The order psychosomatic]. Paris: Payot.

McDougall J (1985). *Theaters of the mind*. New York: Basic Books.

Meltzer D, Bremner J, Hoxter S, Weddell D, Wittenberg I (1976). *Explorations in autism*. Strath Tay: Clunie Press.

Milner M (1960). The concentration of the body. In: *The suppressed madness of sane men: Forty-four years of exploring psychoanalysis*, p. 234–40. London: Tavistock, 1987.

Milner M (1969). *The hands of the living god: An account of a psychoanalytic treatment*. London: Hogarth Press.

Ogden T (1989). *The primitive edge of experience*. Northvale, NJ: Jason Aronson.

Rosenfeld D (1986). Identification and its vicissitudes in relation to the Nazi phenomenon. *Int J Psychoanal* **67**:53–64.

Tustin F (1986). *Autistic barriers in neurotic patients*. New Haven, CT: Yale Univ. Press, 1987.

Winnicott DW (1949). Mind in its relation to the psyche-soma. In: *Through pediatrics to psychoanalysis*, p. 243–54. New York: Basic Books, 1958.

Winnicott DW (1960). Ego distortion in terms of true and false self. In: *Maturational processes and the facilitating environment*, p.140–52. New York: Int. Univ. Press, 1965.