The Body in Psychoanalysis
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In this presentation I will endeavor to give you an overview and some tools that will help you begin to incorporate the body more usefully into your clinical practice. After a brief introduction incorporating my own experience, I'll attempt to account for what looks like a beginning rapprochement between body and analytic psychotherapies. I will then introduce some basic concepts, principles and techniques that you might begin to introduce into your own practice

Introduction

Both attachment theory and neuroscientific evidence are making increasingly clear the importance of the physical, somatic aspect of the psychoanalytic process. Infants are born with the sympathetic nervous system basically in place, but the relationship with early caretakers is necessary to mold the functioning of the parasympathetic and relationships between emotion, sensation, perception, cognition and behavior. Similarly, fMRI's are able to track some of the changes in both the patient and therapist in the psychotherapy session. With the right tools, we are thus able to make use of the almost endless neural plasticity that characterizes us as human beings.

Until fairly recently, body psychotherapy had developed in large part independently of most psychoanalytic theory. Only about 20 years ago did some body psychotherapists begin paying significant attention to developments in developmental psychology and object relations, and more recently, the relational and interpersonal schools. The advent of applied neuropsychology (e.g., works by Schore, Siegel, Cozolino) has hastened that process as it validates (and invalidates) and refines techniques and the theories supporting them.

Nonverbal communication is ubiquitous and ever present. At the very least, it signals to the patient what material interests the therapist and what does not. fMRI's measure the resonance between nervous systems, but most of us have a highly developed ability to both measure and use that resonance. We need only to bring it to our conscious awareness and make use of it along with our other clinical skills. This is especially true in the treatment of trauma, which is a disruption and a truncating of the functions of the nervous system.

We do not need any special arrangements or equipment to incorporate this exiled aspect of ourselves and our patients into what we do every day. Many of the techniques developed by body psychotherapists can be seamlessly incorporated into psychoanalytic practice to deepen and enlighten the process. Integration of bodily experience, which can be a tremendous source of information and, along with awareness, an effective agent of change, can increase the effectiveness of psychodynamic treatment.

"[However] it is [also] important to combine traditional talking therapy techniques with body-centered interventions that directly address the neurobiological effects and procedural learning of trauma by using 'just enough' of the narrative to evoke the unresolved somatic experience. We attend first to how the body has 'remembered' the trauma and attachment failure and later to cognitive and emotional meaning-making" (Ogden 2002; Fisher 2006).

Analytic Police and the Closet: My Training Compartmentalized

When I first became interested in practicing psychotherapy, I sought training in both body psychotherapy (Reichian) and psychoanalysis. Although I incorporated them seamlessly in my private practice, their worlds remained rigidly separated. Reichian therapists held that mere "talk therapy" did absolutely nothing, while Reich was virtually unmentionable in psychoanalytic circles. It is gratifying to see them finally approach each other and begin to interact and integrate. Somatic Experiencing, EMDR and Sensorimotor Psychotherapy have been and continue to be important bridges as more analysts are becoming trained in these methods. After all, when we are encouraging our patients to bring all of themselves to the treatment, how can both patient and therapist check their bodies at the door?

Those trained and licensed in both bodywork and analytic work have often kept them rigidly separated. Analytically oriented psychotherapists, unless specifically trained in dance/movement/body psychotherapy, have not felt able to incorporate the body in treatment. Until quite recently, I rarely admitted how integrated they were for me. Until now, in analytic milieus, I just excluded any mention of the body, simply deleting that part of a session or process notes I presented to the group.

That is not to say there have not been forays into this no-man's land. In 1998, at the first international conference of the USABP, I was on a panel moderated by Bill Cornell and including psychoanalyst Martha Stark, entitled "When the Body Meets the Mind: What Body Psychotherapy Can Learn from Psychoanalysis." Trauma, affect regulation, and attachment were still on the far horizon for us. And in beginning to explore this topic, I have in the last few months amassed a foot-high stack of articles and another pile of books on the body in psychoanalysis.

We are all at least somewhat aware of the attachment, neuroscience and infant research literature. Along with voice and eye contact, touch is one of the earliest formative influences and continues throughout the life cycle, affecting blood pressure, heart rate and endorphins, just to enumerate some of its easily measurable physiological effects. We therefore ignore it at our peril in the treatment situation. Touch, and certainly lack thereof, needs to be processed along with other aspects of our bodily existence.

Why are these bridges appearing just at this point in time? Certainly neuroscience research and its implications are a large factor. Allan Schore emphasizes the body in virtually every paper he writes and every presentation he gives. In a 2005 article, Schore heralds a "new paradigm" in psychoanalysis that must inevitably include non-verbal, bodily-based interventions directed toward nonconscious, procedural processes. In this same paper, he quotes V.M. Andrade in the International Journal of Psychoanalysis, citing research from neuropsychoanalysis: "As a primary factor in psychic change, interpretation is limited in effectiveness to pathologies arising from the verbal phase related to explicit memories, with no effect in the pre-verbal phase where implicit memories are to be found" (p.677). (Reichians, by the way, are deficient in understanding much of anything pre-Oedipal).

He goes on to point out that body psychotherapy, originally a product of "certain pioneers of classical psychoanalysis and trauma theory," has developed independently and often in opposition to contemporary psychoanalysis. But the body psychotherapies are also now adopting an interdisciplinary outlook. Psychoneurobiological data and attachment research have supported a neglected dialogue between psychoanalytic and somatic psychotherapies.

I shall now introduce to you a few useful concepts and procedures that I have gleaned from two modalities of body psychotherapy, Somatic Experiencing and Sensorimotor Processing, which are based on neuroscience and trauma research.

Useful Concepts for Therapy

One major principle of these body therapies is that it is crucial to work within the patients' range of resilience: don't push through resistance or promote catharsis. Furthermore, the narrative aspect of therapy is used primarily to track activation, not to search for and bring up memories.

In order to keep patients' activation within this range of resilience, we can use two concepts, pendulation and titration, which are easy to apply to psychodynamic sessions. We have been trained to allow the patient to complete a horrific narrative in the hopes that the neocortex will make sense of it and thereby lessen its ramifications in the person's present life. The autonomic nervous system, however, is hard-wired in its optimal state to pendulate between sympathetic and parasympathetic modes. Furthermore, we have learned that the energy locked into the system by trauma is most effectively released in small increments, or in titrated amounts. Therefore, pausing in the account to allow the nervous system to "recycle" avoids iatrogenic retraumatization. This can be done in a number of ways: by resourcing at the beginning and as it unfolds, by asking the patient to focus in the present, and by any one of a number of grounding and stabilizing exercises. Pendulation allows for titrating the experience in smaller, manageable pieces to lower arousal and prevent retraumatization.

Another concept useful for therapy is found in the acronym SIBAM, which denotes the elements that form the whole of our experience. This includes: Sensation (any of the 5 senses); image, which can be internal or external (red ball in chest vs. sunset); behavior, which can be verbal/nonverbal, voluntary/involuntary, conscious/unconscious; affects/emotions or patterns of sensations; and meaning, or explicit linguistic concepts or statements. SIBAM elements are useful because they enlarge the experience and make it both wider and deeper. Any elements of SIBAM can be used as resources during

therapy. They are both reparative and can aid in titration, which keeps the nervous system activation within the "window of tolerance."

During these steps (pendulation and titration) it is important to allow the patient lots of time, to encourage curiosity, and to use language characterized by open-ended and invitational questions, like "How would it be to…?" It's very important for therapists to use mindful language, for example, "I notice when you talk about him your body tenses up," rather than, "Why do you think you have that reaction to your father?" (Ogden 2005, Fisher 2005). Through using this kind of language and asking open-ended questions, the patient and therapist can explore, helping the patient to savor and deepen sensation.

Physical discharge of energy is an important part of somatic therapy, which can happen through awareness of any of the elements of SIBAM. To understand the basis for this, we can compare humans to animals in the wild: Why do animals not suffer from PTSD the way people do, even though they are often faced with life-threatening situations (i.e., predators)? After a traumatic event, animals exhibit a physical shaking and release of energy followed by a calm return to their normal activities (Levine, 1997, 2010). However, animals that are restrained and unable to dispel this post-trauma energy are far more likely to show human-like symptoms of PTSD. This is what SE teaches the body to do: shake and dispel the energy. It is important to be able to recognize signs of discharge without inhibiting them in both self and the patient. Signs of discharge can include: exhaling, yawning (a parasympathetic response), burping, tingling/numbing (depending on context), sense of flow, warmth/heat or mobilization, sweating, crying, shaking and trembling (trembling may have fear mixed in), and coughing. "Traumatic symptoms are not caused by the event itself. They arise when residual energy from the experience is not discharged from the body. This energy remains trapped in the nervous system where it can wreak havoc on our bodies and minds" (Peter Levine).

In order to promote this discharge of energy, sessions of SE often begin with discharge meditation to open the body and to allow energy to flow and be dispelled. Energy is often discharged through the joints, which contribute to proprioception, so it's important to open the joints for subtle discharge. There are a number of steps that can be taken to initiate this: Have the patient start with the toes and make contact with floor. If patients are having trouble finding their bodies, just have them move their joints slightly. This may lead to intrinsic, non-voluntary movement. As the patient feels their feet on the ground and their seat on the chair, bring awareness to the joints of the toes and see if there is any impulse to move ankles along with the toes. Notice what happens in the body as they do this. It's also important to notice that when we are in body time, everything must slow down, including speech. After starting with the toes, you can continue to work up from there, adding in the knees, exploring, and bringing awareness into joints. When ready, you can add the hips, and have the patient let their body move them instead of them moving their body. Have them allow energy to move down their legs: they may feel a flow, warmth, or tingling. Let them sense the muscles of the torso that contain the viscera. Continue to move up, having them stretch their arms up, forward and back. You can also invite discharge in the arms by starting with the finger joints and moving to the elbows. The shoulders often hold a lot, and the neck is very important for dealing with threat, so it's important to include it in this process.

Attachment and the Body: Creation of a Secure Attachment

It seems that a secure attachment results from the attunement of the caregiver to the infant, especially in its first 18 months, when the emotional connections in the brain are literally sculpted by this interaction and implicit, procedural memories are formed. Cognitive development does not come effectively online until approximately 18 months of age. This means that early developmental deficits and trauma can be most effectively accessed through non-verbal and non-verbalizable memories and experience. Attachment begins in the body through physical actions: reaching and holding sensations of warmth, muscular and postural adjustments, gaze-to-gaze contact, sucking, rocking, carrying, turning towards, moving closer, making eye contact, facial expressions, mimicking/echoing, touching, wiggling, laughing/smiling, and holding on/letting go. Because of this, addressing attachment and creating secure attachment during therapy are most effective when incorporating the physical body.

Secure attachment promotes the development of self-regulatory abilities (Schore) and is crucial to the child's ability to self-soothe and regulate emotions. This includes interactive regulation, which involves the child's ability to utilize relationships to modulate arousal and distress to either stimulate positive feelings or provide calming, as well as auto-regulation, which refers to the child's slowly developing ability to self-

regulate independently of other people: the ability to play independently, calm down, recover from distress, distract from unhappy feelings, or seek out sources of positive feelings.

Similar to a secure attachment relationship, the focus during therapy should be on minimizing negative affect and increasing spontaneous affect regulation. "The earliest phase of [attachment formation] involves calibrating the infant-caregiver relationship in regard to maintaining a positive state for the infant. The parent's role in regulating negative arousal during the first year is not simply to respond with comfort when the infant is disturbed, but to avert distress by maintaining the infant's interest and engagement in a positively toned dialog with the social and physical environment" (Hennighausen & Lyons-Ruth 2005). Providing psychobiological attunement contributes to this as well: Even though "good enough caregivers are inevitably somewhat inconsistent in their attunement with their children, they promote recovery from breaches of attunement by providing interactive repair… This transitioning between negative and positive affect helps the infant to develop resiliency and later, flexible adaptive capabilities" (Tronick, 1989; Ogden, 2004; Fischer, 2007).

Attachment in the Psychotherapy Relationship

Traumatized patients bring their attachment style to transference during psychotherapy. The sense of threat can feel present, "Here, now—with you." The autonomic responses, emotions, and body sensations stimulated by attachment cues are misinterpreted as indicators that the individual is still in danger. Therefore, therapy must deliberately challenge, rather than reinforce, procedurally learned patterns of response.

Therapy must address post-traumatic "procedural learning" in two ways: "The first is to…observe, rather than interpret, what takes place, and repeatedly call attention to it [in an attuned, respectful manner]. This in itself tends to disrupt the automaticity with which procedural learning ordinarily is expressed. The second therapeutic tactic is to engage in activities that empathically but directly disrupt what has been procedurally learned" and create the opportunity for new experiences (Grigsby & Stevens p. 325). "[The therapist must act as an auxiliary cortex] and affect regulator of the patient's dysregulated states in order to provide a growth-facilitating environment for the patient's immature affect-regulating structures" (Schore, 2001). "Therapeutic progress occurs within the joint activities of co-regulating affect and co-creating meaning" (Hughes, 2006).

One of the therapist's jobs is to act as a neurobiological co-regulator and co-creator, or arousal manager. Being a neurobiological regulator requires that the therapist stay attuned simultaneously to both the regulating and dysregulating effects of the therapeutic relationship and, like a "good enough" mother, strive to create an optimal level of arousal in the moment and from moment to moment. Effective neurobiological regulating on the part of therapist requires paying more attention to how we are affecting autonomic arousal than to the content of the patient's communication (Fisher, 2006).

Strategies for neurobiologically regulating clients include varying voice tone and pace (soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone); titrating and encouraging affective expression; and increasing the client's ability to draw on somatic and affective resources (Fischer, 2006). Embracing both attachment-seeking drives and trauma-related defensive drives simultaneously can help to promote integration. For example, invite the patient to experiment with reaching out with one hand and then putting up the other hand to make a boundary and explore what happens for them. Does this make things better or worse? In addition, you can with the right balance of connection and protection: does it feel safer just to reach out with the dominant hand or to set the boundary with the dominant hand? What happens if they reach out beyond the boundary, or if they keep the reaching out safely inside the boundary? (Ogden, 2001; Fisher, 2007).

For interactive regulation, invite the patient to pick an object in the room to represent the attachment object. First, have the client orient towards the object and study what happens in the body. Does he/she want to pull back or lean forward? Are there any visceral sensations or thoughts? Next, have them notice what happens in the body when he/she orients away from object or creates more distance from it. Experiment with the orientation that is more resourcing or transformative for them: how does it feel when they are turning toward it? Turning away? Moving toward or away? Creating a boundary? (Ogden 2006 Fisher 2007).

To create a relational connection, have the patient to reach out, engaging the shoulder girdle, and study what happens inside. Have them reach out just a little bit, then move and discover what feels "right". Have the patient practice reaching out with one hand, and compare that with reaching out with the other hand or with both hands. Experiment with holding on versus letting go—ask them which feels more

familiar and unfamiliar. Also notice what happens when you and patient make eye contact, and what happens when one of you has eyes open and the other's eyes are closed (Ogden, 2002; Fisher, 2007).

Various Exercises to Try

Attachment Exericse: Then and Now

First, review your own attachment model concerns. Make a list of relationship concerns regarding an important current relationship—friend, family member, or partner—and write next to each concern whether it is a reflection of the current situation or if you have had this worry before in earlier relationships to detect the influence of the past. Put "N" for now and "P" for past along side of all concerns. It's important to work through past wounds in their original context. The goal is to determine as clearly as possible the presence of the Virtual Other in your adult relationships and when you are seeing the Authentic Other objectively (John Gottman).

Attachment Exercise: Parents Then in Relationships Now

First, make a list of both parents' inconsistent behaviors, boundary ruptures, lack of presence at times, etc. Notice as you are reviewing these behaviors what feelings come up for you, and work with a partner to begin the healing process through corrective experiences or re-establishing creative self-regulation in a relationship context. Make the emphasis on re-establishing consistency and attunement in the felt sense experience, for example "Getting Gotten," or "Feeling Met." Make sure to follow your own pace and rhythm instead of over-focusing on the other. After you have done this, flip the Object Relation and see how you may be drawn to acting out the behaviors of your parents in your own adult relationships.

Attachment Exercise: Repair of Attachment Difficulties

Parents and partners need to repair ruptures when they happen. Ask yourself these questions: Can you as an adult practice repair in your relationships? Are you aware of what was missing in your attachment history? If you ask yourself, "What difference would make a difference?" what did you and do you need to repair that part of the past? We often have "encapsulated experiences" at certain ages with extreme difficulty. What ages do you revisit and do not yet feel integrated? What resources can we import that may give that self the support it needs to complete developmental tasks and to discharge excess arousal for the scary event or lack of connection?

Therapy Vignette
Adam 3/21/07 – "Today I had one of the most profound experiences of my life"

Adam, a 53 year-old playwright, enters the consulting room and sits opposite me. He has recently broken up with Deborah, an artist with whom he'd been in a relationship for about a year. She was his first lover in close to 17 years, a period during which he was chronically ill and in debt. After, at my suggestion, reading Peter Levine's book, Waking The Tiger, Adam wants to explore on a somatic level traumatic experiences from his childhood that have made him frightened of intimacy with a woman, and of feeling free to express himself artistically. We have been doing various forms of somatic work over the years as seemed appropriate. One of his most debilitating health problems has involved constant pain and malfunctioning of his intestines. So, recently, I had begun very gently placing my hand on his abdomen for a few moments as he lay on the couch. We had very gradually increased the time from one minute to about ten. Over the couple of months we were doing that, his symptoms improved markedly as did his courage to seek a relationship with a woman.

In the session I am recounting, he mentions that he wants to explore the trauma he experienced being emotionally abandoned and rejected by his mother, but I surprise him by asking a broad question, which takes the session in a direction neither of us had anticipated.

"What images come up for you when you hear the phrase," traumatic experiences in your childhood?"

Adam is surprised by the first image that surfaces: of his dad slapping him in the face when he was 12 years old. The therapist asks him to return to that experience and to let himself be there as it occurred. He closes his eyes and begins to speak. Because I know him well, I am not concerned that he will dissociate, so I do not comment on his closed eyes.

"It was a weekend in February, probably over Lincoln's birthday," he tells her," and Dad had taken Mom and me to a ski resort in Vermont. We stayed in some kind of lodge near the slopes that had separate duplex apartments. In ours there was a bedroom with bunk beds on the first floor where I slept; mom and dad's bedroom and the kitchen and living room were upstairs. I think it was a Saturday afternoon when I became furious at dad for lying to me about something he had promised to do and then denied that he had. I remember confronting him in the living room and accusing him. I can't remember everything I said, but I'm certain I said, 'You're a liar!' "

At this point, Adam's legs have begun to tremble. He's agitated and breathing rapidly as fear courses through his body. I tell him to just allow the trembling and his rapid breathing and to notice what else is happening in his body as he feels himself solidly in contact with the couch against which he is leaning and the floor on which his feet are resting. He moves slightly to feel the couch and the floor under his feet. I suggest he notice what is happening in his arms and he says they are tingling, especially his fingers. I assure him that this is a natural discharge of the autonomic nervous system's blocked orienting response to danger, which could not be called upon. As the trembling begins to subside, he mentions that he scared himself by saying such a thing to his father. But, then it becomes more complex.

Adam continues….
"At that dad became enraged and slapped me very hard in the face, probably with his left hand because I remember holding the right side of my face afterwards."

Adam puts his hand up to the right side of his cheek and his legs begin to shake harder than before, seemingly uncontrollably. He's shocked by strength of the movement in his legs, but I encourage him to stay in the moment. "It's your desire to flee," I say. "You couldn't then. It's all right. You need to let your legs run the energy out now. It's okay." I invite him to imagine himself running and he sees himself running up and then down the ski slope to the room of his old nanny, Mary. As his legs make more purposeful running movements, they at first increase in strength and then subside.

"Tell me what happened next." Adam's legs slowly come to rest as he speaks.

"I was stunned and hurt, more by his anger than the pain. I certainly knew I was provoking him but it never occurred to me to run before he could hit me, or to fight back. Maybe it all happened too quickly, or more likely I became immobilized out of fear. All I can remember is my face stinging as the sound of the slap reverberated, looking at dad with hurt and astonishment, then running to my bedroom. I locked the door and began to sob. I had never felt such profound hurt in my life. I had been certain dad didn't love me and now it was proven. Dad came to the door and asked if I would let him in. Eventually I did and he apologized, but I remained turned away from him and wouldn't speak. I wanted to teach him a lesson he'd never forget: that if you fail and wound someone, you cannot count on their forgiveness. "

J: As you imagine yourself there in your bedroom with your father, what do you feel in your body?

Adam: Nothing. I am numb, frozen, cold, unfeeling…….At this point Adam begins to sob. He reaches for my hand with one of his hands and covers the right side of his face again with the other. His shoulders shake as he cries and then they gradually relax and he releases my hand and brings his other hand down from his face. We both sit for a few moments, just letting his experience wash over us. I contemplate just letting the session end here, but counting on his resilience, I ask him if he would like to take a step further. He sits up a little straighter, and with interest reflecting in his eyes, says, "sure."

"Can you go back there now? Would you go back there and talk to him?"

Adam takes a deep breath. "What is it you might want to say to him?" I ask carefully. "I'm not sure I can

talk to him," Adam replies, so I make a suggestion. "Try talking to someone else, someone you trust who would comfort you. Who would that be?"

"My friend, David. He's warm and direct, a great father. I wish I'd had a father like him."

"Then talk to David. Tell him how you feel and what you need."

Adam imagines David sitting opposite his 12 year-old self, allowing him to reach out and touch his hair and then hold and comfort him. It morphed smoothly into being held by his father. He mentioned later in the session that the feeling of being held was "palpable." As soon as he is able to speak then, he is able to do so directly to his father, often sobbing between sentences.

"I need you to recognize who I am….to love and support me; hold me. Can't you see how sad and frightened I am, how shy? I get teased at school and you're not there to help me.(He had inherited a genetic anomaly of overly large ears from his father, which were operated on only very late and very traumatically in his childhood) Nothing I do ever gets your approval. I'm so lonely, Dad. I need you so badly. Please hold me and tell me that you love me."

He is sobbing deeply again, but with less tension. I encourage him to imagine his father reaching out and touching him. Adam is able to describe his dad stroking his hair, embracing him with love, apologizing with all his heart. And Adam is able to return the love.

After he has stopped sobbing Adam reminisces that when his dad was dying in 2004, they never talked about Adam's childhood misery, and Adam never asked for an apology, but one was made obliquely to a nephew who came to visit. Adam's father apologized for letting him down as an uncle and burst into tears. Adam knew his father was speaking to him and was filled with gratitude that his dad could even come that far in admitting his failures as a parent.

After the session Adam reported a feeling a surge of optimism about his life that was new. Curiously there was also a bruise around his right eye that lasted for several days and then healed. He said he couldn't help but assume that in re-enacting the experience of being hit by his dad, there was a kind of body memory, which brought the bruise back. A week later he wrote about another result of the session.

"The experience of being held by dad was as palpable, as real, as if it was actually happening. I felt an enormous relief and surge of love; a combination of forgiveness and profound connection to this man who I know loved me deeply yet could never express such feelings directly. I was aware of healing myself and also him at the same time, despite the fact that he was dead. So I suppose I was healing the part of him that I have carried in me, the shadow. Somehow I felt the healing that occurred had not only an emotional but a spiritual basis; that somewhere I was releasing dad from his guilt and shame over hitting me, and in acknowledging my need for him to love me, and the fact that he did indeed love me with all his heart, I was helping to make him whole as well as myself.

I had worked with Adam for the majority of his celibate 17 years as he fought a syndrome of immune system disorders. Progress had been slow, and only in the last couple of years had I been sure he would survive. Sessions such as that described above had to be carefully titrated and worked through, but the patient and I both agreed that it was this sort of work that had begun to materially loosen his creative drive and his willingness to seek and find a relationship with a woman.

4/14/04

My work with Jacquie is yielding new results. Since I began to acknowledge the pleasure I feel in self-denial, I've opened the door to examine the ways in which I cut off pleasure and excitement. Piano playing has become a kind of workshop and focus for this process. Writing is the other. Jacquie has asked me to be aware of how the excitement is building when my creativity and pleasure begin to flow, and then notice how I cut myself off. Her feeling is that I can learn to slow it down so it doesn't become overwhelming. I believe I can channel it into the work I'm doing. The truth is that since my early teenage

years, I've had very little experience with real pleasure and truly immersive and transformational creativity. Yes, it's been there in spurts, and certainly when I was sexually active the channels were more open, but I've never kept them open, thrived on them, used them so they become a consistent part of my being. That's what I need now; that's what will allow me to have a full and satisfying life.