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The Analyst's Body at Work: Utilizing touch and sensory experience in psychoanalytic psychotherapies

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Abstract: This paper discusses the functions of somatic experience within the therapeutic and analytic process as both the nonverbal expression of conflicts long held within the patient's (or analyst's) body structure as well as movement toward self-agency. Therapeutic attention and responsiveness to nonverbal communications and spontaneous bodily actions are seen as providing significant avenues of access to the forward intentionality of unconscious, dissociated states of being. Direct, analytic involvement with somatic experience is illustrated through sensate focus, movement, and physical contact between patient and therapist.

Key words: somatic experience, movement, touch, sensate awareness, gesture, enactment, nonverbal communication, somatic agency

> *If the developing child feels increasingly free to release the body to its being, to embody their subjectivity, they will develop a very particular expression which we know as 'sensuality'. This capacity to use the senses is an acknowledgement of the body's freedom of movement and the sensual self has matriculated into gestural being. (Bollas, 1999, pp. 152-153)*

Each session Adam sat precisely in the middle of the couch, facing me as I sat in my chair in front of my desk. Each session began in precisely the same way, with Adam picking up the throw pillows that lay on the couch, checking the backs to be sure they were buttoned and, if they weren't, buttoning them. He would then place them in the corners of the couch before seating himself in the center. As I watched this careful positioning at the beginning of each session, after the 4th or 5th session, I observed, "All is in order. Now we can begin," an observation that was greeted with a fleeting grin and a nod of the head. Adam leg crossed over the other, his foot twitching. His face would come alive with rapidly

changing grimaces of half-finished expressions. His eyes rapidly scanned me, my desk, and the details of my office that he could see without moving in his place. Adam opened the session by reminding me that his life was pointless, that he had accomplished nothing.

Adam was approaching his 17th birthday.

He had been asking his parents for over two years to see a therapist and finally succeeded by threatening suicide. His older sister was severely anorexic and qualified as the official identified patient of the family. In spite of these rather striking signs of a troubled family, Adam presented his parents as wonderful, accomplished individuals. In fact, as I was to find out later in our work, his sister, father, and mother were in constant, often screaming, conflict. Adam's role was to be that of the successful, admired son, and only that.

Adam hated being an adolescent and having to put up with other adolescents. A high performing student, he had no friends, was quite socially isolated at school, and rarely ventured out of his bedroom. His time was spent alone, doing schoolwork, reading history, and writing novels and poetry. Seeing himself as much more mature than his fellow students, he was disgusted by any traits within himself that reminded him of being a teenager, something that he desperately wanted to be beyond. He insisted he had no interest in dating and declared that he would not date until he was a reasonably mature adult. He saw all the dating dramas going on around him at school to be absurd, and he wanted no part of it.

Adam wanted to go to West Point. For Adam, this represented the accomplishment of the highest academic standards and physical self-control. He also mentioned, fleetingly, that both of his parents were "peace types". I could see his careful scanning of my face when he announced his parents as peace types, and I imagined he was wondering where I fit into the political landscape of war and peace. When I inquired about there being a bit of a gap between poetry and the military, he shrugged off the question with a wry smile. Case closed.

Our early sessions were dominated by his rants against adolescence. Inquiries into his home life and relationships with his parents were warded off.

It was clear from the beginning that our sessions were important to him. Next to my desk are photographs of the poets who had a profound influence on me. He asked after each of them the kind of poetry they wrote. He did not ask what drew me to any of them. Reading the book titles on the bookshelves behind me, he wondered aloud, "You have a lot of books about war and politics. Is that usual for psychotherapists?" "No, I don't think so," I replied. "So why do you have them?" he asked. This was Adam's first direct question that expressed some personal interest in me. I suspected that his question reflected some anxiety that

I would judge him for his military inclinations, so I was reluctant to answer it at the level of conscious content. At the same time, it seemed premature to inquire as to his possible anxiety. I simply replied that I had long been interested in history and that the time would come when we would take up his question.

There were, obviously, many cues in my office space that would prompt transferential fantasies for Adam. Furthermore, I felt a keen identification with Adam's intellectualized isolation from his peers and his profound adolescent awkwardness from the very start of our work. I knew that my intense countertransferences to Adam had both the potential to inform our work or distort it.

To process my countertransference reactions to Adam I sought consultation in a rather unusual format, working with my ongoing seminar group facilitated for this particular meeting by Alberto Pieczanski (Lisman-Pieczanski, N. & Pieczanski, A., 2015), an Argentinian-trained psychoanalyst. Pieczanski proposed a process of clinical "research" for the group. His instructions to the group were:

> A necessary first clarification is that though the work can mimic what is done in supervision, it is quite different from that. The group will work on process notes read by the treating therapist, and although the experience may resemble supervision, our intention and mindset will be quite different.
>
> We will not engage in any supervising of the presenter. We will take his understanding and interventions as presented to us not to compare with "better" ones but to identify what is it that he understood, and what did he mean to communicate to the patient.
>
> In this process we will try to determine if unconscious ideas informed the therapist's interventions. (Pieczanski, personal communication, March 24, 2015)

My task in the group was to read the transcript, accompanied by descriptions of Adam's nonverbal expressions, and my own bodily experience and fantasies. The task of the group was to imagine the unconscious "theories" that were guiding my interventions. The result of this extended group process was revelatory (and exhausting). It became clear how frequently (unconsciously) I would let go of a line of inquiry from the very first time Adam would block it. I consistently side-stepped his direct and indirect expressions of anger, commenting instead on what I saw to be his positive intentions and efforts at repair. The question quickly emerged in the group's discussion as to how it was that I seemed so reluctant to speak my observations of what was happening to Adam more directly and forcefully. My unconscious "theories" regarding what might be generating my clinical interventions as they emerged through this group discussion included:

--Adam is basically healthy. It is the family that is fucked up so the parents should be in family therapy. There is no place for Bill here.

--Bill's theory of "cure" was to transmit a sense of Adam's benevolence.
--Bill is aware of Adam's fragility and the fragility of the therapy, so he reins himself in.
--Adam is so afraid of his aggression that Bill is afraid of his own and reins himself in.
--What is too painful to witness or speak is Adam's anger and aggression, so it must remain unspoken.
--Bill is pulled into the theory that Adam's life is hopeless. There is simply too much hopelessness, too much damage in the family, too much despair in Adam to do anything but prop him up.
--Bill is indoctrinated into hopelessness, so he does not make use of the patient's capacity to use the therapy.
--Adam's rage is so lethal that Bill does not want to look at it.

Entering the gestural field
Up to this point, I had been sidestepping Adam's aggression in favor of fostering a more positive self-regard for Adam. My work had been much more supportive than that of laying the groundwork for more analytic inquiry. Through this process with the group, the unconscious motivations guiding my work the this point became quite clear. The need for me to recognize and attend to Adam's anger and aggression became abundantly clear.

During our sixth session, immediately after my consultation in the seminar, Adam described an argument that took place between two boys in the school lunchroom, accompanied by loud shouting, almost becoming a physical fight. As Adam described it, "Dumb. It's stupid enough being an adolescent. Do they have to be *dumb* too? Probably about some girl. I get arrogant, judgmental. I get angry, but I don't want to get angry." As he spoke, his face was filled with contempt, his leg twitching vigorously. I asked him why not? "I don't know. Don't like myself when I'm angry. I feel better than everyone else by not getting angry." After a long pause, staring at me with a nervous, twitchy smile, he went on in what seemed to be a non-sequitor, "I want to *do* something. But I don't. I have all these ideas, and I don't *do anything*. I have a completely uninteresting life." After another long silence he went into a long riff about how self-indulgent and meaningless is his writing. "My Dad wants me to get published. He would feel good. But I'm just alone in my room writing to myself. It's ridiculous, self-indulgent." His voice was filled with contempt and disdain that had suddenly turned inward. I felt as though I am witnessing a process that has gone on for Adam many times, his fury and contempt becoming self-directed. I was sitting silent and furious with his father, imagining his narcissistic indifference to his son's deeply personal writings.

Suddenly Adam shifted, in a low and serious voice, looking straight at me, and declared that he will have to go to the military first and after that he could be

mature enough to write seriously. "It's like I've got two minds. One that wants to go forward, and the other that keeps stopping the first one. Two minds that fight." I suspect that had it not been for my consultation with my seminar group, I'd have said something reassuring about the mind that wanted to go forward. Instead, I said, "Sometimes I think there are more than two fighting inside of you. We need to find ways to begin talking about all this fighting." "Yeah," says Adam, "It gets pretty crowded in here," making direct eye contact with me again. My offer to talk about fighting was accepted. At the session's end, he stood to walk to the door, turned, put out his hand, and took my hand into a firm handshake, saying, "See you next week." We had never touched before. As he turned to leave, standing behind him, I reached out to place both my hands on his shoulders in a very firm grip. He turned back to look at me with a small nod of his head and a smile. "Till next week," I said. Words would follow at some point, but they did not then need to lead. All too often language, be it his own or that of his parents, served defensive functions, cutting him off from the visceral struggles within his adolescent body—a mind precociously at odds with his age and developmental needs (Corrigan & Gordon, 1995).

My gesture was not spontaneous, but rather a purposive response to physically accompany Adam's reorganizing his body toward the end of the session and his very direct way of saying goodbye and that he would be back. Here was a gesture toward the future of our work together. These shifts in his bodily expression were significant communications. Up until now, I had witnessed an almost violent split between his carefully composed body seated perfectly in the center of the couch and the relentless, agitated twitching of his feet, hands and face. Now Adam had found a way to bring anger and conflict into the room, first from the lunchroom at school and then within himself. His bodily reorganization signaled to me a readiness to begin to address these issues with me. I wanted to witness his somatic reorganization with the nonverbal acknowledgement of my firm grip of his shoulders. My hands on his shoulders were not acts of comfort. I was offering an aggressive contact that was a form of joining, a physical contrast to the destructive, killing anger he so much feared having within himself and showing to the world.

The following session, we greeted in the waiting room and as I was headed back to the kitchen to get a cup of tea, I told him to head into the office and I'd be with him shortly. As I came into the office, I was taken aback to not see him sitting on the couch. I saw him seated on the floor in a corner of the room by the bookshelves, holding a book in his lap, rocking back and forth, near tears. I went over and sat on the floor next to him, silent, rocking my own body back and forth. He barely seemed to notice my presence. Finally he turned to me to say, tears in his eyes, "I forget that people get killed. People get hurt. I forget that in my fantasies about being in the military. People get killed." The book he was holding was of graphic photographs from the Vietnam War (Associated Press,

2013). All that I said was, “People get killed in wars.” We sat in silence, gently rocking back and forth, looking at the anguished photograph on the cover of the book.

I sought to offer a *physical* space for Adam’s troubled body. He had tried to create as much psychic distance as possible from his own troubled and troubling body. As I sat on the floor next to him, Adam holding the book taken from my shelves, each of us rocking, words would have risked rupture, a signaling that what he had done, what he was experiencing, was not to be. Of all the things he might have done upon entering my office alone, he sought one particular book, one that he had never mentioned directly to me but had obviously seen. Without saying a word, Adam was signaling me that he was ready to speak of his conflicted feelings about his rage. I suspect that he had not anticipated the impact the pictures in that book would have on him, but there he was near tears, now opening to anguished aspects of himself that had been carefully sequestered from awareness.

After a few minutes had passed, Adam got up and moved to the couch, this time flinging his body prone across it. One of the pillows fell unattended to the floor. His fear and dread of his own and everyone else’s anger were now open to discussion and became the central focus of our subsequent work together.

Adam had long known he was in trouble, but there was no room for his troubled self in his family or school. He was desperate for attention, even as everything in his public presentation suggested exactly the opposite. His “anti-adolescent” demeanor was dancing at the edge of a full-blown antisocial withdrawal. Winnicott wrote eloquently and hopefully about the creative aggression embedded in what he called “the antisocial tendency”:

> The antisocial tendency is characterized by an *element in it which compels the environment to be important*. The patient through unconscious drives compels someone to attend to management. It is the task of the therapist to become involved in this the patient’s unconscious drive, and the work done by the therapist in terms of management, tolerance, and understanding. (1990, P. 123, italics in the original)

In a later paper, Winnicott goes on to observe, “Toleration of one’s destructive impulses results in a new thing, the capacity to enjoy ideas, even the destruction in them, and the bodily excitements that belong to them, or that they belong to” (1990, p. 142). The anger and aggression that Adam witnessed at home (but never spoke of until after these two pivotal sessions) was relentlessly cruel, demeaning and controlling. My initial inquiries into life in his families’ lives had been met with a changing of the topic. I suspect that had I pressured him at that time to express his anger about his family, I would have been met with silent, but withering, disregard. And, as became clear from my clinical “research” group, I

had my own reasons for sidestepping his anger. I had been all too eager to cooperate with his avoidance. After the consultation, I was able to meet his first aggressive gesture with one on my own—there was between us a felt sense of an aggression that was *engaging* rather than *withdrawing*. It was my hope that Adam would find in me an object who could not only withstand his aggression and hatred but welcome it, that he would find in me a resilient and responsive object for his aggressive use (Winnicott, 1971; Bollas, 1989; Cornell 2015).

What to do with the body?

Historically, within the psychoanalytic traditions, bodily experience and actions have been framed in terms of being primitive, regressive, pre-symbolic, defensive, and/or as forms of acting out (Cornell, 2015; Yarom, 2015, pp. 123-137). So too, have the somatic experiences of the therapist tended to be conceptualized as forms of countertransference. Increasingly this theoretical positioning has been called into question and the communicative elements of the nonverbal and somatic gaining recognition, beginning with the pioneering work of McLaughlin (2005), Jacobs (1991, 2013), and Bucci (2002, 2011).

Wilhelm Reich (1972/1949) changed his physical position with regard to the patient so as to open the visual field. He wanted to *see* the full range of his patient's bodily expressions and for the patient his patient's to see him and give expression through eyes, voice and movement as well as words. Jacobs (2013) describes the influence of his supervision with Annie Reich:

> Influenced no doubt by her long association with Wilhelm Reich, who was interested in bodily expressions of conflict and especially the way in which defense and resistance are manifest in muscular tensions, Annie Reich emphasized the value and importance of the analyst using his eyes as well as his ears. …the stream of information taken in visually fuses with, but also expands and augments, that which registers via the listening process (p. 11)

Contemporary clinical literature is ripe with efforts to re-conceptualize the meanings of somatic experience and find avenues of working more directly with bodily processes within analytically based treatments (Bucci, 2002, 2007a, 2007b, 2011; Aron & Anderson; 1998; La Barre, 2001; White, 2004, 2014; Bloom, 2006; Anderson, 2008; Cornell, 2008, 2010, 2011, 2015; Alvarez, 2010, 2012; Knoblauch, 2011; Chodorow, 2012; Saketopoulou, 2014; Sletvold, 2012, 2014; Ben-Shahar, 2014; Lemma, 2015; Petrucelli, 2015; Yarom, 2015). Lemma, for example, argues, "Physical movement (and, of course, how others respond to that movement) prefigures the lines of intentionality, gesture shapes the contours of social cognition. It is in this most general *and* most fundamental sense that embodiment shapes the mind" (2015, p. 5, italics in the original).

This is territory that at present seems to evoke at least as much anxiety as it does curiosity and exploration in the analytic literature:

> In the verbatim—the verbal accounts as the familiar form of reporting from analyses by analysts--their words are recorded and feeling added. Bodily communication is occasionally reported under a given topic. But, in my experience, often the sensory and motor experiences stand out like "an elephant in the room," having a marked existence to which neither party knows how to relate, and which therapists tend to regard as too private or invasive, too awkward to put into words. (Yarom, 2015, p.3)

The questions increasingly raised in contemporary analytic thinking have brought that elephant not only into the room with our patients but also into our professional conversations. Now that we can begin to acknowledge the elephant, what do we do with this massive, looming creature?

Sensory engagement

In an essay on "Embodiment," Bollas (1999) observes, "Maternal libido cathects the infant's body and expresses itself through a laying-on of hands in the innumerable caresses that stimulate and gratify the body. A mother's kiss eroticizes the infant's body that responds through the pulsations of instincts." (p. 153). The "maternal" libido, offered by a parental figure of whatever gender, the erotic message is life enhancing. To my patient, Danielle, Bollas' account would have seemed like romantic or science fiction.

Danielle had always known the story of her birth, told to her repeatedly by her mother. Whether she should have been told the story was another question all together. She herself had then told the story many times over the course of her therapies. Somehow the narrative never lost its grip as a compelling reality. The story was that her mother had been diagnosed with multiple sclerosis but was pressured by her husband to continue "making babies". Pregnant again, this time with twins, her mother attempted a self-induced abortion. Danielle survived; her twin brother did not. This story and her fantasies of her dead brother haunted Danielle. As a child and adolescent, she often wondered if her mother would have been happier if she had died, too. Perhaps her mother had wished her dead as well. Her mother, of course, denied this, but Danielle struggled mightily to feel the right to be alive and for her life to be her own. Should she have died, too? Should she live for two? These were the sorts of questions that haunted her life and her therapy. As an adult, Danielle maintained a rather manic grip on her capacities to take care of herself, reluctant to ever imagine someone would care for her.

Danielle had persistent difficulties in sleeping felt that she felt certain to be linked to the hauntings of her dead twin. As we began working, I was immediately filled with fantasies of my own, imagining an unconscious equation falling asleep with

dying (Segal, 2007, pp.111-112). I asked her to close her eyes and fall into her sleepless body. This took time. In time she began to feel the core of anxiety that fostered her sleeplessness and with this came a series of associations and questions. Whose sleepless body was in the bed? Am I going to sleep or am I going to die? I know I have to sleep in order to start the next day, to start again. Do I have the right to start again? Whose question is that? Is this my body or my mother's body? How did my mother feel as night closed in? Out of my own sensate reveries, I spoke some of these questions, Danielle speaking others. Our words were few. We were not seeking answers but opening a space of experiential questioning. Then there was an association to her partner's comment that she often gripped his hand so tightly in the middle of the night that the pain woke him up. His was a comment of concern, not complaint. She began to cry. As she began to cry, I moved my chair closer.

As she stayed within this sleepless body state, some new, tentative psychic space opened. She began to shift attention away from her own struggles with the right to live to those of her mother while raising Danielle and her siblings. She began to imagine and feel the dilemmas of her mother's body, now ill, perhaps wishing that she herself might be better off dead. How was her mother able to grieve her dead son or her own ill body? Was there any recognition for *her* anxieties? She imagined the collapse of intimacy between her parents. Danielle began to get a felt sense of the near impossibility of her mother's body, wracked by unacknowledged loss and grief, to open and welcome Danielle's life. What would it be like to hold, nurse and nurture an infant you had tried to kill?

As Danielle cried, her hand, with fingers curled tightly in, suddenly shot forward toward me. I extended my hand to hers, gently touching the back of her clutched fingers with the back of my fingers. Her crying deepened. Our hands stayed in place, barely touching. We were silent. Slowly, in time, her hand began to move ever so slightly. I could feel that it wanted to rest in my hand, so I turned my hand palm up, such that her hand could rest—if it wished to—in mine. I speak here of "her hand" as though it was separate from her, as though it in that moment had a mind of its own. In a certain way, her hand did indeed have a sensori-motoric mind of its own, as her partner well knew. Danielle was crying. I didn't yet know the meaning of her tears. Perhaps she didn't either. That would come, but in the meantime, her hand had begun to move, to explore. Her hand, fingers still curled tightly in upon themselves, did rest in mine. I waited. We were silent. Gradually her fingers began to open, and her hand turned so that the palm of her hand was resting on mine, and her fingers curled into mine. The touch was tender. And the movement of her hand continued. Her eyes were closed, mine were open, watching her face, her breathing, her posture. She continued to cry. Her hand continued to move. Her fingers tightened on mine (as I imagined they did in her sleep with her partner). She moved her hand away. Mine stayed in place. Her hand returned, this time pressing into my hand.

My fingers curled into a fist, and we pushed against each other, fist to fist. Her hand pulled away, opened again, and returned to take mine—this time with her hand supporting mine. She wept. Her touch turned into a caress, as did mine in reply. We remained silent, but our hands spoke. My hand followed her initiative and exploratory movements. There emerged a kind of dance between these two hands, exploring, playing with different kinds of contact and rhythms. Opening here between us was a Winnicottian field of "play" (Winnicott, 1971; Cornell, 2015, pp. 98-112)

Winnicott wrote frequently of the importance of sensori-motor activity in relation to both the physical environment and the interpersonal realms for the child's development of personal agency. He spoke of the "spontaneous gestures" of the young child that he saw as "the True Self in *action* …. The True Self appears as soon as there is any mental organization of the individual at all, and it means little more than the summation of sensori-motor aliveness…. Every new period of living in which the True Self has not been seriously interrupted results in a strengthening of the sense of being real." (1960/1965, pp. 148-149, emphasis added). Reich's model of character analytic intervention had placed the primary emphasis on the patient's defensive reactions of muscular and interpersonal "armoring" against environmental failures and impingements. Winnicott's focus was on the original intention/direction/aim of the gesture that was interrupted and the subsequent loss of the originary impulse.

One can only imagine the innumerable times Danielle's gestures toward her mother were interrupted rather than welcomed. As I had been listening to Danielle I was imagining the many times her tentative aliveness may have been met with her mother's anxious deadness, taken in by Danielle as a wish that she (Danielle? her mother? both? perhaps impossible to know which) were dead. It was as though in the session Danielle suddenly released the death grip on her sleeping partner's hand to move out toward me. It was a bodily gesture calling for a new welcoming—a gestural completion.

Somatic intentionality

In time, Danielle began to speak, putting words to the experience of her hand. She said that as her hand began to move and she began to feel the freedom to explore, she could feel the struggle and inhibitions that had constrained her in so many ways. She felt the beginnings of a differentiation between her body and her mother's. Her tears had been for her mother rather than for herself. Through her adolescence and adult years she had lived the story of the attempted abortion and her dead brother as something that had been done to her. Now she had begun to feel the impact of what her mother had done to herself. She felt her mother's loss and frozen grief that had been inhabiting Danielle's body. The narratives of her traumatic birth and the sequela she had told herself, lovers, and therapists were true, but they were only a partial truth. The narrative was an

accounting dissociated from her mother's unbearable grief and un-witnessed suffering. In bringing her attention, her sensate experience in the here and now, to this body-that-could-not-sleep (a body that should not rest?), the dissociative gap began to close, and the dissociated affects and desires began—literally—to *move*. Up to this point, Danielle's repetition of the official narrative of her birth constituted an unconscious repetition and reenactment of the past. The shift into a sustained affective state and the spontaneous movement generated from it carried something novel, unpredictable, an opening.

In this session Danielle and I were working within the subsymbolic and nonverbal symbolic modes of a fundamental "emotion schema" (Bucci, 2007a,b). As described by Bucci, "The subsymbolic sensory, somatic, and motoric representations constitute the *affective core* of an emotion schema, the basis on which the schema is initially built. …Emotion schemas, like all memory schemas, are active and constructive processes, not passive storage receptacles. (2007a, p.173, italics in original). Danielle expressed her dissociated states of the subsymbolic affect that underlay her sleeplessness through bodily movement in nonverbal symbolic mode. The interactions of Danielle's hand with mine became a form of nonverbal, symbolic communication. Following a sustained, nonverbal communication through touch, we could then enter a narrative mode, the verbal symbolic, which was *associated* to her history in newly meaningful ways.

Sensate "listening"

Jon Sletvold (2011, 2012, 2014) describes the intentional utilization of sensate experience in the training of psychotherapists in an embodied character analytic model of psychotherapy and psychoanalysis. He blends the training and supervisory approaches typical of psychoanalysis with those more grounded in body-centered models. Body-centered training and supervision, of necessity, is experience-near, that is, grounded in the therapist's receptivity to the information and understandings to be garnered through one's own somatic experience of the engagement with a patient. Sletvold (2012) observed that while written case studies by trainees "were engaging and the candidates came up with many ideas… It was as if the written reports and especially the ensuing discussions created a *distance* to the actual interaction…" (p. 419, emphasis in original). He then describes the process of nonverbal case presentations in supervision in which the supervisee mimes bodily ways of being in the session and in relation to the analyst (2012, pp. 420-427). Innovative in the psychoanalytic fields, this process is central to most body-centered therapy modalities.

Sletvold observes that in sensate oriented, experience-near training and supervision:

> An aspect of this approach is that it easily triggers personal issues for the supervisee. If the supervisor does not pay adequate attention to personal emotions activated in the supervisee,

> supervision will easily turn into a stressful and unproductive experience. …When the supervisor, however, pays attention to the supervisee's personal emotions the two have the possibility of exploring countertransference issues in-detail. (p. 425)

It has been my own experience as practitioner and supervisor that with repeated engagement in somatically based supervision, therapists come to recognize and separate the elements of their own bodily reactions that are indications of countertransference from those that can be informative of the patient's own body-based conflicts and desires. Trainees become more comfortable with "the elephant" in the room, such that coming to be less of a looming, exotic, threatening creature of otherness and more an ally in the treatment process.

Nancy Chodorow (2012) chaired a panel at the 2011 conference of the American Psychoanalytic Association entitled, "Analytic listening and the five senses" that undertook a fascinating discussion:

> …We wonder how these features of the analyst's individuality—if she is visual, musical, tactile, or sensitive to sounds, rhythms, and meanings of words and the spaces between words—affect her listening. (p. 748)
>
> *We wonder what developed and undeveloped senses we bring to our work*. (emphasis added, p. 749)

As I read Chodorow's wonderings about the underdeveloped senses analysts bring to their work, I could not help but think of the century-long technical consequences of Freud's personal discomfort:

> I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of sight. …it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more). (1913/1958, pp. 133-134)

When the use of the couch and the foreclosure of the visual field were taken as technique fundamental to psychoanalysis, how much of the sensory field was lost to patient and analyst alike? It has taken decades since Freud's passing and the opening of the interpersonal and relational models of psychoanalysis to bring nonverbal communication and sensate experiences into an analytic field of exploration.

Perhaps such a reframing of the analyst's somatic experience as those described by Chodorow's panel may help to reduce the privacy and awkwardness to which Yarom alludes. As stated by Yamaguchi (21012), a potter and analyst, in her closing commentary on the conference panel, "each of the panelists described a kind of knowing that emerged trough sensory listening, not consciously known but operating on a presymbolic, preconscious, and unconscious level" (p.814). *A kind of knowing:* somatic experience framed as a means of psychic organization

rather than psychic retreat or regression. As a somatically oriented psychotherapist, it was fascinating to me to read her account of the audience reaction:

> The ballroom was packed, and an air of excitement filled the room. There was often laughter of relief, murmurs of agreement, a deeply felt gratitude that something known was finally spoken about. It was obvious from the audience's questions and comments that the panel had touched on something important, and too long ignored. (p. 814)

In her overview of the panel discussion, Chodorow argued, "All these sensory modalities take us directly to the body, and we find differences among analysts, as we listen to our colleagues and read the literature, in how much their clinical listening involves observations of body in their patients or of direct body experiences in themselves" (p. 753). The somatic elephant is invited back into the room, and this time is held squarely in gaze. Significantly, Chodorow's and her colleagues (Palmer, 2012; Hamer, 2012; Goldberg, 2012) open a field of the discussion of the analyst's sensory-somatic receptivity framed *outside* the familiar structure of transference and countertransference. In his contribution to the panel, Goldberg described the analyst's use of sensory experience as a form of "active perception," that is, an "essentially inductive, performative dimension of the analyst's sensory participation" (2012, p. 792). As Goldberg stresses, this level of sensate perception occurs at the subsymbolic level—presentation rather than representation; although not organized at a verbal level, sensate perception is a form of knowledge and can become an aspect of the analyst's conscious repertoire.

Goldberg makes the important distinction between the analyst's *"receptive, responsive* functions" which have been well examined in the literature on countertransference and enactment and those he characterizes as "*inductive* or *initiating* functions—the way he actively engages the patient" (p. 794, italics in original). He goes on to note, "the phenomenology of sensory engagement *in its own right* remains sparsely described in clinical theory" (p. 794, italics in original). Goldberg argues, "the distinctive thing about being jointly alive in the act of shared perception is that one is, in a sense, sharing the sensorium—the body—of the other…"(p. 796). The case illustrations that follow with Zeke and Marie are efforts to illustrate the careful, deliberate effort to deepen the sensate experience of both myself and my patients, so as to open new possibilities of self-understanding.

Maintaining a sensate focus

His father long dead, and an only child, Zeke's therapy had been focused on his mother's ever more rapid descent into dementia. Although his relationship with his mother had been troubled and distant throughout his childhood and adult life,

Zeke felt an abiding wish to accompany his mother through this last stage of her life. Through this period, he had struggles both his anxious concerns for his mother's deepening loss of identity and his own desire to get to know the woman who had been his mother. Through his efforts there came to be a rather unexpected deepening and sweetening of their relationship. Now she was settled in the safety and security of a nursing home, Zeke was unsure if or how to continue his therapy. "Ya know, it's just the ordinary highs and lows," he said in a tone of voice that suggested the case was closed and there was little if anything left to explore therapeutically.

I suggested that he sit quietly, eyes closed, for a few minutes in his experience of the "highs". After a few minutes, I suggested he visit the lows in a similar fashion. We sat in silence during this time. When he opened his eyes, he said, "They're not all that different. Just this anxiety always in the background." My inquiries into the possible meanings or objects of his anxiety were greeted with a series of "I don't know" replies. I asked him to hold the edge of this anxiety in his body and see what came to mind. At the same time, I was imitating his posture and body movements, "holding" in my body what I knew of Zeke through our previous work, and trying to inhabit his anxiety in my own body. Zeke quickly associated his experience of his anxiety to his manic behaviors that we had often explored in previous work. "Ya know, alone, moving, just keep moving. I mean, I get a lot done (with a laugh), but the anxiety never goes away. It just stays. If it gets too bad, I go for a run. That does it." "And you go for the run alone." I note. "Is there any other way?" he replies with a quiet laugh.

I urge Zeke to stay with the anxious edge in his body and ask a series of questions to explore the meaning of this persistent anxiety. Each of my questions was met with a one word reply, "Difficult." I asked if, as he recalled in his body various times of anxiety, he could sense the moments that preceded the anxiety. "Difficult." It became abundantly clear that my verbal inquiries were not helpful. During all of this interchange, I was continuing to feel and explore in my own body my sense of Zeke's anxiety. Zeke could find no words, so I decided to voice my own in a kind of freely associative style, speaking from and for my own sensate experience, "Alone… Always alone… Be prepared… When I'm alone, my mind can't rest… My body can't rest… Always alert… It—I—can't rest… Anticipate… Scan… Know in advance… No one there… Alert, scared, ready to move…" "I know that place," says Zeke, "I know that place, but I can't feel it by myself." There were, for Zeke, aspects of his inner experience that he could not access alone—alone was simply the ground of his manic, lonely and anxious self-management. He then begins talking about his wife with whom he has developed the closest sense of partnership he had ever known. "I can talk to her about this, and maybe with her I can begin to feel the moments before the anxiety takes over." As observed by Goldberg, "In this domain of shared or

communal [sensory] perception lies something inherently transformative, something not found in the act of individual perception alone…" (2012, p. 796).

After a two-year break from work with her previous therapist, Marie comes tentatively for an exploratory session to see if she could find a different way of engaging in therapy. While her previous therapy had been very fruitful in many regards, she felt that there was some way that "it hasn't taken hold." She had worked hard to address and work through the profound abandonments she had experienced in childhood but reported that she still could not take in the love, affection, and enjoyment that her friends offered her. "My mind can see it, but I can't take it into my body. Nothing. It just doesn't feel real to me." As she speaks about it with increasing distress and frustration, her voice grows tight, and she motions to her throat and chest getting tight. "I can't take it in!" Then, suddenly, she drops into a state of rage. "I am locked in this rage," she screams, as there is an outpouring of often-told stories of the repeated abandonments she suffered as a young child. Her father had left her mother during the pregnancy. At 8 months her mother had given her to her grandmother, returning 3 years later, now with a one-year-old son. "She kept ***him***, BUT SHE GOT RID OF ME," she screamed, tears streaming down her face. I struggled to comprehend this sudden drop into such a raw place of unbridled affect.

My throat had tightened and my own breathing nearly frozen. As I watched and listened to Marie, I let my awareness shift viscerally to my throat. I found myself having a strong impulse to spit, maybe even vomit. This is not a common experience for me to have in the middle of a session, so, of course, I was wondering what this might be indicating about what was happening for Marie. I asked Marie if she had any sense of what she might be experiencing if not this rage. She said she didn't know but had often wondered this herself, as this rage seemed to take her over so easily and had been a constant presence in her previous therapy. Her rage continued.

I let myself drop more deeply into my own sensate experience of a tightened throat, frozen chest. My chest began to feel panicked. The tensions rose into my mouth. My mouth…I wondered to myself was this about needing to suck? I could feel a rising sense of panic. My mouth could spit but not suck. My panic triggered a deep sense of my body trying to hold something out, ward something off. The language I use here to describe my bodily experience is quite intentional. It was not my felt experience that ***I*** wanted to suck or spit. *It* was my *body* that was having these experiences and impulses—experiences that I took to be importantly informative as a kind of somatic reverie.

I found myself having a very distinct impression/reverie that her mother's decision had been a caring decision, protective rather than abandoning. I asked Marie if she had ever talked with her mother (who was now dead) about the

circumstances of her birth and her decision to turn Marie over to her grandmother's care. They had indeed talked about it. Her mother told Marie that she had been an anxious baby, suffering from colic and digestive problems. She felt overwhelmed, alone, and inadequate to care for her baby, and she needed to work. She decided Marie would be safer in the care of her own mother, who could devote herself full time to her granddaughter. "But it didn't change how I feel. It didn't really make any difference." She asked why I had asked that particular question.

I told her that as I listened and felt the impact of her distress I found myself having quite a different experience from hers and wondered if it might be helpful for me to verbalize what I had been experiencing. As I described earlier with Zeke, I spoke in an open, freely associative manner, which was something like "I can spit. Vomit. Impossible to suck. SUCK. NO. I can't….I won't… Bitter, anxious milk. Anxious eyes. Nowhere to look. Anxious skin. Anxious… I can't take it in. I can't suck. Bitter. Frightened. Tense. I can't take it in. I can't stand it… If I suck, it all comes in… Who does it belong to? I can't stand it. She is falling apart… I will fall apart… An 8-month old body. Too little… It's all too much. GET IT OUT OF ME!"

I waited. I could see the impact of my words. Marie's face softened. I ventured forward a little more, "Impossible for an infant's body, but now you have the mind and body of a 40-year-old woman. Perhaps now you can begin to bear what was not possible then." It became clear that Marie's constant, consuming rage warded off the threat of an unbearable and disorganizing experience of intrusive and overwhelming anxiety. As I listened to Marie and allowed my body the freedom to "wonder," my body was able to enter a range of sensations that Marie had long ago learned to dissociate from her young body and any lived sense of self. My body had the capacity to tolerate and associate to affective and sensate states that for Marie had always been unbearable.

Concluding reflections: The analyst's body at work

Each of these case illustrations were drawn from points in these therapies, periods that could be defined as periods of impasse (or potential impasse), in which previously productive modes of verbal exploration and analysis had come to a halt. There needed to be a shift in the level of investigation. Here the sustained, conscious attention to my sensate experience, opened different means of exploration. The use of movement, touch, and a deepening of previously dissociated states of affect and meaning allowed a gradual emergence of new, languaged possibilities and meanings. It was essential that I could hold, in my own sensate experience, the dynamic tension between defensive forces and those conveying a forward intentionality.

I have come to think of interventions at this level being in the domain of "reclamamtion" that Alvarez (2012) characterizes as the "intensified and vitalizing levels of work" (p. 21). She argues that in those domains where "it is a matter of defects both in self and internal object, where *both* are experienced as dead and empty, useless or capable of deviant excitements" (p. 21) the analyst must offer a different level of engagement. As Alvarez states succinctly, "Something and someone has to matter" (p. 25).

With Adam and Danielle, somatic-centered attention and inter*action* created a space within which we could enter and explore compelling emotion schemas. From an analytic perspective, reenactment or enactment is understood to be an unconscious process, often defensive in origin a replay of history in the present. Seen from a somatic perspective, body-centered intervention and exploration can constitute a more conscious effort at seeking meaning through an associative process that does not yet have or need language. Somatic interventions offer forms of *action* that may reduce the need for and inevitability of enactments or reenactment within the therapeutic dyad.

Jim McLaughlin (1995, 2000) and Danielle Quinodoz (2003) are among the psychoanalytic authors who have wrestled most deeply with the use of language to "touch" domains of unconscious and sensate experience. Drawing upon Quinodoz' accounts of "incarnate language" (p. 35) I have written elsewhere, "Incarnate language is a kind of speaking *to* the analysand's body rather than speaking *about* it" (2011, p. 433), which, of necessity, must come *from* the deep resonances within the analyst's own bodily experience. It was my hope and intention in speaking the way I did to Zeke and Marie that my words would "touch" and vitalize aspects of self-experience and potential that had lain disavowed for decades.

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