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# A Conceptualization of the Body in Psychodynamic and Body-Based Psychotherapies: Areas of Overlap and Possibilities for Integration

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A Conceptualization of the Body in Psychodynamic and Body- Based Psychotherapies – Areas  
of Overlap and Possibilities for Integration

By

Aleksandra Rayska

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the  
requirement for the degree of Doctor of Philosophy The City University of New York  
2017

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Aleksandra Rayska

This manuscript has been read and accepted for the  
Graduate Faculty in Clinical Psychology Doctoral program to satisfy the dissertation  
requirement for the degree of Doctor of Philosophy.

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## ABSTRACT

### A CONCEPTUALIZATION OF THE BODY IN PSYCHODYNAMIC AND BODY-BASED PSYCHOTHERAPIES- AREAS OF OVERLAP AND POSSIBILITIES FOR INTEGRATION

By

Aleksandra Rayska

Adviser: Benjamin Harris, PhD

The distinction between verbal and nonverbal psychotherapies is clearly visible in theory and clinical practice. Moreover, this duality of approaches promotes a split between the body and the mind, defining them as separate from each other. This dissertation helps bridge the divide between the literature in body-based therapies and verbally-based psychotherapy by (i) exploring the conceptual frame used to understand the body in psychodynamic therapy (ii) identifying the areas of overlap between psychodynamic theory and theories that underlie body-based psychotherapies, and (iii) proposing ways in which psychodynamic and body-based theories can inform one another.

A clinical case is used to share possible ways in which nonverbal attunement, somatic countertransference, mirroring and embodied use of language could contribute to bridging the gap between the worded and wordless. In the case and the analysis, it becomes apparent those therapeutic interventions that are coming from the field of body-based therapies, could be used in verbal approaches to contribute to a fuller understanding of the therapeutic process.

*Keywords: psychodynamic psychotherapy; body-based psychotherapy; nonverbal attunement; embodiment; dance-movement therapy*

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## Overview

This dissertation contributes to a conversation between two related but distinct fields in psychology: psychodynamic psychotherapy and body-based psychotherapies (e.g. dance/movement therapy). Drawing from professional experiences both as a trained dance/movement therapist and a clinical psychologist, the writer identifies points of tension and commonality between a psychodynamic conceptualization of the body and the ways in which the body is conceived in dance/movement therapy and other psychotherapies that focus more specifically on embodiment. The point is not to prioritize or compare, but rather to treat both disciplines with respect while looking at ways in which they inform one another (Bloom, 2006). The focus of this work thus is on possible ways of integrating practices from body-based psychotherapies (i.e. mirroring, bodily attunement, nonverbal reparative experience) with primarily verbal psychotherapy, to show the opportunity to extend the scope of clinical interventions to serve patients better.

The distinction between verbal and nonverbal psychotherapies is clearly visible in theory and clinical practice (Miller, 2000). Moreover, the lack of conversation between these approaches furthers a split between the body and the mind, defining them as separate from each other. This dissertation aims to help bridge the divide between the literature in body-based therapies and verbally-based psychotherapy by (i) exploring the conceptual framework used to understand the body in psychodynamic therapy (ii) identifying the areas of overlap between psychodynamic theory and theories that underlie body-based psychotherapies, (iii) proposing ways in which psychodynamic and body-based theories can inform one another, and (iv) illustrating this dialogue with a clinical vignette.

The first chapter of this dissertation provides an overview of the history of psychodynamic theory about the body and the role of the body in the therapeutic process. To this end, the inherent tension between the role of verbalization and bodily expression in the psychodynamic literature is reviewed by examining the concepts of the body ego and the history of somatic symptoms.

The second chapter defines a conceptualization of the body in body-based therapies, including dance/movement therapy and other embodied psychotherapies. Specifically, it considers the body as a channel of communication and as the primary mover of the therapeutic process.

The third chapter probes into areas of overlap between psychodynamic conceptualizations of the body and body-based therapies conceptualize the body. Furthermore, this chapter provides a framework within which these schools of thoughts inform one another. It shows how body-based approaches can inform clinical psychodynamic practice.

Chapters four and five provide an in-depth clinical illustration of how dialogue between these schools of thought can enrich clinical work, and discuss possible clinical implications of a more embodied clinical practice. Specifically, the role of the therapist's physical presence as a factor in treatment as well as an examination of the nonverbal process in verbal psychotherapy, using phenomena such as somatic countertransference, nonverbal reactions, observation, and attunement. Later the role of the body in the expression of unconscious process and the use of the body as an agent of change will be explored. Clinical material from over 100 hours of psychotherapy session with Tina, is used to bring those concepts to life.

Chapter six provides a discussion that will summarize the key points from the literature overview and case material, to show ways in which body-based therapies can inform

psychodynamic psychotherapy. It focuses on techniques such as mirroring, bodily reparative experience and embodied use of language to illustrate the potential contributions to the field made by this integrative study.

## *Tina*

*Jewelry. When I saw her for the first time, I couldn't stop looking at it. She wore a ring on every finger of her right hand, and a huge heart shaped red ring on the middle finger of her left. She had massive earrings, multiple shimmery bracelets and at least two large necklaces. In her hair there was a big red rose. She wore multilayered clothes covering up and exposing different body parts. Her body had a striking presence. As we were walking to our therapy room, I was trying to imagine how would she look without "all of that", and I couldn't. I didn't know then that this would be the patient who would tell me that I am the worst therapist ever. That sometimes I will be afraid of her. That at times I will wish that she wouldn't show up. But that I will also venture with her into undiscovered, non-verbalized levels of pain and suffering, when my own eyes would tear up and I would feel overwhelming empathy for her. Then I was just walking down the hallway listening to the jingling sound of her jewelry.*

This is Tina, a patient with whom I worked for over 120 psychotherapeutic hours. This work has influenced my thinking about the interrelation of mind and body, as they appear in the context of psychodynamic psychotherapy. In this dissertation Tina makes an appearance in Chapters 4 and 5, where the specifics of the bodily process in the course of our treatment are discussed. I also refer to our work together in Chapter 3, where the overlap of body-based and psychodynamic approaches will be explored. Tina's bodily presence and our mutual bodily communication were shaping how the therapy progressed, giving a lived proof of the mind – body matrix (Perin, 2011).

## **Chapter 1 – Conceptualization of the Body in Psychodynamic Therapy**

“Our bodies are the only possessions that we are born with, live with, and die with.

Thanks to our bodies, we can sense and act. These senses, which perceive this living body and our brain, which stores all those information is also an integral part of the body”

(Castle & Phillips, 2002, p. 1).

The body is the container that enables all our various abilities as human beings, including the abilities to generate ideas, to free associate, to listen, or to make interpretations. However, psychotherapy has positioned the mind at the center of its inquiry, and words not movements or bodily sensations have become the chief medium of therapeutic inquiry and intervention. In this way, as a discipline, psychotherapy has staked its territory on the side of the mind in mind-body dualism.

Elisabeth Perin, a historian of psychology noted: “The lack of a consistent model of the relationship between qualities of mind and qualities of body has resulted in ever-evolving theories of philosophy, medicine, religion, and psychology.” (2011, p. 3). While people experience a complex and at times confusing or contradictory matrix of body-mind-brain interactions on an daily basis, psychotherapy as a discipline has struggled to articulate a model of the mind that adequately accounts for this phenomenological reality (Perin, 2011).

This chapter looks at ways in which the body has been conceptualized in psychoanalytic psychotherapy, tracing the development of the role and meaning of the body through Sigmund Freud’s writing. The chapter concludes with a brief review of Reich’s contributions to the understanding of the role of the body in psychotherapy. In chapter 3, I discuss the ways in which contemporary psychodynamic theory and attempts to overcome the mind-body dualism that Freud’s writing laid as a building block for later psychoanalytic theory.

## **The mind-body dilemma**

With the writings of Descartes (1984) a long-standing dialogue was established regarding the relationship between the mind and the body, and which of these entities acts and which is acted upon. Positivistic science based on the theories of Descartes (1984) underlie empirical science and every-day assumptions that tend to be taken for granted. Is physicality merely a container for the mind, or is there an interaction between the mind and the body, where both the mind can act upon the body, but also the body can act upon the mind? Descartes's famous revelation, "I think, therefore I am" has been deeply ingrained in western thought. The mind-body split is deeply ingrained in the intuitive understanding of a person's self. That is why one's body can be experienced as separate from their self.

Since the time that these positivistic rules became a basic assumption of western thought, developmental theory has generated insight into how people's interactions with the world, including thought, are first and foremost built upon bodily experience. For example, the body is the medium through which an infant first begins to sense the boundaries between the self and the other. As such it is a "me-not me" object – body is not perceived as the feeling, thinking, suffering psychic self, but rather as "something different." In Winnicott's (1988) perspective the body is a container for the developing self – as such it provides us with the first experience of a boundary between me and not me. The body can be seen as a distant enough object that, when moved willfully can give experience of taking control over something outside of the self (Sloate, 2008). Meissner (1997) writes that the body is not only involved in being seen but is also in the very act of seeing as well. Freud (1905) similarly describes instincts in sexuality that are rooted in the body and the ego being first and foremost the body ego (Freud, 1923) – body being both an object and an agent in that sense. A person cannot be separate from their body at any point in

time: “All psychological stories are first stories of the body's history. All narratives, fantasies, defenses, ego functions, symptoms, and finally sentences, no matter how we conceptualize them, bear the primeval trace of the body's signature” (Meissner, 1997, p. 435).

### **Basis of Mind – Body Duality**

The division between the body and mind is intertwined not only with questions related to limits of our self-examination, but also with the idea of separation between the body and soul (Plato, 1997). Perin (2011) credits Parmenides of Elea with taking the initiative to approach a pure abstract rational logic and as a result, to step away from the overlap between mythic and scientific explorations while stressing the difference between the real and the apparent. Sensory perception became, for the first time, a questionable basis for truth. The new truth was a rational, abstract one as the historian of psychology Perin explains (2011).

In Plato’s philosophy (Plato, 1997) there exists a distinct division between the material and spiritual worlds, between the divine world and the matter that comprises our surroundings. Plato in his theory of forms (Plato, 1997) argued that the body is part of the material world, as opposed to the soul, which belongs to the immortal world of ideas. The psychoanalyst Steven Mitchell (2002) remarks that part of Plato’s heritage is also attaching a moral value to a division of human nature along mind-body lines. He elaborates that Plato’s vision of human condition is one that is composed of a lower bodily nature, driven by passions of flesh, and a higher nature of reason and spirituality. This hierarchy is visible also in later speculations around the body-mind distinction.

In philosophy of mind, dualism assumes that mental phenomena are of a nonphysical nature, and as such mind and body substances are separate. Rene Descartes, considered by many the father of dualism, argued in his theory of mind – body duality that mind and consciousness are separate from the physical brain. In the dualistic view, the body is incapable of feeling or

thought. This philosophical doctrine is the historical background for the formation of the conceptualization of the body in the psychodynamic school of thinking (Mitchel, 2002).

### **Freud's Ideas about the Body and the Meaning of Somatic Symptoms**

Freud's early contributions to the conceptualization of the body – mind connection are undeniable. As a dance/movement therapist Katya Bloom (2006) points out “psychoanalysis has never ignored the body” (p. xi), however the relationship between the physicality of human existence and psychoanalytical conceptualizations of the body, has been changing over time. For example, Freud's work (1893) which was inspired by Charcot's findings about hysteria, followed by the split from Charcot's anatomic view of the location of psychic conflict (Breuer, Freud, 1981), through his work, *Interpretation of Dreams* (1900), where Freud's moves away from an anatomical towards a metaphorical understanding of the body, and concluding with Freud's treatises on emergence of psychosexual symptoms (Freud, 1905).

### **Freud – The body and medicine**

Freud not only theorized that the ego is first and foremost the body-ego (Freud, 1923), but in the beginning of his career he worked extensively with the body using a pressure technique to ameliorate neuropsychological symptoms (Breuer, Freud, 1981). In this way, the roots of psychoanalysis can be found in body -based psychotherapy. From inception, Freud considered the body not only a metaphor but also an instrument of change.<sup>1</sup> As Anzieu (1989) wrote: “Freud the hypnotherapist was more a man of sight and touch than a man of words” (p.138).

Freud's neurological and medical education shaped his thinking in the early days of psychoanalysis, so much so that, in the process of his own self- analysis, he made a goal of

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<sup>1</sup> This early approach was much closer conceptually to body-based therapies that are discussed in Chapter 2

freeing himself from the “neurologization” of his psychological insight (Silverstein, 1985). This tension between what is the mind’s control over the body in hysteria and neurosis, and what is the body’s control over mind, is quite visible throughout his early writing (for example Freud, 1900; Freud, 1905). Freud began his explorations of psychosomatic symptoms (Freud, 1905) with the intention of creating a scientific psychology that would be based on the anatomy of the body and brain.

Freud studied with Jean–Martin Charcot in Paris from October 1885 through March 1886. He joined Charcot with hopes to examine the role of cognition in producing physical symptoms (Silverstein, 1985). While Charcot considered psychogenic factors as causing hysterical paralysis, he also believed that there had to exist an anatomical damage or lesion in the part of the brain that controls the affected area of the body. In Charcot’s view, the hysterical symptom was a product of anatomical damage to the brain.

Freud took a more psychological approach to hysterical symptoms, arguing that paralyses and anesthesia were determined by the patient’s notions about the body, not by the anatomical factors in the patient’s brain: “I, on the contrary, assert that the lesion in hysterical paralyses must be completely independent of the anatomy of the nervous system, since, in its paralyses and other manifestations hysteria behaves as though anatomy did not exist or as though it had no knowledge of it” (Freud, 1893, p. 169). With the recognition that the mind is capable of producing somatic symptoms that are non-neurological, Freud concluded that the mind is much more than a simple property of brain functions.

As Silverstein (1985) underscores, Freud distinguished between mental and somatic phenomenon, and he attributed a key role to the mind. The hysteric’s body was for Freud merely expressing a vulnerability that was rooted in mental processes, it is the “psychical insufficiency,

as consequence of which abnormal somatic processes arise” (Freud, 1895, p. 114). The mind in this conceptualization is the subject, whereas the body is the means of expression of a mental conflict. Conceptualizing bodily symptoms in hysteria Freud (1894) speculates that in hysteria it is the physical excitation that takes a pathological, solely somatic direction, when a person cannot accept a specific sexual thought. As a result of that process the excitation that is associated with those sexual unconscious thoughts is turned into a somatic symptom.

### **Freud – body, dreams and words**

However, at that point Freud’s ideas about the interaction between the mind and the body were not yet crystallized. In his later work, starting with *The Interpretation of Dreams* (1900) Freud sees the parallel between the somatic processes and the process that unravels in dreams. The underlying assumption is that psychic processes have roots in the body, and it is only when the libido from the body is “translated” into the language of the mind, that the psychic content can emerge (Perin, 2011). In *Analysis of a Case of Hysteria* (1905), Freud proposes that analysts pay as much attention to the social context of the patient’s life as to their bodies, because this context may provide the logic by which libido is “translated” in such a manner.

In the same year, conceptualizing Dora’s case (1905), Freud pointed to somatic compliance as a necessary condition for the development of the hysterical symptom. The psychic meaning is lent to the bodily symptom in the case of hysteria. It is the somatic compliance that allows “the unconscious mental process a physical outlet” (Freud, 1905, p. 40). Serving this function the bodily symptom becomes “anchored fast in the patient’s mental life” (Freud, 1905, p. 41). Freud interpreted the psychosomatic symptom (Dora’s foot dragging, that he interprets as her embodiment of the sense that she made a “false step”) as an “infantile prototype” (Freud, 1905, p. 102). Freud’s analytic technique assumes that it is only when patient accepts the

interpretation of their hysteric symptom that they can improve, and that the somatic symptom, now deprived of its unconscious meaning, will dissolve.

In Freud's view, the somatic, even though it is a necessary channel of expression, can only be worked through verbally. The mind is privileged over the body in taking control of symptoms. The body can be verbally interpreted, but does not necessarily have its own means of interpreting the mind – which feeds into the supremacy of mind over body.

In Freud's 1905 writings, the body is correlated with the unconscious, whereas the psychic is correlated with both the unconscious and the conscious, depending on whether the psychic content has reached a threshold of perception. He elaborates on the ties between mind and body in *Three Essays on Sexuality* (1905) – this theoretical positioning of the body points to its inferiority and primitivity, as compared to the more evolved mental content. Psychosomatic symptoms are those that didn't develop into thought, and as a result had to be located in the metaphorical space of the body. This assumes a developmental hierarchy between the somatic and psychic. The capacity to symbolize is in this context seen only as occurring in the verbal, and not in the bodily realm. This points to a suggestion that bodily communication is a primitive form to be outgrown with time and maturity. There is an implicit assumption of the superiority of verbalized experience that diminishes bodily communication. This is a clear difference with the body – based therapies that are described in Chapter 2, see the body not only as a tool, but rather as a means of therapeutic change.

Contemporary psychodynamic theory (cf. Aron, 1998; Stern, 1997; Beebe, Lachman, 2002) is also making strides to integrate the mind and the body as they mutually affect each other and the therapeutic process.<sup>2</sup>

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<sup>2</sup> For possible areas of integration and overlap see Chapter 3, as well as the clinical illustration in chapters 4 and 5.

The “talking cure” rests on the essential idea that expression of affect and meaning via words is “healthier” than anything more concrete. “Anything more concrete” may include acting out and somatization; it may also include bodily experience, bodily expression, and embodiment (Perrin, 2011, p. 10).

With this downplaying of the physical expression comes an inability to trust the information that comes from the body. Thus the body is placed in the position of inferiority to mind and verbalization. Cornell (2015) identifies that moment as pivotal in the development of psychoanalytic theory, seeing it as a time in which the practice became identified solely with mind and symbolization and developed “dis-ease with somatic life” (p. 20).

### **Freud – The actual body and the metaphorical body**

Freud’s (1905) later adoption of a biologically based notion of instinct ties his psychological theory to the somatic dimension. In his instinct theory (1920), Freud describes the cycle of energetic processes in the body that exert pressure on the mind. The mind has the capacity to transform them into mental content and act accordingly in order to release those pressures. “The instinct became the concept for this frontier between psyche and soma; instinctual drive embodies the process by which somatic process become psychological” (Perin, 2011, p. 86).

However, as Perin (2011) noted, it is not clear if Freud emphasizes the tie to the actual or metaphorical body. Freud further develops his conceptualization of the somatic symptoms as well as erotogenic zones away from the physical, and towards the symbolic. As Hughes explains: “An erotogenic zone was initially bound up with something somatic, with a vital bodily function; subsequently it became separated from bodily needs; it became an archive of experiences of satisfaction. . . . The body had ceased to be merely physiological” (Hughes, 1994, p. 165 in Perin, 2011, p. 67). In this evolving conceptualization, the body takes on a metaphorical meaning for the psyche and is not understood as having its own meaningful forms of expression. While

analyzing Freud's abandonment of the physical body for the symbolic one, McDougall (1995) claims that some bodily manifestations (in forms of psychosomatic symptoms or other bodily expressions) cannot be attributed purely to the symbolic body – which makes the psychoanalytic theory lacking. What appears to be lost in this new approach to the mind – body relationship is the influence of the physical body on the psychic, and the idea that the internal conflict will have an impact on the actual physical body (Bloom, 2006).<sup>3</sup>

### **The mysterious leap from mind to body**

The struggle with this mind-body dichotomy, or what Felix Deutch (1952) called “the mysterious leap from mind to body,” is deeply embedded in psychoanalytic thinking. When seen as separate processes and matters, mind and body appear to be impossible to integrate. The invaluable contribution and heritage of Freud's theory is that it sees the roots of the psychic functioning and conflicts in babies' fantasies about ways in which the body functions and the mysteries of the body (Lemma, 2015). Since Freud, several of his students and followers (Jung, Ferenczi, Reich), have made with varying degrees of success attempts to integrate the body into psychoanalytic method and theory beyond the symbolic realm. However, among them, Reich's contributions have been most prominent in light of the development of body-based psychotherapy. Basics of Reichian conceptualizations of the body are often seen as a foundation for development of the body-based psychotherapies.<sup>4</sup>

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<sup>3</sup> The concepts of mutual mind – body influence will be picked up and developed by contemporary, relational psychodynamic thinkers, and are described in Chapter 3.

<sup>4</sup> More current theories and ways in which psychodynamic thought has embraced the bodily phenomena are described at greater length in Chapter 3.

## **Reich the shadow of the body**

Wilhelm Reich was a student of Freud and in 1920 the director of Freud's Viennese outpatient clinic, he could have been one of Freud's intellectual heirs. However, Reich's radical views concerning the role of the body, and his open use of physical touch in therapy caused a schism with Freud.

Reich proposed a functional link between a person's character, their emotional blocks, and tension in their body, or what he called muscular or body armor (Reich, 1982). In Reich's understanding of the body, instinctual demands and the counter-demands of the social world crystallize a character that is visible in the patient's physique. Sexual energy was one of the most powerful forces identified by Reich - "laws of sexuality must transcend the borders of psychic realm" (Reich, 1982, p. 25). Reich worked closely with the body, observing his patient's breathing patterns, and using hands-on techniques of massaging of chronically tense areas of the body, enacting various emotional states. Those basic techniques in their more current state are basis in body – based therapies of modern times. Reich and the Reichian therapists (Cornell, 2015) who followed him worked to dissolve the so-called "body armor" by employing direct muscle manipulation. Since Reich's work was embodied (i.e. it used the body as a mean of change by allowing for a bodily manipulation during the sessions), it was inherently grounded in the here and now, as he was carefully tracking changes in patient's posture and movement as the patient was "expressing" rather than "discharging" their feelings in a bodily way (Cornell, 2015). This distinction is very salient in contemporary body-based psychotherapies that don't seek a pure discharge of muscle tension, but rather conceptualize the body as a channel of expression.<sup>5</sup>

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<sup>5</sup> Those theories are discussed in detail in Chapter 2

Reich's model of thinking about the role of the body in the psychotherapeutic process opposed notions of duality between bodily life and mental life. He saw a primary connection between human bodies and the natural world in his positing that "orgone energy" was fundamental to all living things (Reich, 1982). Orgone energy is a term Reich used to describe his understanding of biological energy, which is roughly analogous to Freud's concept of libido as a motivating or animating force in living beings (Perin, 2011).

Undoubtedly, Reich's techniques were often experimental (especially his use of the orgon machine, which was Reich invention that was designed to release orgon energy from his patients) but he was also endorsing the body and bodily experience, which vanished from the subsequent psychoanalytic development. Partially due to Reich's misguided attempts to reintegrate the body, which was given short shrift in the psychotherapeutic process, the physical body and its movement became marginalized in psychoanalytic thinking. However, modern Reichian psychotherapy is a basis for one of the branches of body-based psychotherapy (Cornell, 2015).<sup>6</sup>

However, parallel to the psychodynamic theory, body-based therapies have been developing and hypothesizing about the use of the body in psychotherapy. Theorists in body based therapies, that are discussed in the next chapter, underscored the value of the body as a medium of therapeutic change, that can be instrumental in facilitating growth in psychotherapy.

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<sup>6</sup> Chapter 2 will elaborate on the development of modern Reichian psychotherapy as body-based practice.

## Chapter 2 – Conceptualization of the Body in Body-Based Therapies

The use of the body in psychotherapy is not a new concept, either in clinical practice or theory. Yet it appears that dance/movement therapy, as an example of a body-based therapy, therapeutic alliance and process have been developing in parallel to psychodynamic thinking. Marlock and Weiss (2015) state that: “the lack of recognition and exclusion from the mainstream psychology” has overshadowed the development of body-based practice, and led to a lack of integration between those two fields.

There is a wide variety of psychotherapeutic forms that use the body in their process (i.e. neo-rational psychotherapy, dance/movement psychotherapy, somatic experiencing) – this variety of paradigms and theoretical frameworks shows the diversity and vibrancy of this branch of psychotherapy (Marlock, Weiss, 2015). Looking at the diversity in the field Marlock and Weiss identify existing theoretical polarities, based on which various approaches differ among each other. Those poles are: (i) treatment vs. learning, (ii) energetic body vs. knowing body, (iii) analytic, insight oriented vs. functional – developmental, (iv) non – verbal processing vs. verbal processing, (v) regression vs. here and now.<sup>7</sup> Those approaches to treatment concentrate on the patient’s psychic life through the use of movement and bodily attunement. Using Marlock and Weiss’s distinction this dissertation will focus on exploring those approaches that: (i) are designed as treatment, (ii) use the body knowledge, (iii) are insight oriented and analytic, (iv) use nonverbal processing of patient’s experience and (v) focus on the here and now of the therapeutic session. In this chapter and in chapters to come, the terms “body – based therapies” or “dance/movement therapy” is used interchangeably to refer to those process oriented and experiential forms of treatment.

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<sup>7</sup> In this dissertation particular attention is given to those approaches that are psychotherapeutic rather than merely focused on teaching skills.

Despite the variety of approaches to body-based therapies, there are some concepts that are central to those forms of treatment, and distinguish them from primarily verbal forms of therapy: the concept of embodiment, the role of the expressive movement as a medium of change, reliance on the connection between the emotions and the physical expression.

## **Embodiment**

Embodiment is defined as a tendency towards integration of various aspects of self (sensory, affective, and mental) within the structure of the physical body of the person (Bloom, 2006). The view that mind and body are inseparable carries the assumption that the embodiment shapes the mind as the person develops. In that view internal processes become visible in the bodily structure and movement (Lemma, 2015), as much as the bodily concerns can become the content of the psychic life of the individual. When describing how trauma impacts the mind, brain and the body, Van der Kolk (2014) describes uncoordinated movements of traumatized patients, showing how their stilted motility is a reflection of blockages that happen on an emotional and cognitive level. However, what is often overlooked is the fact that regardless of the presence of traumatic experiences, the body stores the life history of every person. As such, body is implicated in all treatments, weather the patient has experienced trauma or not. Lemma (2015) developed a term “body imaginings” that denotes the way in which the body is represented in the mind. Body imaginings form during early experiences with the body, and impact later relationships to oneself and others.

Stawarska (2006) discussed embodiment as the essence of empathy. Referring to the research done with infants and their caregivers, she stated that babies are able to imitate facial expressions and gestures of adults. According to Stawarska, this is related to their ability to embody the internal state of the caregiver. Similarly Beebe (Beebe, Lachman, 2012) sees the

roots of empathy, affective attunement and ability to relate in the early nonverbal experiences with primary caregivers. Those early experiences of imitation indicate that from very early on human beings organize their experience on a somatic level (Grand, 1998). Stawarska saw the process of embodiment as a natural part of everyday interaction and as a base for empathy. In that view empathic relationship steams directly from the body, without the mediation of verbal processing. Both conscious and unconscious mirroring thus happens during the therapeutic session; and if used as a therapeutic tool can aid the therapist in understanding a patient's internal world (Rothschild, 2004).

Block and Kissell (2001) viewed dance and movement as being the ultimate form of embodiment. They referred to the embodied experience as knowledge that most individuals block, but that is the most basic part of human experience. The hope is that in an uninterrupted development the mind can inhabit, embody the soma, instead of being split off from it (Weiss, 2015). In the body-based psychotherapeutic practice, embodied knowledge and embodiment of interactions with patients create the relationship. "Most people do not allow their bodies to think; in fact, we are trained from childhood to repress embodied knowing." (Block & Kissell, 2001, p. 10)

From this perspective, movement that is mindful and connected with embodied knowledge has a fundamental connection to meaning. The basic premise on which body-based therapies are formed is that the way in which we move and the way in which we inhabit our bodies carries meaning and is formed in the life long process of accepting and rejecting conscious and unconscious stimuli (Siegel, 1984). In that perspective dance/movement therapy and other body-based therapies work directly with bodily manifestations of the psychic life, and use the body as a way to access patient's inner life and promote change. Stromsted (1998)

specifies the goal for an embodied psychotherapy as “re-inhabiting” one’s body, showing that a body-based therapy could be a source of tuning back in with a potentially ruptured relationship with the body. Unlike in psychoanalytic psychotherapy, in body-based psychotherapies, the body is not solely an expression of a psychic conflict or a symptom. body-based therapies postulate that all of one’s history is structured in the body and embodied and as such can be accessed through movement (Eckberg, 1998). For example, during a session a patient can be asked to look within themselves for a movement that expresses how they feel, instead of telling the therapist. The movement that emerges can be a basis for questions and associations that come up both verbally and nonverbally. This points to a major difference with the psychodynamic heritage that understands the bodily process as a “side effect” of the internal process that operates in the psychic zone.

### **History of Development of Body- Based Therapies**

The notion that the body is an integral part of psychotherapeutic treatment, has been present in the practice of psychoanalysis from the beginning. However, the developments in modern dance and other body practices first led to the formal launching of dance movement therapy as an insight oriented psychotherapeutic practice in the 1940’s (Chace, 1993). Systems of modern dance, such as the Denishaw School formed by Ruth St Denis and Ted Shawn in 1920 turned attention towards the idea that movement can express spiritual and emotional struggles (Stanton – Jones, 1997). Concurrently in Europe, Mary Wigman explored the potential of expression of one’s authentic self through the medium of dance. Those, and other similar movement practices in conjunction with Rudolf Laban’s exploration in the area of codification of the nonverbal, which resulted in the development of Laban Movement Analysis in 1928, have laid the groundwork for psychotherapeutic approaches that used the body as a medium of

expression of internal conflicts (Bloom, 2006). Laban created a system is used in dance movement therapy to identify both patient's and therapist's movement repertoire (Laban, 1956). In this complex system of the analysis of the movement, Laban classified such elements of movement as temporal sequence, space, kinesphere, movable and non-movable body parts, fluidity of the movement etc. into a system that allows for a nonjudgmental observation and description of a patient's movement with the aim of removing subjectivity.

In the United States dance movement therapy and insight oriented body work have been pioneered by Marian Chace, Trudi Schoop, Francizka Boas, Alma Hawkins and Mary Whitehouse, who starting in 1940's worked independently of one another integrating movement and psychotherapy (Stanton – Jones, 1997). Chace brought her work to St. Elisabeth Hospital in Washington DC to work with World War II veterans, who had become nonverbal as a result of war trauma. Her approach emphasized group unity and the used of mirroring in order to establish a therapeutic connection (Bloom, 2006). In Chace's approach, movement was used to “mobilize the group's capacity for emotional expression and social interaction” (Lewis, 1979, p. 27). Chace developed a technique, called in contemporary dance/movement therapy a “chaician circle,” in which she would encourage each person in the group to suggest a movement and everyone else followed the movement. As the group moved synchronously, the therapist looked for patterns and themes in movement, which reflected psychological themes present in the group. In 1958 Trudi Schoop based on her own work on an inpatient unit, described her approach of using movement to get to unconscious material, which was in line with psychodynamic approaches “Mind and body are in constant reciprocal interaction, so that whatever the inner self experiences comes to full realization in the body, and whatever the body experiences influences the inner

self. “ (Schoop, 1974, p. 44).<sup>8</sup> This constant feedback between the mind and the body, allows the patient to draw both from verbal and bodily resources while in the session. They can be complimentary to each other, and allow for constant feedback between the physical, emotional and cognitive elements.

The practice of body-based therapy developed concurrently in mental health institutions and in less structured settings, where in 1950’ Mary Whitehouse, a modern dance teacher, introduced a technique of authentic movement. She described her work as “physical movement as a revelation of Self” (Lewis-Bernstin, 1979, p. 65). Whitehouse developed a practice in which a person looks for an impulse from the body, while being witnessed by a nonjudgmental “other”. Whitehouse has been crediting psychodynamic approaches, especially Jungian conceptualizations, as inspiration for this form of practice that embodies the dynamic of the psychotherapy setting, while using bodily action (Stanton – Jones, 1997).

Coming from traditions of psychotherapy, dance and body work, body-based therapies developed as a varied field that engages both therapist’s and patient’s bodies as part of the therapeutic process. The next section looks at the ways in which body-based therapy differentiates and defines itself, not as opposed to purely verbal approaches, but rather in the presence of other forms of psychotherapeutic intervention.

### **Defining Body – Based Approaches**

The fundamental assumption in body-based therapies is that important life themes are encoded and embodied in our physicality, and as such can be uncovered through a systematic process of psychotherapy that uses the body as a resource (Weiss, Harrer, 2015). Nonverbal aspects are present in every form of therapy. However, it is important to underline a distinction

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<sup>8</sup> More about Trudi Schoop’s synthesis can be found in Chapter 3.

between what might be called “body language” or “nonverbal presentation,” as a natural part of each communication, and the bodily process, which can be seen as an agent of change in psychotherapy. In body-based therapies the body with its mobility becomes, not an addition but rather takes center stage as a way to access the unconscious process in the patient and the countertransference in the therapist.<sup>9</sup>

Despite the variety of techniques and approaches in body-based therapies<sup>10</sup>, there are some important defining commonalities in these therapies including: (i) the belief that psychic and bodily dimensions of lived experience are inseparable and equally important, (ii) the sense that the self-emerges from body based consciousness, (iii) and the belief in formative experiences shaping not only the brain and psychic structure but also the body and its movement (Marlock, Weiss, 2015).

Therapies that use bodily experiences as a source of therapeutic information postulate that bodily sensations, cognitions and emotions are intertwined. Mind, feelings, and the bodily sensations are inseparable – and as such the body (of both the patient and the therapist) is a necessary agent in psychotherapy (Bloom, 2006). As Marlock and Weiss (2015) put it the: “body is a manifestation of subjectivity,” and as such an essential instrument in psychotherapy. Bodily subjectivity is experienced on an everyday basis i.e. when we recognize a person that we know based on the way they walk – we notice this person’s particular movement repertoire, which is a result of their lived experience. In body-based psychotherapy, movement functions as an indicator of patient’s developmental stage, inner conflicts and ability to form relationships (Trautmann- Voigt, 2015).

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<sup>9</sup> More about this distinction can be found in Chapter 3, where ways in which the body is introduced in psychodynamic therapy is discussed.

When defining the usefulness of the use of the body and movement in therapy, Bloom (2006) points to a few areas: (i) the value of the attention to the whole person in psychotherapy, (ii) paying attention to the tactile experiences of the patient, (iii) paying attention to the body in treatment, which allows the patient to connect with their experience of the body as it is not as it exists in their fantasy, (iv) movement, which allows for new avenues of exploration of patients psyche. Body-based therapies offer a setting in which interventions and impact can go beyond the conscious, verbalized material that the patient brings, they allow to integrate the unspoken experiences that are coming from organs, movement and somatic perceptions (Gottwald, 2015). For example, in a body-based therapy session I could ask a patient of mine to show me, instead of telling me, their reaction to a recent break up. The movement is not to “illustrate” or be a pantomime of an event, but rather a nonverbal exploration of internal feelings and sensations. Let’s assume that in that exploration a movement of a clenched fist emerges, I could then ask the patient to deepen that movement make it stronger, bigger or weaker, more gently, and notice any changes that occur. Attending to the bodily cues by both the trained therapist and the patient, allows the therapist to gather information from the body. Similarly, quoting his exposure to body-based therapies, Van Der Kolk (2014) defines goals for treatment as: (i) drawing out the sensory information blocked in the body (i.e. bringing meaning to a body part that is chronically tense) (ii) allowing the patient to familiarize themselves with the bodily expression of inner state (i.e. to recognize emotions that emerge in the body, to have a better understanding of them) (iii) allowing the body to complete its cycle of repetition compulsion (i.e. recognizing movements that represent past traumas, and allowing for modification).

Meekums (2005) underscores that body-based therapies did not evolve in opposition to talk therapy, nor as an adjunctive treatment modality, but rather as a form of psychotherapy that

uses creativity, the body-mind relationship, nonverbal communication and bodily expressiveness as pillars of therapeutic intervention. For example, in a session of dance/movement therapy, a patient can be invited to spontaneous movement that can emerge into a personal dance in response to emotions that they feel. Expressive movement is an essential medium for treatment in dance/movement therapy, and other body-based psychotherapies (Geuter, 2015). As Lewis Bernstein (1981) describes: “Dance-movement therapy is a process entailing the use of developmentally based movement awareness, expression, identification, exploration and integration toward the experience of wholeness”. The point is to be able to acquire information that wouldn’t be available in a purely verbal therapy session, and to use this insight to deepen understanding of patient struggles.

### **Process of Change in body-based Therapies**

Insight oriented body-based therapies share a great deal with their verbal psychodynamic counterparts: “Dance/movement therapy provides a therapeutic approach which focuses on the body and bodily experience; psychodynamic thought provides a framework with which to understand the powerful emotive phenomena that arise in working with the body movement and its concomitant affective experiences, imagery and interaction.” (Stanton – Jones, 1997, p. 11). In many ways, despite the difference in technique, which allows for the use of the body in movement, body-based therapies share similar views about the paramount role of the therapeutic relationship, the usefulness of transference and countertransference as well as the value of unconscious material.

The use of movement and attunement to the body as the agents of therapeutic process provide body-based therapies with some additional, unique means of change. Body-based therapists not only encourage their patients to fully embody their bodies, but also are encouraged

to listen to their own bodily reactions by their supervisors.<sup>11</sup> When I struggled with a clinical challenge I would look for a way to “move with it” or “breathe through it”, before I would try various ways of talking about it. Mirroring my patient’s movement would help me get closer to their experience. For example I worked with a woman, who has a very particular way of sitting on the edge of her seat, bent forward, and adjusting her sock or shoe as she talks to me. If I was examining my work with her from a body-based therapy perspective, I might try in supervision to lean forward while scratching my leg with a claw like finger, to temporarily inhabit her movement. And my supervisor might bring to my attention the way in which the tempo, muscle tension and the constriction of her movement may reflect something about our work together. This information can be used to guide therapist’s verbal interpretations or to adjust a way of relating to the patient. Not all nonverbal insight has to be immediately shared with the patient, as comparable to verbal therapy, where the therapist doesn’t share all the interpretations with the patient, but rather waits for an appropriate moment, and allows the patient to gain a better understanding by themselves.

Allowing for the movement to emerge in the session opens up nonverbal channels of communication between the therapist and the patient (Stanton-Jones, 1997). Therapists, when mirroring their patient’s movement, can rely on synchrony as a healing factor (Chace, 1993). Movement that is shared and synchronous in rhythm, shape or quality will enhance a sense of solidarity and being understood, beyond words (Schmais, 1985).<sup>12</sup> Empathic reflection in movement is one of the foundational concepts in body-based therapies, and allows the therapist to engage with the patient on an intimate, nonverbal level. As theoreticians of body-based

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<sup>11</sup> The phenomenon of somatic countertransference and ways of working with it is discussed in Chapter 5.

<sup>12</sup> Empirical studies supporting this argument are discussed in the section referring to the use of body-based therapies with particular patient populations.

therapies underscore the point is not to mimic but rather to gather the essence of the movement in an empathic way. The therapist might reflect patient's movement to understand their internal state better and to engage with them (Sandel, 1993).<sup>13</sup>

Clair Shmais (1995) was the first one to write about modes of change that operate in dance/movement therapy, and other body-based therapies, she lists among others: (i) movement expression that allows for the internal states to be shared, (ii) vitalization of the body that heightens awareness of one's internal states, (iii) integration of the emotional and bodily experience, and (iv) symbolism that allows the patient to translate their internal state to a movement expression.

Dance/movement therapists would say that the verbal processing is not always needed as the body can do the work by itself, and that the body is a different, but equally valid instrument of therapeutic change.<sup>14</sup> The medium of change in dance/movement therapy can be nonverbal, and the change can be visible in the shift in patient's movement repertoire or in the increase of the bodily awareness, not only in verbalizing of the insight (Lewis Bernstein, 1981). Comparing the process of change in dance/movement therapy and more purely verbal approaches Siegel (1984) underscores that an awareness of "what has happened" (p. 3) is crucial, which doesn't mean that it can only be achieved through verbalization, as an increased bodily perception and awareness could serve the same purpose. She goes on to explain that sometimes embodied insight proceeds one that is cognitive and can be verbalized.<sup>15</sup> Change in movement can be seen before the patient is able to elaborate upon it. Siegel (1984) gives an example of a patient, whose

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<sup>13</sup> The clinical vignette provided in Chapters 4 and 5, expands on the use of mirroring as a way to form an empathic relationship, rather than mimic the patient.

<sup>14</sup> The research and evidence for the effectiveness of dance/movement therapy follows in the later section of this Chapter.

<sup>15</sup> More thoughts on the relationship between verbalizing and nonverbal processing can be found in Chapter 5, while discussing ways of bridging the gap between the worded and wordless in the psychotherapeutic process.

hips were immobile as she entered treatment. Siegel describes this patient's inability in using her pelvic area in warm-up exercises: she consciously wanted to mobilize her hips, but yet was unable to expand her range of motion in that area. During the course of her work in dance/movement therapy the patient was first, through the therapist's attunement, mirroring and verbal feedback, able to mobilize this area of the body, before she gained insight into the roots of the stiffness. The patient and the therapist together uncovered the message that the patient internalized from her mother. The patient's mother's insistence on modesty and her idea about what a modest girl should and shouldn't experience in her body, was embodied by the patient in blocking the mobility of her hips. Body-based therapies promote the idea that the change can be coming from the body as much as it can come from an emotional or cognitive insight in therapy.

### **Motion and emotion**

Emotions are bodily experiences, and as such they can be accessed when using body and movement in psychotherapy (Goodill, 2005). Infant research and theory based in observation of babies and their caregivers, sheds light on the basis of communication and ability to share affective states very early on (cf. Beebe, Lachman, 2012). Research shows that mirroring another person's emotion on a physical level, can lead to experiencing a similar emotion (Gottwald, 2015). Gottwald explains as such movement can be very useful in directly accessing the affective experience of the patient, since changing gestures, experimenting with new breathing patterns and a wider range of motion, can lead to modulation in the emotional states. The experience of change can initially be nonverbal, and it is not necessarily through verbalization that it will be integrated by the patient.

The direct use of the body as a channel of therapeutic change, allows the patient to work with emotions, affects and traumas that are locked in the body beyond verbalization (Stromsted,

1998). By paying attention to the body, body-based therapy defines itself as using different processes of therapeutic intervention and change than verbal therapies. Another important benefit of the use of body in based therapies is that: “fundamental experiences that are missing can then be re- created in concrete and embodied ways” (Gottwald, 2015, p. 142). The connection between the physical action and the neuro-pathway that it creates, allow the patient to rewire and reshape old experiences that are frozen in the body. Grand (2015) calls it the “somatic direct intervention,” underscoring that working directly with body and movement, the patient has an opportunity to work with their experience on a level that is very close to their direct experience, and not only to a symbolic approximation of it.

### **Expressive Movement**

In body – based therapies what makes the therapeutic change and expression of emotion possible is that the movement that is happening in the session is coming from “inside out” as opposed to from “outside in” (Lewis Bernstein, 1981). This distinguishes dance/movement therapy’s expressive use of movement, from those movement forms (such as a dance class), where the movement is suggested or taught. Chodorow (1991) writes: “Movement, to be experienced, has to be found in the body, not put on like a dress or coat” (p. 27). Stanton – Jones (1997) goes even further and proposes that any manipulation of the patient’s movement, or imposing on the patient a particular way of moving, can be seen as counter – therapeutic, as it prevents deeper understanding of the movement that the patient is using spontaneously. That is not to say that a structured movement or directives don’t have their place in body-based approaches - they can be very useful as a way to mobilize and warm up in preparation for improvised movement. As in conversation with a therapist, similarly in a session where movement is used, both conscious and unconscious material will emerge (Stanton-Jones, 1997).

The process of finding the movement expression in the body could be seen as a form of free associating on a bodily level (Bloom, 2006). Siegel (1984) expands on that approach when she writes about a verbal interpretation in dance/movement therapy as always grounded on what the patient has “produced” in movement. Somatic exploration, which follows the patient’s lead, and emergence of impulses, has a lot in common with analytic listening: “I wait and tentatively respond to precarious emergence of impulses, using both my body to help give them force and form and my language to help give them meaning.” (Cornell, 2015, p. 63). Siegel (1984) compares a successful work in dance/movement therapy to an effective verbal therapy session, where the therapist listens and follows the patient’s clues. Similarly in a body-based session the therapist could attempt to “teach” the patient a new way of moving but that would most likely cause resistance, because the patient is not yet ready to make a change. Likewise a purely verbal interpretation that is premature and coming solely from the therapist without any basis in the patient’s material, would be ineffective in a comparable way.

Body allows the expression of the content that is maybe not yet symbolized, or that is preverbal and not symbolized in its very nature. The ability to tend to the physical sensations allows the therapist and the patient to track the here and now of the session. As Eckberg (1998) writes: “focus on sensation provides a doorway to the unconscious mind” (p.23). In body-based therapies, the body is used as a metaphor, a form of nonverbal communication that facilitates the establishment of the therapeutic relationship. The body becomes an object of symbolization, merging the boundary between the symbol and what it symbolizes: “Metaphor, because of its capacity both for holding many layers of complex meaning and for mutation of these meanings, is an ideal medium for exploration in therapy.” (Meekums, 2005, p. 25). The movement metaphor in body-based therapies facilitates expression of emotions that are stored in the body.

Working with the body could be compared to working with dreams, where the psychic content is raw and less defended by the conscious mind (Holifield, 1998). In using the body as metaphor, dance/movement therapy facilitates direct access to affects, memories and cognitions. During a group dance/movement therapy session that I used to lead once at an inpatient unit in a hospital, a warm up a movement of reaching up emerged in the group. Patients were standing in the circle, and from what first was a pure stretch of the arms up, one of the patients shifted to a movement of reaching up and grabbing, all others joined in with energy, reaching higher and higher. As the movement progressed, one of the patients identified it as a metaphor of reaching up for freedom, while being locked up in the hospital. The movement led to a metaphor, that allowed for a creating of shared emotional meaning.

### **Movement and alliance**

The theory of dance/movement therapy and other body-based therapies is deeply rooted in the clinical practice that underlies its theoretical conceptualizations (Johnson&Grand, 1998). Body-based therapists speak of the power of their method and of how individuals have transformed before their eyes, using their bodies to move through pain and gain insight into their deepest levels of unconscious processing (Winters, 2008). In sessions, dance/movement therapists accompany their patients using not only their own emotions, thoughts, and feelings but also their bodily sensations. The therapist may choose to mirror patient's movement, to understand their experience better, or might encourage a change in the quality of the movement.<sup>16</sup> Attunement to a patient's breathing patterns, body parts, body attitudes, movement, conscious and unconscious verbal and nonverbal expressions are listed as elements that form the psychotherapeutic process in dance/movement therapy (Lewis Bernstein, 1981).

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<sup>16</sup> Examples of the use of those methods in a verbal therapy session, are provided in Chapters 4 and 5.

In primarily verbal therapy, the therapist might as well be conscious of the nonverbal messages coming from the patient, however in body-based therapies this nonverbal communication would constitute the substance of the therapeutic intervention. When reacting or intervening, the therapist uses clues from each of those sources, being aware of subtle shifts in the patient's posture, eye contact, breath patterns, and voice changes, as well as of the content of what the patient is saying. The therapist might invite the patient to move a particular body part in response to what the patient is communicating verbally or encourage a development of a movement that the patient might be doing unconsciously. Some of the things that, I as a body – based therapist would look for, while I sit with a patient are: body in its totality and in relation to its parts (maybe the patient's body is still, except for a shaking foot); movement coordination and fluidity (is the movement of the gesturing arms blocked by the tightness in the shoulders? Or maybe the palms are flowing as the patient talks, but the rest of her arm appears to be stiff); harmony between affect and movement as well as coherence between the verbal and nonverbal communication (movement can become agitated and rapid as the patient declares being at peace with her decision to quit her job); symbolic content of gestures (one of my patients would dab the air with her finger as she was talking about her disappointment with her mother); habitual and soothing gestures (some people have a particular way of stroking, touching or caressing their face or arm as they try to self soothe in distress).

Heckler and Johanson (2015) give examples of clues that can be meaningful when working on a body level: slight readiness of the neck or tightness of the jaws that might indicate more anger than the patient verbally expresses, or leaning back from the therapist when they speak, as a way to maintain one's own space. Those signals can be brought to life and allowed meaning when used by a therapist who is attuned to nonverbal processes. Similarly, to therapist's

insight during a primarily verbal therapy, some of those sensations that the therapist experiences may be shared with the patient, and some might guide therapist's interventions. The therapist's ability to observe a client's body and the client's somatic response provides the therapist with a great deal of additional intervention that guides both verbal and nonverbal interventions (Eckberg, 1998). In this way, the therapist can also be attuned to what is happening with their own body, as well as to how their body is reacting to the unconscious processes unfolding in the session.

One of the pioneers of dance/movement therapy Marian Chace, called what happens in the session a "basic dance" (Siegel, 1984). This basic dance was, for her, a way to externalize feelings that could not be expressed otherwise, and were finding their symbolic expression in the body's movement and rhythm. Kurtz (2015) describes a process of a body-based psychotherapy session in five stages: 1. the therapist maintains active focus on the patient's bodily expression, 2. from those expressions the therapist gathers information about the patient's psyche and unconscious structures (what is the symbolic meaning of the patient's movement? what verbal or nonverbal associations is this movement bringing? How are emotions expressed or blocked in the patient's body? 3. using those ideas the therapist can introduce a movement or verbal intervention, 4. the patient reacts to the intervention, 5. the patient gathers meaning and has a chance to integrate new insight. For example, a trained dance/movement therapist observe patient's movement and attunes in her own body to the movement that happens in the session. Based on those observations she can encourage additional exploration in movement or in words, to look for meaning i.e. if patient always moves in one corner of the room, the therapist might encourage defining boundaries of the space that patient feels comfortable in, or encourage venturing the rest of the space, while observing what emotions come up. Those experiences can

lead the patient to understanding something more about their hesitation or fear of newness that was embodied in standing in one corner.

In dance/movement therapy, bodily movement is not only a way of expression, but a building block of the therapeutic alliance. Payne (1992) states that it is through the creative potential of being in movement that the therapist and the patient can build a therapeutic relationship. Body-based therapies discount the split between the mind and the body, and highlight the role of a reciprocal relationship that develops between the psychic content and its bodily expression (Goodill, 2005). The emphasis is on the encouragement of self-expression and understanding of nonverbal communication rather than on proficiency in any particular way of moving: “All movements – from crawl, to run, to a waltz – and even standing still are included in the vocabulary of dance/movement because they all have the capability of becoming communicative.” (Tortora, 2006, p. 4). The body’s expressiveness, even in its idiosyncratic, hard to understand expressions, is a basis for those therapies that place value on embodiment. In dance/movement therapy a person’s expression of self and experience of the world is conveyed through the media of the body and the body in motion.

### **Use of Body-Based Therapies with Various Populations**

Historically, dance/movement therapy was first used to address the needs of severely and persistently mentally ill patients, for whom verbal insight was challenging. The group experience of the rhythm and movement helped build cohesion on an emotional and cognitive level as well as encouraged social interactions on inpatient psychiatric units (Bloom, 2006). In persistent mental illness the bodily as well as verbal expression can be seriously compromised; that is why body-based therapies use mirroring and shared rhythm to access patients’ creativity and open up the flow of expression (Goodill, 2005). In working with this population, the use of movement has

been helpful in increasing sensory awareness, regulating psycho-motor activity, revitalizing the grounding in reality of the body, fostering autonomy and coping with self – destructive tendencies (Röhrich, 2015). Randomized control trials have shown that body – oriented psychotherapy may be an effective treatment for negative symptoms in patients with chronic schizophrenia (Röhrich & Priebe, 2006). Tonella (2015) conducted research with patients experiencing psychosis who participated in body-based psychotherapy during their inpatient stay, and noted that after those interventions the number of interactions initiated by patients (with peers, family and therapists) rose by 42%. This demonstrates that the use of the body in psychotherapy, can help bridge the mind – body duality, and promote change not only on a somatic level.

When used with patients struggling with symptoms from the borderline personality spectrum, the use of body-based therapies can help in increasing capacity for self – reflection and self – control by heightening awareness of one’s body (Lavender, Sobelman, 1995). The structured approach to movement improvisation, is less threatening and as such helpful in strengthening patient’s ego function, while at the same time helping them to tolerate ambiguity. Preverbal aspects of self-mutilation that can be addressed through the use of movement, make body-based therapies a suitable choice in the treatment of patients who are self-harming (Hitchcock Scott, 1999).

Dance/movement therapy and other body-based therapies have been used in treatment of disorders of body image and eating, as this symptomatology tends to be located concretely within the body of the patient (Stark et al. 1989). Prevalent in that population is the experience of not inhabiting one’s body, or being disembodied, and this can be navigated with the use of grounding in movement.

In the body-based therapies the emphasis is on the use of various channels of experience in order to achieve personal integration, as opposed to using only verbalization to address patient's various needs. Using patients who experienced trauma as an example, Van Der Kolk (2014) writes that: "Only by getting in touch with your body, by connecting viscerally with yourself, can you regain a sense of who you are, your priorities and values" (p.249). He underscores that the path to self-knowledge and psychic integration leads through embodiment. He also recalls his patient who exhibited symptoms of severe trauma, yet she stated that her childhood was "good." Through their work together the patient's body became the vehicle by which the past experiences, although not named, become embodied and expressed. Meekums (1999) encourages the use of nonverbal techniques when working with survivors of childhood sexual trauma specifically, underscoring that the creative process and the creation in movement can "speak" for the patient's unspeakable experience, without forcing premature insight or interpretation.

It is the aesthetic quality of movement in dance/movement therapy that differentiates it from dance, or another form of physical activity (Siegel, 1984). The expressive, rather than aesthetic use of movement in body-based therapies, makes it a suitable form of treatment for patients with variable mobility, diagnosis and age range (Becker, 1997). The therapeutic process is based (as in more purely verbal approaches) on the forming of the therapeutic relationship that allows for the expression of a wide variety of symptoms and problems that bring the patient to treatment.

Movement or bodily expression is seen as an instrument in alliance-formation, and a means of therapeutic change. However, as the next chapter delineates, contemporary psychodynamic theories and these conceptualizations of the body overlaps, with the embodied

clinical practice. Both approaches are examined more on a continuum to avoid polarization, and underscore commonality.

### **Chapter 3 – Overlap Between Psychodynamic and Body- Based Therapies**

Psychodynamic theory and body-based clinical practice are speaking about similar concepts in different ways. These different practices can potentially inform one another. This chapter underscores the commonality between two distinct psychotherapeutic practices (psychodynamic and body-based methods) that exist actually on a continuum, and as such could greatly impact and inform one another. Shoop, one of the pioneers of dance/movement therapy wrote: “Where psycho-analysis brings about change in the mental attitude, there should be a corresponding change in physical behavior. When a dance therapist brings about a change in body behavior, there should be a corresponding change in mind. Both methods want to change the total being, body and mind.” (1971, p. 5). Both body-based approaches and psychodynamic work agree that past experiences and regressed elements reside in the unconscious psyche of the patient - what the body-based approaches accentuate in addition to this common assumption, is that those fragments of the psyche reside also in the body (Siegel, 1984). With the rising awareness of the interrelation between the mind and the body and their repercussions on a neurological level, contemporary psychotherapy is overcoming the mind-body dualism (Marlock, Weiss, 2015).

Attachment theory and its basis in nonverbal attunement is pertinent to body-based therapies and is reviewed here. An examination of relational theory and the concepts of mutual influence of psyche and body, communicative function of projective identification, and bodily expressiveness follow. This chapter concludes with looking at ways in which the body can be thought about as bridging the gap between the symbolized and unsymbolized.

## **Attachment Theory**

Foundations of attachment theory are deeply rooted in the assumptions of nonverbal attunement as a base for relationship formation. Bowlby (1951) saw attachment as an innate need that is realized between the child and the caretaker. It is the nonverbal interaction between the child and the caregiver that formed the basis upon which Ainsworth (1979) observed the quality of attachment. The “*secure base*” is described by Ainsworth as the presence of an attachment figure who is believed to be accessible and responsive, and whose presence leaves the baby open to stimulation that may activate exploration. Securely attached infants frequently engage in affective sharing with their caregiver and, when distressed, are able to seek comfort and be calmed by the attachment figure (Carlson, 1989). All of those interactions happen nonverbally; the caregiver, even if they use words, does not rely upon the verbal content, but rather their prosody to communicate with the baby. Beebe, Lachmann and Jaffe (1997) use microanalysis of videotaped mother-baby interaction to show that the interaction, although purely nonverbal, shows elements of both self – regulation and sensitivity to the state of the other. Caregivers’ recognition of the child’s intentional stance is communicated fully nonverbally at this time (Fonagy, Target, 1997). Speaking of the power of the nonverbal interaction, they also claim that the quality of those early purely nonverbal interactions is predictive of the capacity for reflection and mentalization in later years.

Interdisciplinary evidence shows that implicit right-brain to right-brain attachment transactions occur in both the caregiver – infant and in the therapist – patient relationships (Schore, 2010). Those moment to moment attunements that bypass conscious examination express and communicate in the speed of lived experience, not slowed down by conscious process of verbalization (Stern, 1997). However, as much as the impact of the implicit

communication in infancy has found its place in psychotherapeutic technique and understanding of early attachment, its role in adult treatment still seems to be underestimated. Beebe and Lachman (2002) draw serious implications for therapeutic interventions with adults based on the caregiver-infant relationship and research that is based on attachment theory. They conclude that the difference between the caregiver and child interaction and interaction between the therapist and the patient is undeniable, but the basic principles that underlie the early attachment relationship can shed light on to how nonverbal interactions are organized in adult treatment: “Infant research is most fruitful because the basic process of interaction at the nonverbal level remain so similar across the life span.” (p. 22). Based on the findings from microanalysis of video they note that much of the organization of non-verbal communication remains similar across the life span, because the “interactive regulation” (p.46) that it is based on remains the same. The body-based psychotherapies can be seen as stemming from similar assumptions with the neurovegetative basis of early relational and attachment processes between babies and their caregivers (Harms, 2015).

Through those early nonverbal interactions, the person learns how to interact with their own body, and how to express through the body. Those embodied defenses and reactions endure long beyond childhood (Bloom, 2006). It could be said that nonverbally imprinted patterns remain locked in the body as the person ages and interacts with other people (Johnson, Grand, 1998). Thus early interactional patterns have an impact on a person’s embodiment, and as such carry meaningful information about a patient’s past experiences and relational patterns if used in psychotherapy (Stromsted, 1998).

## **Contemporary Conceptualizations of the Body in Psychotherapy**

As Bloom (2006) so eloquently has put it - both mind and body can be used to avoid or express feelings, so the conundrum between the traditionally verbal therapies and body-based therapies arises when the body action is reduced to acting out, where in fact the body could be a source of powerful means of clinical contact and information:

“therefore it stands to reason that an intertwining of psychoanalytic principles with a therapeutic method that brings the body, its movement, its sensations, and the recognition of emotional affect within the body into the foreground may prove fruitful for both disciplines.” (p. 7).

The mind-body dichotomy has been challenged in contemporary psychodynamic thought; for example, as Slavin and Rahmani (2016) write: “This return to the body is notable because this is where psychoanalysis lived for a half century after Freud turned away from his trauma theory” (p.153). An attempt to find alternatives to the verbal – nonverbal binary, false assumption that the body is what is given to us biologically, and as such is uninfluenced by the cultural, social and intellectual processes, has to be exposed (Mitchell, 2002). Based on research in neurophysiology, Mitchell highlights that mind and body are in constant interaction, mutually influencing one another. He challenges the view of the lower, bodily nature as the heritage that is imposed on humans by their biology, and looks for a more relational perspective that accounts for the interaction that happens between the mind and the body, one that operates outside of the hierarchical dichotomy: “Our bodies generate mental states in which we experience feelings that themselves affect our brain chemistry. These ways of experiencing our bodies actually change our bodies” (p.73). In the contemporary thinking about the role of the body in the psychotherapeutic process, it is important to keep in mind that the earlier preverbal levels of expression and development are not simply outgrown as the person matures, but rather coexist with the developing ability to verbalize (Cornell, 2015). As such it is not that the presymbolic,

nonverbal is in some way regressive and in need to become verbal, but rather it might have a language of its own, in which it expresses itself.

Words create a symbolic space for the patient's experience in psychotherapy, but minding the body can also help to form a felt sense of the body as a container for thoughts and feelings. It is useful to remember the importance and inseparability of experiencing and thinking "we think *with* our bodies and with our bodies we encounter with the material world" (Slavin, Rahmani, 2016, p.154). Slavin and Rahmani stress that the physical brain, the body's experiencing organ and the mind are inseparable in their functioning and in the ways they interact. This points to the deep connection between experiencing physicality and the thinking mind that has been omitted in earlier phases of development of psychodynamic theory. Mitchell (2002) sees this relationship as an interaction in which one is created by the other, and neither is in the position of supremacy: "There is no sexuality or aggression or any other bodily experience that is unmediated by social and linguistic shaping. And conversely, we experience all social and linguistic influence as embodied creatures, with bodies that have particularly human parts and a particularly human configuration "(p.68).

The longstanding divide between the mind and the body in many aspects of psychoanalytic thinking has left the contemporary approaches with a heritage of notions that the body is primitive, regressed and that bodily states in order to be "mature" have to be verbalized (Cornell, 2015). Taking this thought further, Cornell examines how "acting out" and movement have been classically seen as infantile modes of expression. To overcome this heritage Mitchell (2002) emphasizes the interplay between the culture and the body, looking at how they mutually influence each other in creating new meaning. The contemporary relational psychodynamic

thinking is making an effort to integrate the body into an understanding of the internal conflicts and the way the mind works (Slavin, Rahmani, 2016).

In this search for linkage between the verbal and nonverbal, Stern (1997) points that “if there is no one thing to know, there can be no one way of knowing” (p.8). Here, he gives credit to the nonverbal as a medium of meaning making, underscoring that creative, open-ended psychotherapeutic process is necessarily inclusive of various sources of knowledge. Cornell (2015) underlines that when one is focused on the verbalization as the main focus of therapeutic action, the idea that the body could be used as part of the treatment might seem bizarre, intrusive or shaming, but after a closer examination there might be more space for integration between those approaches than meets the eye. From the other end of the spectrum, dance/movement therapist and theoretician Siegel (1984) writes that it is the psychoanalytic interpretation along with the movement intervention that makes it possible for the patient to fully develop their strengths.

### **Projective Identification – Bodily Phenomenon**

The communicative power of nonverbal, indirect communication is visible in the development of the concept of projective identification (Klein, 1946). In understanding countertransference that unfolds between the therapist and the patient, contemporary psychodynamic theorists conceptualize the body as an instrument for registering and understanding countertransference.<sup>17</sup> In a broadest definition, countertransference can be defined as the entire body of feelings that the therapist has toward the patient, and also includes cases where the therapist takes on the suffering of their patient (Jung, 1993).

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<sup>17</sup> The clinical illustration in Chapters 4 and 5 bring to life the concepts of somatic and embodied countertransference.

States of projective identification are based on the nonverbal interaction that reminds us of the one between the newborn and the caregiver. If the caregiver can receive, digest and embody their baby's projection, then the communication that happens on the nonverbal level has an adaptive rather than defensive character (Bloom, 2006). Ogden (1989) sees projective identification as a direct form of communication between the patient and the therapist. In his view the patient is unconsciously inducing feeling states in the therapist. Those feelings that the therapist is experiencing are congruent with feelings that the patient experiences but cannot digest on their own. The therapist can actually "feel" as opposed to more cognitively "know" or "understand", how it is to experience what the patient experiences.

In describing intense states of projective identification, Bion (1959) writes about attacks made by the patient's mind at every attempt that is directed at linking one internal state with another. Patients who make the "attack on linking" are described as having a mind in a perpetual state of disaster that cannot be contained or resolved. In that state, it is not only and not necessarily through words that the patient makes the attack and as a result transforms the therapist into a hostile persecutory object. Kernberg alludes to those early, somatic states when he writes:

With very sick – borderline or psychotic – patients there may be onslaughts of acting out in the transference that are so intense that to contain them makes the analyst experience a regression in his countertransference. . . . While one should separate what comes from oneself from that which comes from the patient, with very sick patients we get something like a compromise formation that includes elements both from the patient and from one's own self (Kernberg, 1987, p.81).

Those states are not verbalized, but rather induced using other (also bodily) channels of communication. McDougal (1995) calls it "expression in action" (p.15) and a way in which emotion is acted out on a visceral, bodily level, rather than thought through or even connected with a particular feeling state.

## **Expressiveness of the Body**

Contemporary psychodynamic approaches (cf, Aron, 1997; Stern, 1998; Beebe, Lachman, 2002), unlike classical psychoanalysis, are more inclined to view therapeutic change as occurring both on the bodily and on the verbal level. This view overlaps with a perception of the body as a medium of expression more so than a passive tool of psychic conflict, and as such is more in line with the way that body-based therapies conceptualize the body. “There is no need to express verbally what the body has already said in its own language. All too often, translating the body’s language into words fragments and undermines a significant and rich process, which stands out as such and needs no useless specifications” (Pacifici, 2008, p. 109). Each person uses both the verbal and the nonverbal language alike, and they interact with each other to create full meaning (Beebe, Lachman, 2002). The full communicative language of meaning is created in the interplay of the verbal and nonverbal, and from a place of perceiving language as a function of a living human organism (Bloom, 2006). A patient might not always be able to instantly verbalize their experience, and may prefer or need to express herself through body language (Pacifici, 2008).

More and more the body is being conceptualized in contemporary psychoanalysis as a useful source of clinical information that is on equal footing with a patient’s verbalizations. Eldredge and Cole (2008) stress that the “talking cure” can minimize certain crucial aspects of the clinical situation, especially those that cannot yet be put into words. Increasingly, the body is understood as a channel of access to those parts of the psyche and those problems that arose in the preverbal stage of human development, or to those experiences that are too painful to verbalize. In order to understand the patient, the therapist has to be equally attuned to the verbal and the nonverbal communication that the patient brings to the session (Smith, 1985). Just as

with body-based therapists, the body is viewed as a channel or “even channels” (Smith, 1985, p.8) of communication that unfolds in the therapy session.

### **Embodiment of Experiences**

Another line of commonality between the body-based approaches and contemporary views in psychodynamic psychotherapy, underscore that: “Children’s experiences with human and nonhuman environments result in the development of embodied metaphors that represent these experiences, give meaning to current environments, and prescribe actions, emotions, and what the person should search for and expect.” (Santostefano, 2008, p. 513). It is the patient’s embodied mind that interacts with the environment and with the therapist in the consulting room. Santostefano (2008) underscores, similarly to body – based therapists, that constructing of meaning involves integrating patterns of body motions, sights, smells, sounds, images, and spoken words that exist in the child’s, and later in the adult’s surroundings. Santostefano gives an example of a child that is able to regulate herself, by repeating a movement that a parent did while playing with the child. Similarly, the therapist can help the patient self-regulate by using mirroring of the patient’s movement, to bring those embodied experiences to life in the moment.<sup>18</sup> As such, patient’s preverbal experience of attachment, relationships and embodied emotions are accessible not only as they are directly articulated by the patient but also as the patient embodies the experience in the therapist’s presence. Santostefano (2008) calls those movement “embodied life metaphors”, that can be used to change affective states of the patient – a similar concept is underlying the idea of active imagination, used in body-based therapies.<sup>19</sup> Santostefano highlights that one must engage in those physical, self-soothing rituals over and

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<sup>18</sup> This mechanism is described in Chapters 4 and 5.

<sup>19</sup> Those concepts in body-based therapies are described in Chapter 2.

over again, so that they become engrained and functional through adulthood.<sup>20</sup> Similarly Winnicott (1988) saw the connection between the mind and the body as inherent to a state of personal integration: “The basis of psyche is soma, and evolution of soma comes first. The psyche begins as imaginative elaboration of physical functioning.” (p. 19). It is the state of embodiment that allows for interaction with others and the environment.

### **Communicative Silence**

Nonverbal patterns can be observed in the consulting room, and even if they are perceived out of awareness they will inform “the analyst’s verbal and nonverbal interventions” (Beebe, Lachman, 2001, p.129). Even the moments of verbal and nonverbal “silence” bring meaning and are highly communicative as they can reveal the mismatch, attunement and rhythms that occur in the therapist – patient dyad. As Grossmark (2012) puts it there is no “silence” in treatment, as the therapist and patient witness together the unfolding of patient’s narrative, even if no words are spoken. Describing the case of Kyle, Grossmark writes that the way in which his patient “dropped” onto the couch, told him something about falling, being let down, and about the way in which his patient carries himself. All without a single word spoken. The idea of an “unobtrusive therapist” that Grossmark postulates is expressed both through a verbal and nonverbal stance, and encourages the therapist to take stock of the patient’s bodily expressions.

The notion that body language does not necessarily need to be translated into, and potentially misrepresented by words is also gaining traction. McDougall (1995) writes that when words cannot perform the function of the symbolic container for experiences, due to trauma, internal conflict etc. the body becomes the messenger of the internal life of the patient, which allows her to “circumvent the restraining links of language” (p.101). She adds that the body can

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<sup>20</sup> Chapters 4 and 5 show ways in which those “embodied life metaphors” come to life in therapy.

be used to tell the story, and by bypassing the verbalization, the dreaded impulse that cannot be thought about finds a release in the bodily action. Van Der Kolk (2014) emphasizes the importance of nonverbal work when working with traumatized patients, stating that “all trauma is preverbal” (p.43). The trauma is encoded on a level that is not easily accessible through words. Van Der Kolk explains that when a person is in a state of traumatic shock it is the body that records what happens beyond verbal or symbolic recognition. In his opinion even if a verbal narrative of what has happened doesn’t exist, there is a nonverbal story that is written in the muscles and tissues of the patient. “The body always speaks” (Lemma, 2015, p. 1) whether it is in the form of somatic complaints, symptoms, bodily attunements or it can speak in the patient’s neglect and denial of the bodily presence.

Limiting our understanding of bodily expressions to unnecessary acting out along the lines of the meaning of hysterical symptoms of early psychoanalysis, is very constricting (Petrucci, 2008). Hadar (2001) reformulates this idea, pointing to what she calls false attitudes of psychotherapists towards the use of the body in therapy. One of these false beliefs is that there is a relationship between treating the body and the danger of temptation and eroticism in the therapeutic relationship. Another of these false beliefs is that using the body in psychotherapy is “suggestive” therapy. However, as though to counter those false assumptions Beebe and Lachman (2002) clearly indicate that one of the benefits of the attunement to nonverbal clues in adult treatment is that it makes no assumptions about the content of the experience, but rather allows the therapist to track the process of the interactive regulation that occurs in the therapeutic dyad. Cornell (2015) points to a similar phenomenon writing about the need in the patient to be witnessed by the therapist, not only with their cognitive processing but also on a bodily level. The use of movement as a tool to tune in to one’s body that leads to self-regulation has been

shown in empirical studies that use both breath work and movement practice when working with survivors of trauma and other patients (Van Der Kolk, 2014). Van Der Kolk states that body awareness that allows one to track sensations, helps in developing pathways between the feeling and bodily response that in turn promotes not only self-awareness but also subjective perception of agency.

### **Using the Body to Bridge the Gap**

It is easy to take for granted that words accurately describe how one feels. Individuals tend to have a sense that the words they use to articulate their inner states are an accurate representation of those states. While putting experiences into words is a vital part of therapy, there appears to be an underlying assumption that the therapist and the patient can share reality in words only (Grossmark, 2012). That assumption is questioned in body-based therapies, and, to an increasing degree, in contemporary psychodynamic approaches. “The problem is not that words are evil, or that they are not performing their task; the problem is that their limits are not being respected” (Stern, 1997, p. 19). Stern goes on to expand that at times words can create a divide between the verbalizing and the experiencing aspects of the self.

Despite the aim of integration of the worded and the wordless, there seems to be a gap between the lived experience and its symbolic equivalent that perhaps cannot be bridged. Stern (1997) notes that words cannot be seen as mirroring nature and as such mirroring patient’s or therapist’s experience. He explains that as far as limitations of worded and wordless - knowledge is encoded in words and can be reflected on a cognitive level, whereas action is encoded nonverbally and that is how it manifests itself and can be made use of. As such, he concludes that some of the non-verbalized experiences end up being banished from the psychotherapeutic encounter, if the therapist and the patient meet only in words.

The overlap between the body-based therapies and psychodynamic approaches points to the body as a possible vehicle that can bridge the gap between the experience and its symbolic equivalent. Smith (1985) suggests that insight therapy fails because it operates only on the level of ideas lacking the emotional charge necessary for change. On the other hand, body-based therapies postulate that actions, gestures and all forms of nonverbal expression can inhabit emotional expression with more immediacy than words. “The focus on language and text within discursive methodologies means that we have to rely on the expression and representation of embodied experiences through the spoken world. (Tischner, 2013, p. 29).

The gap between the experience and its representation in language cannot be removed, but it can be approximated when attending to bodily communication. As Lowen (1967) stated: “any person experiences the reality of the world only through his body.” (p.5). Symbolization can be seen as the bridge between psyche and soma. Winnicott (1966) underscores that no aspect of personality can escape being embodied in a body of a particular person. He sees the integration of the psyche and soma as a goal for every person “the indwelling of the psyche in the soma” (p.515) that allows the person to “enjoy the psychosomatic unity” (p.515). In his perspective the body is the very container for the multidimensional sense of self. Similarly, Winnicott (1988) saw the body as the container for the person’s experience, and as such occupying the space between what is perceived as me and not me. He proceeds to explaining that it is the conscious bodily awareness that allows a person to enjoy the state of integration between the mind and the body, failure in the area of integration would lead to “depersonalization” and lack of fulfillment – that he calls “splitting”, in contrast to Klein’s (1946) ideas, Winnicott is referring here to the idea of the false self, which leads to an overly intellectualized existence that cuts the person from their somatic existence. The more embodied approach to psychotherapy

takes into account that the psychotherapeutic session can be a space for not only verbalization but also more experience – based learning and experimentation, and as such bridge the gap between the experience and the spoken word (Cornell, 2015). As such the use of the body in psychotherapy can facilitate the process of substitution of one idea or mental representation for another (Hurvich, Simba-Alpern, 1997).

More prominent integration of the body, as essential in psychotherapy, seems like a natural step for psychodynamic theory. The awaited shift from polarizing verbal and nonverbal approaches in therapy is taking the field more in the direction of looking at a spectrum of patient and therapist experiences. As such the body is no longer thought to be only a vehicle for the mind that is an object of psychotherapeutic exploration and integration, but rather as an active, contributing agent.

Psychodynamic theory informs and compliments body–based therapy theory looking at concepts of projective identification, unsymbolized content and expressiveness of the body. The theory of nonverbal attunement in childhood and later in therapeutic process are both possible ways to bridge the gap between the worded and the wordless zones was delineated. Building on those identified areas of overlap between psychodynamic and body-based conceptualization of the body, Chapter 4 provides an overview of ways in which bodily experiences are present in clinical practice. It is a reflection on the preverbal and unsymbolized elements of patient and therapist experience that could be accessed more fully if attending to the body.

## **Chapter 4 – Clinical Illustration - Possible Ways for Integration of the Use of the Body in Psychotherapy – Patient’s Unformulated Experience**

Clinical material can bring theory to life by providing real life examples of therapy cases. By showing snippets from over 120 psychotherapy hours with Tina, a 35 year-old female, I hope to show the prevalence of the body-based themes in what might seem as a purely verbal therapy. This chapter focuses on the patient’s experiences that were unformulated and accessed by the patient only through her bodily sensations. In that way, it is a reflection on the interplay of the somatic realities shared by the patient and the therapist, expanding on the topics presented in Chapter 2 and Chapter 3. As the vignette develops in Chapter 5 it also demonstrates the therapist’s use of non-verbal attunement to understand the patient’s struggle, as well as the use of the somatic countertransference. Those specific examples provide an opportunity to speculate about clinical implications of the use of the body as a mean of expression in psychotherapy, and ways in which they may be useful for the therapeutic process.

### **Identifying Information and Initial Presenting Problem**

Tina<sup>21</sup> is a 35 year old Hispanic female of Mexican and Dominican descent. She has been living in New York for 7 years. She came to the US to pursue graduate studies and graduated in 2010 with an MFA from City College. She obtained an artist visa and started working as an independent film producer. She is heterosexual, single, her last important relationship ended in January 2013 and she has been in a series of short relationships with different men since then.

Tina sought psychotherapy in January 2009, her intake therapist and later therapist for almost four years Amanda<sup>22</sup> wrote in her chart: “*Patient complained of anxiety and depression*

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<sup>21</sup> The patient’s name has been changed, for confidentiality purposes. Coming up with an pseudonym, I was inspired by Tina Turner’s song “What’s love got to do with it,” which seems to speak to many struggles that this patient faces, hence the alias.

<sup>22</sup> Tina’s previous therapist’s name was also changed for confidentiality purposes.

*related to conflict in a romantic relationship. She described her depression as “blues” that are generally intense for about a week after the disruption of a romantic relationship and continue for about a month in a milder form, until a new romantic relationship initiates (cycles occurs 6 or 7 times a year).”* At that time Tina was complaining of insomnia, itchy hands, tight jaw (for 1 or 2 days) and crying. In reviewing my notes from working with Tina, as well as her chart it became clear to me that all of Tina’s complaints at the time were of a somatic nature. This shows that sometimes in a verbal paradigm, we might lose sight of unexpressed bodily cues. She noticed that her symptoms would occur about once a month and were usually caused by stress stemming from money or work – related issues.

Tina was in therapy with Amanda for close to four years and later for two years with me. Her case was transferred to me because Tina herself expressed the desire to continue treatment with a different therapist after Amanda has left the clinic. From the very beginning I was intimidated not only by the fact that Tina had been working with a more experienced therapist before, but also by her awareness of the therapeutic process – what I later found out she calls “*being a good patient*”. Tina felt that she made strides in various respects: being able to identify her feelings, asking for what she needs, being able to stay connected to difficult feelings without fleeing from them. This all sounded very positive– Tina appeared eager, motivated and hopeful. Little did I know about her capacity for anger, rage and intense projections that were hidden under this mask of optimism.

It seems that in verbal therapies, the body, although it always exists in external reality, comes onto the therapist's horizon only when it becomes in some way an object of mental processing (Lombardi, 2009). Thus the body is placed in the position of inferiority to mind and verbalization. After I started working with Tina, I realized that it was quite the opposite in her

case. The essence of her experience was communicated in the atmosphere of the session, and she seemed often unaware on a verbal level of what was happening – to use Grossmark’s (2012) phrase she would “show rather than tell” what was happening for her internally. Atlas (2016) writes about patients like Tina that “actual words are not particularly important” (p.90), it is rather what happens and what is sensed in the body that carries the deep meaning that is communicated in the therapeutic exchange.

### **Individual History**

Tina is a second child born and raised in Mexico City to a Dominican mother and a Mexican father. Her brother is 7 years older, currently married and living with his wife and his wife’s daughter in Mexico. When Tina was 2 her parents divorced after it was revealed that her father was attracted to men. After that point, her father was absent from Tina’s life until she was 7 years old and not spoken about in the household.

When Tina’s father moved out, she was left in the care of her older brother because of their mother’s work. She remembers her brother being very resentful of those responsibilities and annoyed that he has to take care of his younger sister. Both her mother and her brother would, as Tina describes, “*bully*” her. She was called names, blackmailed and frightened with abandonment – around that time she went through a period of bedwetting. Tina would spend a lot of time alone at home, while her brother was with friends and her mother was at work. Tina’s mother would react to her fears and anxieties with anger, and expressed her disappointment in having such a “*whiney*” daughter, who can’t take care properly of herself.

When Tina was 7 or 8 (she is not sure when) the family moved to New York to live with Tina’s maternal aunt. Tina remembers the South Bronx of the 1980s as a very dangerous place. Her mother would ban Tina to go out, as she was afraid that something might happen to her

(even more interestingly Tina's mother was worried something might happen to Tina's body, but remained unperturbed by the emotional trauma her daughter was experiencing). On one occasion a bullet went through the window and got stuck in the wall of the apartment. Tina, as well as her brother, wanted very badly to go back to Mexico City. Tina returned first (again it is not clear to Tina, why was she sent back first and her brother and mother joined later) and lived for 6 months with her father, at that point almost a stranger to her. In our work together Tina revealed to me, what she claims she didn't tell anyone before, that during that time she would sleep in the same bed with her father, and he was always naked – which marks another bodily transgression. She stated that she was feeling incredibly uncomfortable and ashamed, but denied any sexual activity.

Tina was engaged in sports (she always underscored that movement had “*healing*” properties for her) and art activities, but her mother mocked her artistic aspirations, which made Tina abandon those hobbies. Once her mother found Tina's notebook with her poems, and read them as a joke to her brother and a group of family friends, shaming Tina, and making her a source of laughter. This incident made Tina very vigilant – she stopped bringing her art work home and stopped writing in her diary, terrified that her mother might discover it and “*use it against*” her.

Tina remembers that around that time her brother would invite his friends over and they would touch her breasts and other intimate body parts. As in Van der Kolk's (2015) theory the trauma experienced in the body is stored in the body. She recalls one incident when she was trying to escape and was stopped in the staircase by the group of boys, who were groping her, not letting her get out from the building. Tina links those instances with her weight gain at that time,

which made her look unappealing and undesirable. Orbach (1978) writes about fat as a protective factor, for women, who want to “hide” inside their bodies from being abused.

As she was growing up, Tina’s relationship with her mother became progressively more conflictual. They would get into very heated arguments and at times Tina would be slapped by her mother, and resisted her own urge to strike at her mother. In our work together she would revisit those moments in the countertransference with me, once again, quite literally clenching her fists not to hit. Tina felt unsupported, manipulated and blamed by her mother. She experienced her mother as someone who couldn’t tolerate any mistakes or imperfections. Tina felt that she shouldn’t complain when she was sad or anxious, but should rather “*suck it up*” and “*be strong*.” At age 16, Tina was raped by a cab driver that she had hired to drop her off at home. She never told her family about the incident, as she is afraid of mockery and blame.

When she was 18 Tina began dating and remained with her first boyfriend until she was 24. This relationship had been a very challenging one with instances of verbal, physical and sexual abuse on behalf of her partner who was a drug addict. After their final break up, Tina, even though she hasn’t been using drugs with her boyfriend, started using marijuana, mushrooms and ecstasy. She described this time as trying to “*numb*” both her mind and her body – Tina’s underscoring the duality of mind, separate from the body, shows that it was difficult for her to feel as a whole. Despite those difficulties Tina graduated from college in Mexico City and moved to New York in 2008 to start her MFA studies. Tina’s mother remarried in Tina’s early ’20s, and has been supporting Tina financially when she moved to New York. This financial dependence was a source of tension and would end up turning into arguments that would bring Tina back to their fights from childhood and adolescence. Tina gained her full financial

independence only a couple of years ago. Tina's mother died in July 2014. Tina decided to move back to Mexico and terminated her treatment in March of 2015.

### **Course of Treatment – Initial Stages**

For our first session Tina came 40 minutes late. She didn't call to let me know that she was running late. As I was waiting for her, I had a feeling that this treatment will never start. This feeling would reemerge whenever there was a prolonged gap in our treatment (Tina would miss a session, would come significantly late or when there was a planned school break).<sup>23</sup>

Soon after we started twice a week treatment – to accommodate my schedule Tina had to come at a different time for the first time in four years. She didn't verbally express any disappointment related to that change, but I could feel that something was “bubbling” in her. She would at times settle in her chair, but couldn't quite position herself, fidgeting, moving the chair back, forth, left, right, as though her body couldn't find a place in this new relationship. Similarly, I would also feel restless in my body, crossing my legs, uncrossing, folding and unfolding my arms – I couldn't quite “position myself” in the session. This sense of “bubbling” is what Aron (1998) refers to when he encourages the therapist to pay close attention to what is not spoken, but rather felt in the room with the patient. Tina was consistently coming late for our appointments, without any prior notice, or mentioning her lateness. What she was verbally communicating was that she is “*grateful for the opportunity*” to work with another therapist, and that she is “*curious to see a new perspective.*” It sounded very rational, and well thought out, but it was hard for me to “feel” the emotional content of those statements – this discrepancy, made it difficult for me to have a sense that Tina and I are relating to one another in genuine, integrated

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<sup>23</sup> In Chapter 5 I discuss at great length in my own unformulated, somatic experiences that were emerging in the course of this treatment with hopes to shed light on therapist's somatic sensations like this one.

way. They sounded more like polite clichés, than actual descriptions of Tina’s emotions. Everything sounded right, but it didn’t feel right. Atlas (2016) writes about the intimacy of the connection that develops nonverbally in the consulting room in the shared “listening, breathing and dreaming” (p. 3). She brings attention to the poetic nature of the nonverbal encounter that develops – with Tina it was the content of breath, pause, rhythm of speech, gesture and posture that was shaping our encounters. It was “recruiting our bodies” (Atlas, 2016, p.17) that helped Tina and I connect. I decided to recruit a dance/movement therapist in me, to understand better, what was going on. If Tina would fidget in her seat trying to find a comfortable position, I would notice what happens in my own body, how is my own body reacting, and how can I resonate with what is doing. Concrete examples of those nonverbal encounter come in the next passages.

### **Disjointed Verbal and Bodily Processes**

Tina’s ability to very eloquently verbalize multiple dimensions of her experience and her capacity to be such “*a good patient,*” made the use of the un verbalized, somatic process paramount in uncovering new grounds in treatment. One day Tina came to session, and was telling me how much she appreciated being in therapy with me – however she wasn’t maintaining eye contact with me, her eyes were scanning the walls of the room. She was sitting, stiffly in her chair, her body tightly held, and her hands in the pockets of her jacket. I was trying to listen to what was happening both with my ears and with my eyes – it was only by both listening and looking at what was happening nonverbally, that the full message of Tina’s ambivalence was communicated. Her words were telling me the story of her enthusiasm and eagerness, her body on the contrary was withdrawing, fearful and apprehensive.

Each person communicated through their body before they learned how to use words. Bodies have their own narratives. They remember and reveal histories that have been stored in

them. Preverbal experiences can be expressed in their own language, but it is a language of gestures and actions. Levenson (2010) shows the primacy of the nonverbal experience in development, suggesting that learning might be first bodily, related to mirroring, copying on a physical level, and only later psychological and cognitive process. Tina's childhood was very lonely, she would often feel scared, helpless and felt that there was no one that could comfort her in her distress. The impact of those early experiences is visible in Tina's difficulty with regulating her emotions both on the cognitive and somatic level. As in childhood, during our sessions she often felt overwhelmed by feelings that were manifested in bodily experiences and actions – at times she would move restlessly in her chair, or click the heels of her shoes anxiously. In those instances, she sunk into despair, not being able to regulate her somatic distress or access her resources. As I learned to decode those nonverbal communications, I was able to be more attuned to what was happening and shifting in my own body – Tina would continuously keep on clicking her heels together through the session, and I would notice a knot in my stomach. There were no words yet to speak about this somatic resonance, but there was already a thread of connection that was developing beyond words. At that point, I was intrigued by the bodily communication, and didn't share it verbally with Tina, the nervously clicking heels were telling me she might be too startled if I did. However, it informed the way I was relating to her, allowing her to have time and space to experience conflicting feelings about the therapy and our relationship.

Tina would perceive herself as either strong and capable, or as hopeless and unable to take care of herself. Shifting between those states, she had difficulty integrating them. She would at times refer to them as to her “*rational*” (strong and capable) and “*emotional*” (uncontrollable, frightened, reactive and mostly nonverbal) sides. Tina would talk about wanting to get rid of her

“*emotional*” side, and a wish to be only “*rational*.” This duality was reflected in the duality of the therapeutic process – a portion of the narrative was communicated in the manifested – rational – verbal content of the sessions, and the more emotional messages were transmitted in the invisible – irrational – nonverbal content. Her words were saying that she “*enjoys our work together*,” and her clicking heels or shaking hands were communicating anxiety and ambivalence related to this connection. In terms of therapeutic technique one can either interpret this insight to the patient, or as Grossmark (2012) would suggest contain the thought to benefit the patient. At that point in my relationship with Tina, Grossmark’s unobtrusiveness seemed to create a bridge of trust between us.

At the beginning of my work with Tina the loss of her previous therapist was not addressed directly, it took almost a year for Tina to start talking about it with me. However, the absence of the former therapist was present in the room in indirect and nonverbal ways. Tina would refer to how “*things should be done in therapy*.” One day as we entered the room, I noticed an additional chair standing in the corner. For me it was a sign of the presence of Tina’s former therapist, however Tina didn’t comment on it in any way.<sup>24</sup> She seemed guarded, and disappointed with me – she was coming consistently 15 or 20 minutes late and would say that she was not gaining any insights in therapy. Words can fail in psychotherapy (Stern, 1997)– in my experience with Tina, it wasn’t primarily her resistance or defensive reaction, but rather it would happen as we entered those areas of her experience that were not yet verbalized. She was missing her previous therapist, but she “*didn’t know it*” – she would rather show it by coming late to the sessions, by not looking at me directly or by positioning her body in the corner of the chair not facing me, but rather sitting sideways withdrawn from the space we shared. Emotional

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<sup>24</sup> I explore my own bodily reactions and their importance at great length in Chapter 5

patterns, and affective experiences from the past that shape our mental and physical being, can be accessed on a different level, when we listen and react to what happens beyond or beneath the manifested content. That is how what was once “unthinkable” to the patient, can become “thinkable” (Bloom, 2006). At that point with Tina, she had a hard time “talking” and “thinking” about the loss of her previous therapist, and she wanted me to “do the talking.” She on the other hand she was expressing herself not with words but rather with embodied affect and actions.

As described in Chapter 2, the nonverbal process can develop before the patient is capable of processing it on a conscious, verbal level.<sup>25</sup> Cornell (2015) says that in those situations the pressure to put the patient’s experience into words can rather limit that experience rather than allow her to elaborate on it. The technical question is about choosing, if the therapist shares this insight with the patient – basing my understanding in body-based therapy I trust that there is power in not saying the interpretation out loud, but rather creating space both verbally and nonverbally for patient’s development. Cornell gives an example of a patient who shrugged her shoulders in a particular way during the session. Intrigued by that movement, the therapist encouraged her to do it again, while noticing her bodily sensations, which led the patient to express her anger that she was feeling. Cornell says it was “the powerful unconscious communication” (p. 78) that allowed the work to move forward, as it has taken shape and form both in movement and in words (I will describe a similar intervention I used with Tina, later in this Chapter). The technical choice points of whether to share the interpretation with the patient or not, are coming from the “gut feeling” rather than premeditative decision.

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<sup>25</sup> Additional intricacies of this phenomenon are discussed, when describing projective identification factors, later in this chapter.

## Hunger

Tina would often compare her experience with me to her previous experiences with therapy, when she would have “*food for thoughts*” after every session, whereas with me she felt like she was “*getting nothing*.” Often times Tina would use oral metaphors to describe her experience. In this case she was saying that she was “*hungry*” for something in her relationship with me, but at other occasions she would talk about “*starving*” in the relationship with her withholding mother. I heard those metaphors as an expression of Tina’s deprivation in her early relationships that left her hungry for love.

Kuriloff (2001) writes that the mind is of no use in understanding the body, and bodies are of little use in understanding minds. The infant within Tina that couldn’t find a voice, used other means of nonverbal expression to in order to seek understanding, that is why she was expressing her hunger through indirect channels – sometimes by using metaphors of food or eating, at other times by the rumbling of her tummy during the session, or by my own hunger that would manifest after we finished a session. Cornell (2015) encourages the therapist to ask their patients not only “what comes to your mind?” but also “what comes to your body?” “what might you need to do?”, “how might your body need to move?”, “can you describe any sensations in your body as you speak of this?” (p. 44). I would encourage Tina to follow her hunger with her attention. In that way she could notice when it comes up and when is she feeling full, hungry, deprived – what memories come to her when she feels the physical sensation of being hungry or full. Another approach is suggested by Quinodoz (2003), who encourages the therapist to instead of saying “say everything that comes to your mind” to use “say everything that comes...” (p. 37). That change in phrasing can allow the patient to share any bodily

experiences or unformulated sensations. Those questions are geared towards bringing patient's experienced reality into the shared space between the therapist and the patient.<sup>26</sup>

Tina's hungry body existed in the here and now, but was shaped by both her past experiences with her mother and her hopes to be fed by me in the future. That is why Van der Kolk (2014) underscores the value of bodywork for traumatized patients whose bodily here and now is shaped by the past experience of trauma. Being present with one's bodily sensations can serve as an anchor in reality, both for the patient and the therapist (Lemma, 2015). Tina noticed that she tends to chew a gum on her way to the clinic, and became curious about the way in which her body reacts to "not being fed" in treatment.

Eckberg (1998) describes her work with a traumatized woman whom she encouraged to pay attention to the posture her body takes on as she is sitting in the therapy session. As the patient become more attuned to her own body, she was able to notice that she shrugs her shoulders so that they are "almost up to her ears" (p. 25) and assumes the position of fear. It became a starting point both for the patient and the therapist to explore the meaning and unconscious roots of the patient's bodily organization. Similarly, with another patient the therapist brings attention to the breath, noticing how shallow the patient's breath has become, and exploring possibilities for a more expansive breath. The bodily symptom can at times speak before the emotional or cognitive roots are identified, like in the case of a patient who clenches her jaw ruining her teeth in order to hold in a scream (Siegel, 1984). Similarly, for Tina – it was not easy to describe or give verbal meaning to her state of hunger, she could sense it, but not necessarily give feeling words to it, or elaborate on it.

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<sup>26</sup> Chapter 5 illustrates that there are ways in which the therapist could proceed and intervene with even less language, basing their intervention on a nonverbal attunement to the patient, which was discussed in Chapter 2.

Body matters are so weighty, so deeply important, that they often cannot be spoken about (Diamen, 1998). During one of our sessions, I asked Tina where she feels the hunger. She replied by putting her hand on her chest. She looked down, noticed where her hand landed and started to laugh, as it wasn't her stomach, but rather her heart. It was a moment in which she knew that I knew, and I knew that she knew, yet we didn't speak about it in the moment. We stayed with the movement of her hand on her chest, looking at each other and gently smiling. Important moments of intimacy and connection, like this one, happen without words, and in some cases words can rob such moments of their meaning (Petrucci, 2001).

Cornell (2015) brings attention to the fact that “human beings can bear deep and sustaining meaning through the capacity for deep and sustained bodily experience” (p.1), and as such a bodily experience can be a standalone phenomenon that doesn't need translation, or additional explanation. In my work with Tina, I was trying to keep that in mind, and not rush to speak about the nonverbal experiences, but rather give them space. There were moments, when I would notice Tina making a particular gesture (touching her throat when she was talking about being overwhelmed by her mother's presence), or mirroring the way in which I was seated – I wouldn't necessarily verbalize it, but rather allow for the nonverbal process to unfold on its own without words. Cornell (2015) shares an example from his session in which he encouraged his patient to use her force and quite literally “bash” into him, using her strength. When wondering about his choice of intervention, he asks himself if this potential for aggression in the patient could have been explored on a purely verbal level. Yes - he answers, but he believes that the engagement on a physical level can be deeply instructive to the verbal process, and allows for a physicality that speaks for itself. As he elaborates he identifies that it is by using both the verbal and the nonverbal process that the ruptured relationship with the patient's own body can be

repaired. Cornell (2012) emphasizes that both therapists and patients can be split off from their bodies, and inviting the body and physical interventions into the room can heal that divide. It was also my hope that by allowing Tina to communicate with me both with gestures and with words that a relationship that is containing and supportive, will be formed between us. Living organisms have their own way of expressing themselves that words cannot express, and should not be forced to express: “I was, in essence, inviting her to think with and through her body, rather than think about it” (Cornell, 2015, p. 16). I think of the ways in which I was allowing for a similar process to unfold with Tina, was by allowing for her bodily acts (heel clicking, sitting with her hat on her face, clenching her fists) without verbally interpreting them – the body was given a stage in our therapy. My experience as a dance/movement therapist made me aware of the meaning of the bodily process in working with Tina. I was following my own bodily reactions and her unformulated wordless communication that was taking various forms.

### **Worst Therapist Ever – Preverbal Experience of the Traumatized Patient**

We continued our work together and the cycle of Tina bringing her more depressive feelings towards the end of the session, and later not showing up to the next session, would keep on repeating. At first Tina would not address her emotions in those situations and I didn’t know how to bring up this reoccurring pattern in a way that would be helpful for us to process. After another instance of that kind, when I asked about moments when she doesn’t show up after an emotional session, Tina stated how incredibly disappointed she was with me. She felt observed, not supported, she experienced me as distant, looking at her as a “*specimen*”. She felt that I look much more at her hand gestures than I listen to what she was saying. Tina stated that she would like me to talk more, ask her questions, “*not only look*”. She also told me that I am “*the worst therapist ever*”, I can’t help her, I can’t support her, I only idly witness her suffering.

The nonverbal attention that I was giving Tina, was activating her fear and rage. She felt as though that by seeing her I was failing to hear her. Eldredge and Cole (2008) recommended the use of body techniques and the therapist's constant awareness of a patient's nonverbal communication in working with those who experienced trauma. They wrote: "The blocked trauma response stored in the body is most readily reached through attending to the body experience of both the patient and the therapist" (p. 79). The use of the bodily knowledge can become crucial when working with the trauma stored in the body, "in the world of interpersonal abuse, words have lost their meaning" (Chafetz, 2010, p. 235). Tina was aware of the nonverbal attention that I was giving her – what she described as "just looking" and she had been on high alert, on a constant look out for ways in which I, as her mother did before, could use the closeness between us to hurt her. By saying that I only "look" at her, she located the closeness on a nonverbal level, stated that she would prefer some safe distance that could be achieved by "talking."

The intimacy and connection that comes with being witnessed on a nonverbal level was frightening Tina. She struggled with being in a securely dependent relationship, constantly considering if she can be vulnerable with me. She on one hand craved closeness but on the other was petrified by intimacy and the risks that she would have to take in order to trust me. Even though we had been working together for quite some time, seeing each other twice a week, she constantly reminded me and herself that "*we are just starting.*" It appeared that this "qualifier" that she would put on our relationship allowed her to feel more in control, and less terrified of her dependency on me. Tina's experience with her mother showed her, that depending, even on a parent, meant that they can retaliate, or use their power against her – as her mother did when she would mock Tina's childhood diary entries or her pursuits in arts and sports. In therapy, when

she felt emotionally connected or trusting, she would later flee and not come for her next appointment. Tina felt that attachment always comes with a high price to pay and the person who decides to commit is always in a weaker position. She would often anticipate the unavoidable abandonment, and would say that all relationships have “*an expiration date*.” One time before an August break she was recalling to me her conversation with a friend, when she told the friend “*fuck therapy*” and “*fuck my therapist*.”<sup>27</sup> What is important is that those are also verbal bodily phenomena. She mentioned that she is not “*really*” telling me that, she is just repeating what she told her friend. I understood Tina’s anger in this situation as a sign of her anger at herself for feeling connected to me and the terror of feeling that she depends on me.

Theory of dance/movement therapy speaks about ways in which dreads, such as Tina’s fear of dependence, are not as easily associated to verbally, and might be accessible on a nonverbal, movement level (Lewis Bernstein, 1981). Bernstein elaborates that preverbal experiences are encoded in the sensory-motor pathways of the limbic system, and as such might be more readily accessed in movement than in a conversation. The body experience enables the patient to not re-experience but recover and work through early, unnamed experiences (Quinodoz, 2003). This corrective nonverbal experience, can happen when the therapist attunes nonverbally to the patient, when the patient expects the therapist to act in anger or disappointment – being matched on a bodily level, allows for repair. However, at that point it was too challenging for Tina, to trust my good will. When attending to the bodily reactions, Tina’s experience was accessed in a more multi-dimensional, but also in a more terrifying way. The body often remembers what we “forgot” and cannot bring to our consciousness (Modell, 2010). Modell continues to explain that “remembering” of traumatic events is not necessary for

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<sup>27</sup> This could be seen as yet another form of Tina’s hunger.

the therapeutic process to occur, as the healing can happen below the level of consciousness, presumably on the nonverbal, more implicit level<sup>28</sup>. Experiencing one's body more deeply helps to build or re-build links broken by the trauma connections between cognitive and emotional aspects of the self (Bloom, 2006)<sup>29</sup>. Yet, in Tina's state of hypervigilance, her body was telling her to back away.

### **Disorganized bodily states**

I strove to achieve balance between naming Tina's frustration and being more verbal in our next meetings. As I attempted to be more verbal and supportive, I found myself feeling that I was holding a lot of the weight of those sessions – I could feel the sense of burden in my chest after each session with Tina. Once again the worded and wordless aspects of the session were uncoordinated. Tina would come back the next session, stating how helpful it was. I was feeling drained and exhausted. Bucci (2010) locates the analyst's main interest to be in the “subsymbolic” process of therapy, where the emotional information is processed without conscious awareness. She calls it the “affective core of the emotional schema” (p. 207) of the patient. Those levels of Tina's experience that were related to her traumatic past were communicated to me in the weighted, tired feelings that I would recognize in myself after our sessions.

This again, brings to mind the orality of those interactions – I was feeling depleted as she was feeling filled up. Bach (2002) writes about “major distortion of loving” (p. 227), in Tina's case it wasn't a sadomasochistic (in Bach terms) sexual relationship, but rather a way of relating that perpetuates the relational imbalance. Bach points out that this pattern arises from perpetual

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<sup>28</sup> I elaborate on that process in Chapter 5, where I write about ways in which nonverbal attunement helped regulate Tina's emotions.

<sup>29</sup> This mirrors Bion's ideas, that will be described later in this Chapter.

socialization by fear in childhood that makes the child unable to appreciate and be in mutually gratifying and trusting intimate relationships. Looking at Tina's relationship patterns, I found Brown's (2009) phrase "disorganized states of mind" (and I would add of "mind and body"), very poignant.<sup>30</sup> I was at times bewildered by Tina's reactions, not knowing what to expect and how would she react to me on a given day. The somatic and the cognitive were often in a state of dissociation or conflict. The active engagement, which is needed to be present in one's own psychotherapy, can be at times difficult to achieve for patient's whose emotional, cognitive and somatic experience is fragmented (Grossmark, 2012). "Such patients' reality often involves confusion as to whether they are alive or dead, and whether the world, other people, and the self actually exist and can be expected to continue to exist" (Grossmark, 2012, p. 630). Grossmark talks about the mind's deadness, I believe this is true for both mind and body states. Acts that seemed to express my care (i.e. finding a bereavement counselor for Tina after her mother's death), would be taken by Tina as violent, intrusive or manipulative. Tina would become visibly tense in her body and look away when I would express verbally my care towards her. In the moment I would be surprised, or taken aback, only to later understand those reactions as windows into Tina's "disorganized states of mind," or as van der Hart (2009) calls them "manifestations of significant breaches from the past." The attunement to nonverbal process and the ability to address the nonverbal process can be key in working with patients who have similar struggle as Tina (Grossmark, 2012).

Bion (1959) writes about attacks made by the patient's mind at every attempt that is directed at linking one internal state with another<sup>31</sup>. The same could be said for my attempts to try to integrate the verbalized and bodily processes in my work with Tina. What Bion describes

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<sup>30</sup> The idea of the somatic countertransference is discussed in Chapter 5 in great length.

<sup>31</sup> The idea of attacks on linking and its bodily implications is also discussed in Chapter 3.

as the attack on linking can be done in a verbal and/or bodily manner. Tina would sit down, with her arms folded over her chest, and pulled all the way back into her chair. As the session progressed I would find myself sitting in a similar position, becoming aware of that unconscious mirroring, I would then consciously attune to her posture, trying first to match it and then to bring a bit of ease into it, by taking a deeper breath. Tina, would follow, I would first loosen up the grip of the folded arms, and after few minutes would see her do the same. But as soon as she could experience the ease, she would break the attunement and tighten her arms even more. She would become inaccessible once again.

Being with Tina felt challenging and draining. I often felt aching in my spine or tension in my arms that were showing me that I was exhausted after the session with Tina<sup>32</sup>. Primitive emotions need to be communicated in a way that is often not captured in the sophistication of language. Some states of fear, rage, longing and hunger may date back to a time when no words were available and psychic trauma could not be distinguished from physical injury (Field, 1989). Body lends itself to working with that preverbal pain. As McDougall (1995) explains “the emotion aroused is not recognized in a symbolic way (that is, within the code of language which would have allowed the affect-laden representations to be named, thought about and dealt with by the mind) but instead is immediately transmitted by the mind to the body, in a primitive nonverbal way” (p.28). She points to the early, preverbal roots of certain symptoms and bodily reactions, and urges the therapist not to lose sight of those, by only listening to what is verbalized.

At times I saw Tina’s despair and dissociation as her inability to form connections between her self-states, which were expressed in a somatic way. Tina would rather do

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<sup>32</sup> The question of technique of when and if the therapist shares her insights and interpretations with the patient, is discussed in an earlier section of this Chapter.

something, perform a physical action instead of talking about it. She would become “only angry” or “only depressed” and she would be unable to connect it with her experience from a previous week, when she was “only happy” or “only satisfied.” Bromberg (1996) writes about “normal multiplicity of self” (p. 511) when each self-state is a functional whole with its values, perspectives and affects – I also would add somatic sensations to that list. He writes that healthy dissociation is a part of our everyday functioning ” health is the ability to stand in the spaces between realities without losing any of them – the capacity to feel like oneself while being many” (p.512). However, when trauma occurs the content that is unsymbolized and unprocessed can be warded off, and become an unintegrated self-state. In Tina’s case, when her words were expressing the organized self-state, and the bodily actions and affects were showing the disorganized part of her – for example her fists would clench and hold on tightly to the edge of her seat, as she was telling me that she is at ease with her decision to start a new romantic relationship. Traumatized patients lose the capacity to see other self-states apart from the one that is present in this very moment – there isn’t a coherent mind-body narrative. As Bromberg notes there is a protective quality to not being able to “stand in the spaces” and keeping other self-states at bay to protect oneself from overwhelming experiences and chaos.

If the hurt comes from not being seen, on a preverbal level, the body will be a natural vehicle for expressing it – Tina’s early trauma was being processed in the sessions as much in words as it was through her storming in and out of the room, tapping of her feet, or sitting with her coat on in the summer. The raw data of traumatic experience that is not attended to, remain un-symbolized, and as such they are enacted rather than verbalized by the patient (Stern, 1997). Barth (1998) recalls experiences of working with patients with eating disorders to underscore

that those parts of a patient's experience that are not verbalized cannot be associated to, as there are no words to capture that part of patient's history.

When I was able to see through the struggle, I could recognize that there was a relationship developing between Tina and myself.

### **Bodily Process Unfolds**

About a year into our treatment Tina became more depressed and tearful in the sessions. She was struggling to maintain a romantic relationship that seemed hopeful at the beginning, but at that point she wasn't talking with the man with whom she was once in love with, but he was still living in her apartment. Tina was frustrated with herself and anxious that he would not move out. She was expressing a loss of hope and a lot of frustration with therapy and me as her therapist. She would often miss sessions without prior notice (she missed 9 sessions during that time, most of them were no shows). Once again it was her body, rather than her words that was showing me that she was "out." Once again Tina was thus using action rather than words. In that process she was turning passive into active and becoming the parent who leaves, instead of being an abandoned child that she had to be in relationship with her mother. When she would come back after missing a session, she was guarded, resentful and uncooperative. I saw it as a way to cope with her vulnerability and shame of sharing intense emotions with me.

Tina was expressing more depressed feelings, as well as a lack of motivation and engagement in her activities. She was tearful and appeared to be becoming more depressed. That is when a major argument happened between us after I offered Tina a psychiatric consultation. Tina didn't comment on it during that session, she missed her next appointment, but when she came back she was extremely angry. She came into the room, sat down, pulled the hat over her eyes and said that I am "*sending her to a cuckoo's nest,*" that she has been in much worse

situations and no one ever suggested that she should take medication. She was sitting at the edge of her seat, verbally threatening to leave the treatment and ready with her whole body to walk out of the room at any moment. Tina stated that this was a major breach of trust and she could not believe that I would humiliate her like that. She saw my suggestion as a clear sign that I didn't understand her, and didn't actually care about her. Her voice was raised, her arms were waiving in the air, as she was gesturing. She was dabbing the air with her finger pointing at me. Her bodily presence was intimidating.

Tina's anger was powerful. *Powerful beyond words*. I could feel heat that was flowing through my face, and I had a visceral sense that what I am experiencing is a communication. She was becoming what she was feeling, embodying how upset she was at me, and I was reacting to it with a cold sweat and a sense that my head is spinning. Feeling such an intense bodily reaction during the session, I had a sense that Tina is using my own body to communicate something that she cannot fully express in words. My body was used to digest the anger and disappointment the Tina couldn't digest herself. In many ways, as Ross (2000) points out, it is precisely how a baby 'speaks' to the caregiver. It is during those earliest moments in life that a person learns how the body can serve as a mode of communicating and affect regulation (Bloom, 2006). The infant element in the adult patient speaks to the therapist through that sort of object usage that is best 'seen' through the therapist's countertransference. And as with the caregiver-infant communication, a big part of this process is happening nonverbally. Intersubjective meaning continues to be communicated somatically and nonverbally in adulthood long after an individual has acquired the capacity to communicate through words (Dosamantes-Beaudry, 1997). In the instance described earlier, my communication and connection with Tina was largely based not only on talking about those early experiences but also on allowing them to take space in the

room. To use Atlas' (2016) words "recruiting the body" (p. 17) was needed to get a fuller picture of what was happening between Tina and me.

Tina's anger, directed at me, was frightening but was also making me sad and hopeful that I could help her better. As overwhelming as it was for me (and possibly for Tina as well), I tried to make space for her rage, even when she was threatening to leave the treatment and told me that I am completely worthless in what I do. Tina started to come on time. I felt that she didn't want to miss a single minute of our time together, that she was using it to tell me how "sucky" (yet another bodily word) of a therapist I am, and to communicate with me through the sweat that was slowly dripping down my back. Holding on to the feelings and naming her and my own emotions (sensed through my own body), seemed to calm her down in those moments. This brings to mind Winnicott's (1969) "object survival," which allows for therapeutic change to occur. I didn't retaliate at her for her rage and disappointment with me, and I didn't abandon her. We were in a mess, but we were in it together. When she could see my vulnerability, also on a bodily level, she was somehow more able to tolerate her own. Atlas (2016) writes about the fear of destroying the object and the relief in discovering that the rage was not as destructive as one feared it was. In our sessions I would honestly say that I didn't intend to humiliate or shame her, and I want to understand what in my comments made her feel that way. Every session felt like "walking in a field of land mines" – this metaphor is Tina's, and it captures the nonverbal essence of a precarious walk through the therapeutic process. It is not in feeling, but rather in sensing words that she was able to describe to me what was going on for her – Tina would say that she feels like her head is spinning, her legs are weak, she felt flashes of heat and that her vision was getting blurred. She would seat on the edge of her chair, which for me was often a sign that she is ready to run. As I was witnessing her, I would plant my feet on the ground more

firmly, getting the grounding that I needed for both of us to go through this situation. I would also use my voice, not necessarily in the words spoken, but rather in the tone – when Tina would raise her voice in upset, I would speak in a firm but soft manner. Bucci (2010) indicates that a shift in paradigm is needed in order to access the subsymbolic processing, she stressed that the analytic field should become more inclusive of the motoric and visceral processes that will change the way in which pathology and psychotherapeutic change are viewed. In moments of heightened emotions, more than anything else, it was Tina’s body memory that was activated.

The “medication session” was the first of many more heated sessions to come. A few months later I reminded Tina that she had an outstanding balance. Tina told me that I “*shouldn’t bring money between us.*”<sup>33</sup> She said that I am trying to control her as her mother did, and that she “*can’t leave her mother but she can leave me.*” Tina felt let down by me, angry, resentful, and feeling that I am manipulating her to make her feel what she doesn’t want to feel. She told me that she thinks that I reminded her about the payment, just to see how she will react, so that I can gather data about her psychic life. Bion (1959) writes about an attack on linking that is made by the patient, and transforms the therapist into a hostile persecutory object.<sup>34</sup> Tina’s reaction seemed to resemble a paranoid defense, which in the theory of complex trauma (Hien, 2009) arises from the child’s experience of being deprived of control (over their body and their mind) and hypervigilant to every sign that could be interpreted as danger (Ford, Courtois, 2009). Similarly, Grossmark (2012) when discussing his work with Kyle writes about ways in which the patient’s rage is expressed when the therapeutic boundaries are reinforced. He describes the state that is communicated beyond words, in sensations that come up both for the therapist and the patient.

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<sup>33</sup> It is worth noting that the language that Tina uses here, also is a bodily metaphor.

<sup>34</sup> Bion’s approach is described in detail in earlier part of this chapter.

As she was getting more and more upset, Tina would describe to me how she was feeling in bodily terms, she would put her hands on her head, she would say “*everything is spinning,*” “*I will vomit*” – those somatic descriptions captured her experience. It wasn’t through words that she was able to access what was going. It was more like being transported into a very primitive early state, of being manipulated by a powerful other. By using a metaphor of tango, Bucci (2010) describes the dance of therapy, where there is no fixed sequence of steps, but rather the partners are obligated to listen with their body for clues in order to know what the next move will be. Verbal guidance would be too slow or too limited, and would violate the flow of the dance. It is the “flesh,” that Cornell (2015) refers to that allows one to be in touch with the vivid sense of living and experiencing through the body. Allowing Tina to be with her somatic sensations, and not necessarily trying to translate them into feelings, helped her ground herself in the here and now of the session, and trust our relationship.

Looking at this situation as reenactments of her relationship with her mother allowed Tina to see that in moments of overwhelming emotional strain she retreats to very primal reactions. Feeling guilt and shame, she felt threatened and manipulated by me. However, despite the visible tension Tina remained in treatment, working through those moments and allowing for a repair after each mismatch (Tronic & Weinberg, 1997). As in infant research theory, the growth in the relationship comes from repair after mismatch, and this repair happens nonverbally. After a moment of raising her voice, gesturing with her clenched fists and shaking her arms in anger, Tina would look at me in the eyes again – we would meet first nonverbally and only later in words. At some point we were even able to joke about how we are “*getting better*” at managing those situations – as Tina described it: “*a bomb explodes between us, but we are still together to examine the damage and bear the wound.*” Once again, Tina uses a bodily metaphor to describe

her psychic state, showing how to her the preverbal hurt is equal to a physical trauma. The bodily attunement that was so crucial in our relationship, allowed Tina to feel at ease with expressing her more troubled feelings in a safe way. Winnicott (1969) writes that the child and the patient in therapy has to “kill” the subjective-object; that only in that way can she start to exist as separate from her. The symbolic killing is done with the child’s anger and hatred toward the object that then starts to become an independent entity. The object doesn’t retaliate and survives the anger, which moves the relationship forward. Ogden (2014) in his analysis of Winnicott’s fear of breakdown, writes that the past experience has to be brought to the present in the transference. The patient is failed by the therapist, but only to a degree that the patient is able to tolerate. Tina was disappointed and angry with me, but we were both able to live through it. Soon after, the first time in our treatment she called to cancel a session in advance instead of not showing up without prior notice. I couldn’t believe my own ears when I heard her voice on the recording. For me it was a shift from Tina’s purely bodily communication, to being able to express herself also verbally.

### **Here We Go Again**

Working with Tina, I was trying to decode or at least to listen to bodily messages that were coming in the form of repeated power struggles and imbalances that resembled Tina’s childhood. Situations that we were again and again recreating in the session felt like a vital part of our communication – a way in which Tina was letting me know how she is feeling and experiencing the world. Taking my body into account, allowed me not only to acquire new information about Tina, but also about my own reactions and the operating countertransference: “Transference and countertransference can be understood in a more developed way when the nonverbal components in the dialogue within the bi-personal field are recognized and included.”

(Boadella, 1996, p. 7). I was listening for what Tina could neither symbolize nor was able to put into words - that is why I needed to be attuned to my own body's signals – as I was sitting with Tina, I was not only paying attention to my thoughts and emotions, but also to my own body. How am I sitting? Is it complementary to how she is sitting (i.e. if Tina was sitting with her arms and legs folded, am I sitting in a more relaxed, position or I maybe mirroring her posture, to get a sense not only of the content of her words, but also of what her body is expressing). Am I breathing, or do I hold my breath? If so, is it holding my breath in fear or rather in surprise? Not all bodily experiences are translatable to words, and at times it was by checking in with my own body that I would get a hint about what might be going on, but is not stated in words. This unformed, unspoken content is often crucial to the therapeutic process – Bloom (2006) refers to the body as a tool for psychic attunement that moves the psychotherapeutic process forward.

From the beginning of our work together Tina and I would engage in repetitive patterns of interacting that resulted in what seemed like an argument and an expression of strong negative affect on Tina's part. Those repeated instances fueled my desire to understand better this language of action, that would often be present in our sessions more in “doing” something, than in talking about it. Tina would refer to what she was experiencing in those moments as “*old feelings*.” In those moments I would often notice that Tina would look away and I was having difficulty catching her gaze. She would later raise her voice, her breath would become more like panting – fast passed, deep and with a hearable sound. She would start verbalizing louder and at the same time her gestures would become bigger and more expansive. There would be a visible rigidity to her movements - her shoulders would go up towards her ears and muscles on her arms looked tensed. Those feelings were coming from a different time in her life, different circumstances, different relationships, but the emotion, the rush of adrenaline, and the feelings of

being manipulated, abandoned, cornered or viciously attacked felt very familiar. Over the years the body becomes a repository of psychic conflict and affect-laden events that cannot be integrated or resolved (Greene, 2001). In Tina's case it felt that there were conflicts that she was carrying that couldn't be verbalized and could only be enacted between us.

## Chapter 5 Clinical Illustration - Possible Ways to Integrate the Use of the Body in Psychotherapy – The Therapist’s Unformulated Experience

It is not only patients who may react in their bodies, therapists too must be extremely attentive to their own bodies. That is, much of what we pick up from our patients we may first feel in our bodies, and perhaps most immediately in our breathing. Our bodies are the primary arena for the psychophysiological processing of affect (Aron, 1998, p. 28). Nonverbal processes play out in therapy, in various forms from the sensation of an

unformulated experience to different manifestations of somatic countertransference. The unspoken content, and my own attunement to my body were very useful in understanding and moving forward the therapeutic process in my work with Tina.

Tina’s implicit communication were expressed more in her tone of voice, gestures and body posture than in the actual verbal content of the message (Schoore, 2010). During one session, she was talking about being in an amusement park with her mother, the content might seem joyful or benign, however her body was showing something different - she would make a fist and every time she would say that she would go on a slide “*again and again*” she would pound the armrest of her chair. I was “listening” to the fist, and by doing that I was able to receive what is not yet verbalized by Tina, about her anger at her mother for having disappointed her so many times. Schoore (2010) underscores what has been my experience in working with Tina, that communication between the therapist and the patient is a transmission of not only cognitive content but also of bodily states.

Psychotherapists are not exempt from nonverbal communication of their reactions to patients through unconscious body language (Greene, 2001). I would hear from Tina “*are you ok?*” “*you look tired,*” “*are you listening to me? you look like you are drifting away.*” At times it was spot on, at others not, but I knew she was paying close attention to my nonverbal communication. There was no stifled yawn, no shift in the way I was seated that would be

unnoticed. Slavin and Rachmani (2016) encourage the therapist to be “intensely interested” (p.163) in what is going on not only in their mind but also in their body. To that implicit, nonverbal process Schore (2010) ascribes the power of the therapist’s being able to react moment-to-moment to their patient.

Especially in moments of intense emotional turmoil, it was by being present with my own body, and connecting with my own bodily knowledge that I was able to stay grounded in what was happening between us. I would start with planting both of my feet on the ground, not to get swept away with Tina’s emotions. I would pay attention to any of my body parts that were tightening, wondering about the meaning of it – is my tight arm showing me my own anger in this situation? Or maybe tense muscles on my face, are pointing me in the direction of Tina’s sadness that is under her anger? In moments when Tina would raise her voice and gesture with her arms in anger, I was allowing “the experience in” (Grossmark, 2012) instead of trying to block it. That allowed me to stay present with Tina and with myself through are most rocky moments. Body awareness provides a continuous background of moment-by-moment mutual influence between the therapist and the patient that happens outside of the awareness (Beebe, Lachman, 2002). If I noticed that I was holding my breath, I would later become intrigued when I could feel and hear myself exhale more fully. There wasn’t always a precise moment in Tina’s narrative when that would happen, but there was a shift that occurred that my deepened breath was reflecting.

Bodily communication becomes possible when the clinician allows the patient to affect her, and this inevitably means that the therapist must become disturbed by the patient (Bollas 1987). I felt “disturbed” by Tina, many times. I would find myself wishing she would not come to the session to “torture me again”, or I would wish she would finally call me to let me know

she is coming back. At times successfully at other times less so, I was allowing myself to be influenced by her, and to digest whatever emotions she was feeding me with. When she was experiencing me as a manipulative, malevolent being I would often have a headache after our session – as though I was poisoned by the toxicity of the projection. Tina was expressing her own confusion between her past relationship with her mother and me in the present. She would sit with her back squeezed all the way into her chair, as though she had to protect herself from me. I would try to keep my distance, not lean too much towards her in order not to make her feel even more frightened, but I would put my hands, palms up on my lap – showing my openness, and willingness to work with her. Sometimes I would notice the movement as it was happening, but understand its meaning after the session was over. I was making an attempt to listen to what she could neither symbolize nor put into words and react to it wordlessly.

### **Therapist's Body – My Body**

The therapist's awareness of her own body can be crucial for the therapeutic process because much of what is crucial in therapy happens without words (Petrucci, 2001). Often times in my work with Tina, I could feel, but was not necessarily able to clearly verbalize what was being expressed by Tina. All therapists have bodies, and just as they notice their patients' bodies, in the same way their patients look at the therapist's body. Beebe (Beebe, Lachman, 2002) describes an instance in which she became aware of rubbing her feet in a particular way, while in a session with a patient. Being attuned to her own body allowed her to identify this movement as a self-soothing motion. She noticed that it is a particular movement that she has been doing since childhood to put herself to sleep. She says: "My behavior illustrates the usual and in advert self-regulatory requirements of the analyst and the impact of interferences in interactive regulation on the analyst's self –regulation." (p. 134). She decided to share with her

patient that she noticed this movement, and her patient made an interpretation that the therapist moved her feet in that way just after the patient rejected a supportive comment. As Grossmark (2012) underscores relational psychotherapy values intersubjective engagement between the patient and the therapist, which helps make sense out of unformulated, bodily experiences. He explains that the therapeutic process as such requires the therapist's engagement and careful communication of the therapist's experience and countertransference. In relational psychotherapy self-disclosure: "is one way the therapist authentically represents herself in the therapeutic relationship to foster relational movement and growth." (Tantillo, 2004). Beebe's patient suggested that the therapist has been soothing herself after being rejected. That is how the nonverbal content was brought into the consciousness in words to allow for a better understanding of the unconscious process.

In my work with Tina, I have been as well relying on my own bodily self-soothing techniques. I would often find myself feeling stiff, and would gently twist from side to side to "loosen up." I was gathering information from how my body was feeling. At times the stiffness was mirroring Tina's tense posture and hypervigilant fearful body. At other instances, it was my own defense against her rage, and my body was turning into a shield. Bodily knowledge and sensations can be used as a "valuable communication from your client's body manifestations and unconscious messages" (Miller, 2000, p. 448). I was able to attune to my own body, and by doing that automatically in contact with the "now" of the session. Bodies operate in the present moment. If the therapist can read their own nonverbal cues, they can monitor their internal reactions to what happens in the session. It is that "moment-to- moment process that carries the therapeutic leverage" (Beebe, Lachman, 2002, p. 218).

However, at times, like Tina, I would find myself in a state where I couldn't tune in with my body. I would find myself moving my fingers unknowingly, twirling my hair – dissociating in the body. I could give Tina my body as an object of projections and fantasies only when I was not intimidated by what can emerge from the body (Petrucci, 2008). My own awareness of my own bodily presence and comfort with my physicality influenced the treatment. Titner (2010) writes about her struggles with losing weight and how at times her embodiment became a way to build a common ground with the patient, but on other occasions her disowning and shame around her body was creating a barrier to an open dialogue about her patient's bodily struggles. As she writes: "the therapist's body can yield rich clinical material" (p. 289). The bodily transference and somatic countertransference can be much more overwhelming for the therapist, who doesn't feel at home in their skin. Kuriloff (2001) writes that it was only when she was able to inhabit her own body that she was capable of seeing what her patient saw in her, and reacted to, the patient's intense transference.

I, as well as other therapists who are using body-based forms of psychotherapy, have been encouraged by mentors and supervisors to give myself a chance to tune into my body before and after the session, to be able to recognize what is "left behind" in my body when the patient leaves (Bloom, 2006). Bloom expands to state that movement practice, and ability to nonjudgmentally describe movement, as dance/movement therapists are trained to do, allows the therapist to have a vocabulary to name what is experienced by them on a bodily level. This practice allows the therapist to use their bodily sensations as a source of clinical information. In that way body awareness is not only or even primarily a technique to be used with patients, but a tool for the therapist (Johnson, 2015). After my sessions with Tina, I would observe myself, looking for sweets, craving chocolate, and finding other known to me ways of soothing. I was

resorting to what I felt would make me feel better. I was looking for my own, as Tina would say: “*crumbs of love.*” “Furthermore no matter how I was feeling about myself before Mathilde entered my office, when she left I almost always felt inept, unattractive, stupid – and twenty pounds heavier than I had at beginning of that session” (Barth, 2001, p.44). When therapists develop strong physical sensations during or after a session, this suggests that, in these moments, they are thrown into an early mode of operating (Ross, 2000).

### **Embodied Clinical Intuition**

Somatic resonance and somatic attunement are terms used beyond the field of body psychology, to define experiences of nonverbal connection that happens in the therapeutic setting (Geuter, 2015). Through my work with Tina, I often had a sense that I “get her” but not necessarily “understand her.” Bucci (2010) points to the bodily knowledge or intuition of the therapist as underlying therapeutic effectiveness. Often it was hard for me to make sense of my interaction with Tina, when I was looking at a transcript of a session that we just had - but on a visceral level, I had a sense of getting what was going on. Whether it was when I was waiting for her, as she was not showing up to our appointment, or as I was sitting with her in the room, I was often cognitively confused as to what is happening, but had a sense of containing it on an unformulated level, beyond thoughts. This kind of implicit knowing and attunement is, according to Schore (2010), an underlying base of clinical intuition and a major factor in therapeutic effectiveness, as it reflects the ability to understand something without conscious reasoning. As much as the therapist’s left-brain communicates verbally with the patient’s left-brain, the right, implicit, nonverbal brain communicates unformulated experiences within the therapeutic dyad (Schore, 2010). The clinical intuition is not expressed in language but rather embodied in the “gut feeling.” It is the “nonverbal procedural dimension” (Beebe, Lachman, 2002) that allows for

the unfolding of intimacy that allows the therapeutic process to move forward. All of them point to the nonverbal dimension as instrumental in the unfolding of the therapeutic process.

Preceding moments of heightened emotional exchanges between Tina and me, I would often feel that “something is up” first in my body, before I was able to describe it to myself in words. Sometimes I would feel a sense of restlessness going through my spine, or I would notice my hands trembling nervously, before I would become conscious of Tina’s emotion that was about to erupt. Research shows that the body can react to a situation, before one is consciously aware of experiencing an emotion (Weiss & Harrer, 2015). When Tina told me “*I can’t leave my mother, but I can leave you,*” I was first aware of a drop of sweat on my back, and only later of a fear of abandonment, and lastly of my thoughts that interpreted this countertransference. Tina couldn’t fully tell me all about being a daughter of her mother, but she could make me feel how it is to be that daughter and that mother. According to the dance/movement therapy researchers, somatic countertransference reaction is a useful therapeutic instrument, one that can be employed to determine the emotional developmental level of patients and enable the therapist to adapt interventions accordingly (Dosamantes- Alperson, 1987). By therapists who are aware of the bodily processes that operate in psychotherapy, somatic countertransference can be used as a primary resource in understanding a patient’s state of mind and determining how to respond or intervene (Lemma, 2015).

I am using my work with Tina as an example, but strongly believe that the nonverbal process is present, even if it operates unconsciously, in each psychotherapeutic encounter. The nonverbal communication is constantly present. Davis and Hadiks (1990) performed an analysis of the nonverbal communication in an adult dyad concluding that the orientation and bodily position are indicators of shifts in the flow between the partners in the dialogue that

communicate changes in engagement and emotional levels. They also stated that although those subtle movements will occur outside of either partner's awareness, they will be unconsciously perceived by both of them, and will change how they related to one another. That is why Beebe and Lachman (2002) state that reading of the nonverbal cues is a basis for clinician's intuition and a critical part of the therapeutic process. Beebe shares her experience of watching a videotape of herself in session with a patient: "I discovered that I do a great deal of self – regulatory touching much of it out of awareness. I did know that at times I rub my hands together, particularly when they hurt a little, but I did not realize how much I do it" (p.131). She concludes that although such behaviors may remain out of awareness of both patient and therapist, they communicate affect and are perceived at a subliminal level and operate as information to both.

Kuriloff (2001) criticizes therapists' lack of bodily awareness: "Analysts are not trained to engage their bodies. We can engage in the talking cure. We may sit where the patient cannot see how we move or how we hold ourselves. We yearn to symbolize in order to contain and explain our sensations, we use words to capture what feels disorganizing and meaningless or primordial" (p.128). She concludes by positing that analysts might be at times as split off from their own bodies as the alexithymic or somatizing patients that they treat. The therapist's ability to sustain the embodied attentiveness allows them to be tuned into their bodily manifestations of the affect they might be experiencing, and to make sense of those experiences (Quinodoz, 2003).

### **Exploring Somatic Countertransference with Tina**

In psychodynamic treatment, the somatic intersubjective dialogue encompasses all somatic and nonverbal reactions shared between the therapist and the patient. These reactions may be of an emotionally positive or negative nature, and may assume the form of sensory or

kinesthetic sensations, physical symptoms, shifts or distortions of the body image, and enactments (Dosamantes- Beaudry, 1997). Pallaro (1996) described somatic countertransference as pure body sensations, such as: dizziness, emptiness, hunger, sleepiness, fullness, claustrophobia, pain, restlessness, sexual arousal, and so forth; or as images rooted in the somatic unconsciousness, such as: the desire to hold the patient as if he was a baby, feeling penetrated, feeling swallowed, feeling split, feeling choked to death, feeling monstrous, and so forth. As Greene (2001) jokingly noted: “Feeling hungry, for example, rarely means that I am actually hungry (although that possibility needs to be checked out)” (p. 577). I was reminded of that quote one night as I was rummaging through my bag looking for a treat for myself after a session with Tina. Am I just hungry because it was a long day or am I hungry in response to the session?

If the patient is not capable of using symbols or metaphors, they might communicate with the therapist only in nonverbal form. Aron (2001) enumerates those forms of communication: a change in the climate or the air (mediated by breath) or a change in the feel of things (mediated by skin). Those experiences ring very true to my experience while working with Tina, when I would find myself short of breath as I was picking up some of her hypervigilance, or I would notice I am making a sigh as I relate to her deep sorrow. Aron underscores that the therapist must be attuned to the nonverbal, the affective, the spirit of the session, the feel of the material, and to their own bodily responses, so that these may be gradually utilized to construct metaphors and symbols that may be verbally exchanged between the therapist and patient, gradually allowing for the shift and verbal interchange. The value of putting unformulated experiences into words is undeniable, however I would argue that there is also usefulness to moments when those unnamed experiences can be shared in the space between the therapist and the patient, even if it is without words. In my work with Tina, and our meeting when as she would say “*a bomb would explode*”

between us, it was the possibility that one doesn't have to be alone with "it" that seemed to be moving the therapeutic process forward. The "it" was at that time not a feeling, not a thought, but rather an unsymbolized sensation. Kuriloff (2001) gives an example of the somatic countertransference embodied in the language:

In our next session, myself having just returned from the first phase of root canal therapy, Penny noticed my slightly swollen lip. "What happened?" she inquired, somewhat uncharacteristically. I paused for a moment, resisting the impulse to say "I was enraged at you so I was clenching my teeth." I felt exposed, out of control of the treatment. I was literally falling apart in front of my patient, and instead of my prized version of myself as a healer, I wanted to bite" (p.130).

It is not only the analyst's swollen lip that is an expression of somatic countertransference but it is also her thought process and the imagery of biting and clenched teeth that are embodied. Similarly, Ross (2000) brings the bodily expressions to the arena of language and notes that we embody emotions in language as well. When the therapist talks about 'losing heart', getting 'cold feet', 'jumping out of my skin', getting 'gut feelings', 'stomach in a knot', 'weak at the knees', they talk about the embodied experience of the patient. The language serves as proxy for those embodied experiences that the therapist feels in contact with the patient – Grossmark (2012) describes the physicality of listening to his patient: "His words continued to come at and into me, sometimes slamming, sometimes penetrating and sometimes caressing. Always totally physical". (p. 634). Slavin and Rahmani (2016) describe metaphors that use the bodily experience as a way to communicate to another person through their bodily experience, and as such help them understand our mind. They bring up a clinical example of a patient who describes in the session an instance of "slow dancing" at a party. It is through that metaphor and through the mutual bodily connection that the patient and the therapist are able to connect on a new more intimate level. Tina would talk about her life as a "rollercoaster," indicating how scary, unpredictable but also exciting her experiences were. While talking about our relationship we developed a

language of being or not being “*up for a ride*” – can she feel joined on the rollercoaster or not, is it as scary when one is joined, is it easier or harder to be together on the Devil’s Wheel? Cornell (2015) gives an example from his clinical practice, working with a patient who is tightly holding his shoulders and encourages somatic exploration asking if the patient is: holding in? holding down?, holding back?, holding off? It is through the use of the embodied metaphors that he and his patient are able to explore the meaning of patient’s movement.

While working with patients who, as Tina did, evoke somatic reactions, it is crucial for the therapist to ‘mind’ what the body can bring to the therapeutic process. However, somatic countertransference receives less attention than more common ‘mental’ forms of countertransference such as the therapist’s thoughts and fantasies. It is likely that this is because the countertransference manifestations in the form of thoughts or fantasies are in the same register (i.e. language) as that in which therapy takes place (Gubb, 2014). Field (1989) noted that somatic countertransference reactions should not be seen as deviations from good professional practice but rather that the therapist should be aware that for certain types of patients and in certain phases of the treatment, they may prove a vital part of the therapeutic process. However, the elusive nature of the bodily experiences made it not always easy to track what was going on with my own body as I was working with Tina.

My bodily responses in this work may be seen as a kind of internalized body language that offers an additional mean of access to primitive levels of communication. The mere fact that these are bodily reactions may make them less controllable, less easy to disguise and less easy to interpret than other forms of countertransference (Gubb, 2014). However, this bodily-sensory information can be viewed as metaphorically descriptive and informative about the evolving intersubjective dialogue between Tina and me. To be useful, this information must be integrated

with cognitive and emotional kinds of information and be viewed in light of the multiplicity of factors that influence the experience of both the therapist and the patient (Dosamantes- Beaudry, 1997).

### **Somatic Transference/Countertransference in Action -Motherhood as a Bodily**

#### **Phenomenon**

“The real body – to – body, face-to-face connection with the m(other) serves as a container for the unrepresentable” (Atlas, 2016, p. 27) – the unspoken, bodily communication in therapy can be a way of expressing the preverbal anger, hate and longing towards the first other that each person relates to – the mother (or a “mother role” primary caregiver). In the second year of our work together, Tina had to fly to Mexico because her mother had to undergo an emergency brain surgery. This event made Tina even more aware of the loss of the part of her Mexican identity and all the sacrifice she has made to come to the US. She called me from the hospital in Mexico to let me know she will not attend her Thursday session but that she will see me on Tuesday.

We did not meet on Tuesday, nor Thursday, nor the following Tuesday. Tina’s mother died unexpectedly after the surgery, and Tina had to stay in Mexico for a couple of weeks. Lemma (2015) explains that mother’s body is the first body that each one of us knows, the first one to which we relate and the first one, from which we have to separate. Tina’s grief and mourning, and her later decision to move back to Mexico and terminate treatment, was also happening without many words spoken. As well as my embodied reaction to her pain – as in the communication between the newborn and the caregiver, I responded to her not only with words, but also with the embodied, somatic experience. When Tina came back she was white as a piece of paper. During our first session, I did not say a word. Tina was telling me day by day, hour by

hour, what was happening from the moment she got a call that her mother was in the hospital to the moment she died. As many times before I felt unable to help her and to ease her suffering, the only thing that was crossing my mind was “*maybe I should hug her?*”

One day, while I was waiting for Tina to come, a colleague said to me: “*now you are the only mother she has.*” The use of the body in psychotherapy often presents the therapist with a challenge and places unique demands on them, as they find themselves not prepared to create “somatic partnership that can often be wordless” (Cornell, 2015, p. 44). Bloom (2006) came up with a term “embodied attentiveness” (p. 65) to describe a therapist’s ability to engage with states that may be felt but not verbalized. It is the embodied attentiveness that allows the therapist not to miss the unspoken content of the session. This ability allows the therapist to read and receive patients’ bodily expressions, and be attentive to their own. Tina’s mother’s death was a powerful symbolic and somatic experience of aloneness and separation, that each of us experienced in a wordless manner. The old language, old country and old ways of being were dead with the death of her mother, and when I saw Tina after she returned, she was tortured with grief, and guilt over feeling that she was now finally free, and able to establish herself in any way she wants.

Tina’s relationship with her mother, and at times in the transference with me, was extremely complicated in its embodied entanglements. She felt a sense of resentment and hatred towards her mother, and expressed in our sessions death wishes towards her. She felt that it was “*unfair*” that she is scarred for life by the relationship with her mother. Yet at the same time, since her childhood she carried a sense of inadequacy and blame, which made her constantly hope that if she only tried harder, she might be finally loved and accepted. Mother’s body and longing to be a part of and to separate from it, can be a core conflict when working with a

patient, who like Tina, didn't have a chance to experience secure attachment (Atlas, 2016). If there is not a safe experience with the mother, and mother's body in childhood, the longing for repair carries on into adulthood. This duality made Tina experience emotional turmoil in her relationship with her mother, and after her mother's death in her relationship with me or with an introject of her mother within herself. It was also at times visible in our relationship, when Tina felt manipulated by me, and would see me as an omnipotent, frightening figure that she needs to destroy in order to be able to relate to me. Tina felt that she had to protect herself, quite literally on a physical level, from being hurt by her mother, people around her and me.

Her mother disappeared and Tina had to disappear from treatment - announcing to me that she is moving back to Mexico. Making connections between what was happening in the reality of "doing" and that of "feeling" was an ongoing and difficult process for Tina and I, as it required an uneasy "standing in the spaces" (Bromberg, 1998). The realities of what was verbalized and what was not were overlapping in many ways. Some of the uses of the words in the work with the wordless process will be described in the following chapter.

## **Chapter 6 – Discussion**

The need for this exploration came from a very personal place. The body – mind matrix has been in the crux of my clinical and theoretical struggles, my roots and training are in dance/movement therapy, and I have worked for over 10 years using primarily this modality, before pursuing training in a more verbally focused psychodynamic psychotherapy. Asking myself how to assist my patients in verbalizing their experience rather than to work them through in movement, presented for this writer a dilemma of integrating these two separate frames of clinical reference.

### **Unformulated Experience – Therapist’s Way in to the Nonverbal Process of the Session**

Bromberg (2010) points to the difference between the explicit and implicit processes that happens in therapy, saying that apart from easily defined states of “knowing” and “not knowing,” we also experience the “sort of knowing” which escapes those easy definitions. It is the process of sensing (Cornell, 2015) that is neither rational nor cognitive, but at the same time very informative of what is happening in the session.

The unformulated state of being aware of something that one doesn’t consciously know often happens on a nonverbal level (Modell, 2010). McDougall (1995) uses the term “somatic communications” (p.151), when describing communicative function of psychosomatic states in their broadest definition and Stern (1997) describes the phenomenon of “sensation of something coming before language” (p.15). He mentions that the therapist has to pay close attention to those moments, and might have a sense that words don’t necessarily express, or even fit the experience. On the contrary, as Ogden (2001) has pointed out - the unformulated experience can be crushed by words, and might lose its communicative power if verbalized too quickly. “The

moment prior to speaking is not a moment of affective waiting; it is a moment alive with desire, the impulse, the need to give voice to the inarticulate “(Ogden, 2001, p. 9).

### **Why is the Somatic Dimension so Important?**

Nonverbal expression precedes the emergence of verbal language and therefore is less consciously controlled. I became curious, why particular patients, like Tina, get should be “under their therapist’s skin,” they use the embodied expression, they act out their emotions and relive their feelings more so than talk about them. Tina was more inclined to express herself through my body, because she sometimes lacked resources to do it in other ways. My bodily response was well suited to create an empathic connection with this verbally blocked patient, because the nonverbal process so powerfully evokes the preverbal primary experience with the caregiver (Fuerstein, 1997). As it was visible and “feelable” in my exchange with Tina, when she perceived me as a manipulative, omnipotent mother, the role that the patient ascribes to the therapist in their internal world of conflicts, can be felt by the therapist on a bodily level (Bloom, 2006). Although those phenomena might come to the orbit of the therapist’s awareness while working with particular patients, they operate always in the consulting room. That is why it is paramount for clinicians to become more attuned to these processes and not leave them unexamined.

Stone (2006) writes that somatic reactions are more likely to occur in the therapist when a number of conditions come together: when working with patients exhibiting borderline, psychotic or severe narcissistic elements; where there has been early severe childhood trauma; and where there is fear of expressing strong emotions directly. She explains that the more patients are at that moment in a borderline (or even psychotic) state, as distinct to a more conscious neurotic state, the more they will, as Tina did, project their embodied feelings into the

therapist. “The clinician, the analyst, the container of hope and dread must enter and be entered by these toxic worlds” (Harris, 2007, p. 45). Exploration of those “toxic worlds” shouldn’t be equated with the use of words. The entrance to Tina’s internal world was through listening to what is communicated on a bodily level in me. For example, during one session with Tina, I could sense my own stomach turning in fear, which was an indication that maybe Tina is experiencing similar sensations in her encounter with her mother, that she was describing to me. If I haven’t been attuned to my own body, I might have overlooked this important, unstated feeling. Cornell (2015) shares a clinical vignette in which his body seemed absent in the session with a particular patient, and would “report to him” only after this patient has left. It was that uncanny bodily experience that led him to exploring it with the patient to try to understand the roots of that disconnect.

“Before the advent of language, the body becomes the theatre in which distress is played out” (p. 521) writes Dosamantes – Beaudry (1997), but for many patients, like for Tina, the body continues to be a means of symbolic communication and expression. McDougall (1995) use a term “somatic explosion” (p.11) when describing the phenomenon when the body become the medium of communication as she believes that “emotions are essentially psychosomatic” (p.95). When the patient evokes a somatic countertransference reaction in the therapist, the body speaks without translation. Tina was not always able to instantly verbalize her experience, especially when she was transported back to moments of dread when she felt she had to defend herself and fight to stay alive. This is why the unspoken content of her process was expressed in the form of somatic countertransference. Giving an example of a therapist moving her chair towards the patient and patient recoiling, or the therapist shifting forward towards the patient who is hidden in her coat, Beebe (Beebe & Lachman, 2002) explores how those moments that carry symbolic

meaning and can be seen while watching a videotape of a session, since often they might escape the conscious attention.

Dosamantes-Alperson (1997) emphasized the role of the countertransference as a relationship-building factor in psychotherapy. Regardless of content, countertransference emotions that the therapist feels in their body allow them to connect with the patient. Pallaro (1996) considered somatic countertransference as a phenomenon that gives the therapist access to the patient's internal states. Ross (2000) points out that, therapy should consist of listening to what the patient is not saying and noting how the therapist's body has been forced to act out feelings that could not be consciously known by the patient. Tina would express her enjoyment of being in therapy, and yet in my skin I felt unease (I felt gentle trembling in my lower spine), which was a precursor for her disappointment and anger that were not manifested yet. If the therapist feels emotions in her body, it could be a sign that the patient is communicating primal emotions, which could be coming from preverbal layers of the patient's unconsciousness, and as such couldn't be verbalized but are rather sensed by the therapist on the corporeal level (Dosamantes-Alperson, 1987).

### **Possible Ways of Incorporating the Bodily Process in to Clinical Practice**

There are many ways to incorporate the bodily process in a primarily verbal therapy practice. Mirroring, reparative bodily experience and embodied use of language, will be described as bodily techniques that bridge the fields of body-based therapies and primarily verbal psychodynamic therapy. My work with Tina will be used to illustrate those concepts, however they can be thought of as operating universally in psychotherapy.

## **Mirroring**

Mirroring of the patient's posture, body movement or particular quality of their movement is one of the foundational concepts in dance/movement therapy, and serves the therapist as a way of gathering information about the patient's internal reality as well as a means of establishing an intimate, nonverbal connection (Tortora, 2006). Mirroring is also a function of nonverbal attunement, and can happen in interactions beyond the conscious awareness of the participants: the analyst may find herself imitating, or mirroring the behavior of the patient, without even knowing that she is doing it (Levenson, 2010).

As a trained dance/movement therapist, I tend to use mirroring in my clinical work, also with patients, with whom I work predominantly verbally. Being trained in bodily attunement makes me more keenly aware of nonverbal processes that occur in therapy in general. I have been working with a patient who was experiencing panic attacks. As he was sitting in the room with me, I noticed that his foot was shaking in a fast paced, staccato rhythm as he was talking. After observing that pattern during a couple of sessions, I decided to mirror this rhythm by tapping my hand on my knee in a gentle manner. At first I didn't comment on it verbally, it was a way of establishing a connection, getting in synch with one another. He was the one to comment during our next session, that he felt better understood, when we met the week prior, and that is when I offered the shared tapping rhythm together, as a way to start the session, and "tune in" to our work together.

Ogden (1989) describes his encounter with a deeply troubled man who established a connection by mirroring him: "The initial form of contact that he made with me in the therapy was by imitating my posture, my tone of voice, my every gesture, every word I spoke, and every facial expression I made" (p.75). At first the therapist was overwhelmed by that experience, and

unable to see the communicative potential in the patient's actions. It was only when the nonverbal behavior was appreciated that the relationship was established, and Ogden was able to allow the patient to "use him as a second skin." In Chapter 4 I described ways in which at times I would find myself mirroring Tina's movement without consciously deciding to do so. Once I would become aware that it was happening, I would use it as tool, to either understand how is it to be own in her skin – how is it to sit like she is, how is it to have shoulders so tensed etc. On other occasions it was a way to introduce an ease, since when the mirroring happens, therapist follows patient's movement, and patient would follow therapists – I would shift my position, take a deeper breath, with hopes that Tina would follow introducing more ease into her own body to be able to contain her own emotions.

### **Reparative Bodily Experience**

Working with Tina I was hoping to provide her with a new experience of connectedness with another person. In our sessions I could not only with my words but also nonverbally transmit a different, non-pathological response that could break the cycle of negative object relationships in Tina's internal reality. In those successful moments "the therapist can act as an implicit regulator of the patient's conscious and dissociated unconscious affective states." (Schoore, 2010, p. 187). The patient can be joined in their experience by the therapist, when the therapist allows herself to make use of their nonverbal reactions to the patient and co-create an "interactive modulation" (Beebe, Lachman, 2002, p. 222). This process is a visual- facial, auditory-prosodic and tactile – proprioceptive, it doesn't happen in words but in how the words are spoken. As I understand Beebe and Lachman's recommendation, it is by allowing myself to be open in my own body to Tina's often volatile reactions that I was able to provide her with a different emotional experience. I would control my breath and muscle tone, allowing the

experience in and out, instead of freezing in tension. In our work together it was not by defending myself or tightening and armoring my body, that I was able to withstand her attacks, but rather by being grounded in my own breath and bodily sensations. This process can be especially important when working with patients who, like Tina, didn't experience a secure early attachment Atlas (2016) describes the pattern of overstimulation (also on a bodily level) that happens in a disorganized attachment, she underscores how important it is with those patients, for the therapist to be able to be grounded in their body to help with patient's regulation. One time Tina came to the session, sat at the edge of her seat, fully covered with her winter coat, then started talking about trying to get to a session on time. Her speech was fast, her body was swinging from side to side as she gestured vivaciously describing the crowd on the train, all the people on the street, the elevator in the building. She was unbalanced in her mind and in her body. I took a breath and exhaled. She didn't notice or react, she kept on going. I took another inhale, and followed with a gesture of my hand sliding gently down. Tina looked at me, laughed, took off her scarf and made herself comfortable in her chair. Her fast pace slowed down, now she could access her resources better and regulate herself a bit more.

Bloom (2006) recalls a moment from the session with her patient, in which she was able to trust the unsymbolized experience, and by doing that was able to help her patient regulate herself. She describes that her patient came to the session very moved by what happened during the previous session, it turned out that what moved this patient was to see the therapist's ability to relax and lean against the wall. The therapist was at that moment unaware of the impact it made on the patient, but remembered thinking to herself, "What am I doing?" Even though at that moment the regulatory part of that intervention escaped the therapist's conscious mind, it still affected the patient deeply. In the world dominated by verbal expression, nonverbal

interventions are not easy to catch, even though they might have a powerful impact on the therapeutic work.

### **Embodied Language in Working with Bodily Experiences**

In therapy patient and therapist together, as Tina and I did, attempt to put painful experiences into words and in that way allow the patient to establish a firmer sense of the self and the other (Doctors, 1999). It often seems to be the hope that the symbolic discharge or expression through words will eventually substitute for the physical discharge in the form of somatic countertransference. Stone (2006) gives an example of how verbalization and bringing the unconscious feelings to consciousness can make the somatic countertransference dissolve. She recounts a story in which a therapist was suddenly overwhelmed with feelings of sleepiness in a session, and she interpreted that the patient might be angry with her. This was at first denied, but when the patient could acknowledge the anger, the sleepy feeling vanished and she was as wide awake as if a light had been switched on.

Stern (1997) writes about “unformulated experience” as un-interpreted, raw material that can be eventually ascribed meaning by assigning verbal components that bring it to the articulate form. Verbalizing, as he says, can have an integrative, structuralizing potential for the patient’s experience. This theorizing assumes that once the patient’s internal structure is more solid, the acting out of the internal states can be worked through in words, however that the more nonverbal phase is a necessary precursor (Grossmark, 2012). Embodiment and attunement to one’s bodily sensations helps in feeling more grounded in the moment, which in turn allows the patient to verbalize traumatic memories that felt too overwhelming (Van Der Kolk, 2014). Tina would say: *It immediately feels that way, I can feel it in my stomach, I get the shot of adrenaline, and this fearfulness like a little kid, of this impotence. I don’t know what to do, I need time to*

*think if I really fucked up, and if you pressure me, and maybe you didn't but in my mind it is my mom – what did you do with the money? Tell me now? What did you do? And I don't know what to do and I blank out. Now as an adult I want to get the fuck out.*” But she didn't “*get the fuck out,*” she stayed, and we talked.

Un-verbalized bodily enactments ultimately enable the therapist and the patient to engage in verbalized dialogue about those parts of the patient's experience that previously have been unexamined and inaccessible (Petrucelli, 2008). Petrucelli points out that the use of the body as a tool of expression can aid the therapeutic process in moving forward. Similarly, Freedman (1978) states: “The movements are a precondition for verbalization, and constitute the preverbal activities necessary for the attainment of full symbolic representation” (p.173).

### **Summary and Conclusions**

This dissertation addressed the ongoing struggle of integrating the verbal and the nonverbal in clinical work by starting a conversation between two related but distinct fields in psychology: psychodynamic psychotherapy and body-based psychotherapies (dance/ movement therapy). Through theoretical discussions and presentation of clinical vignettes, it has focused on how encoded voices become embodied and reflected in clinical practice. Through the lens of contemporary psychodynamic thinking it offers the perspective of an overlap between body – based and predominantly verbal therapy and endeavors to integrate those approaches in clinical practice. Finally by using both somatic and cognitive reflection, it attempts to analyze and discuss those multiple voices and the necessity to embrace the tension between dichotomizing and integrating them.

## **Contribution of the Body- Based Therapies to the Clinical Practice:**

### **Movement as Support for Words**

It is easy to take for granted that what we say accurately describes how we feel. I struggle with that assumption as I witness myself and my patients not always being able to instantly verbalize their inner states. A patient once said to me that her body is like a lightning rod – the non-verbal message from the body has a different “speed” than the spoken message. The implicit body knowledge strikes like lightning, and only later do we hear the sound of the thunder, which is like the verbalized experience. But we tend to think of it the other way around, we get caught up with the sound of the thunder, believing that words precede the bodily sensation. While discussing the case of Tina in Chapter 4 this process of bodily action preceding the verbal processing was clearly visible when looking at patterns of interpersonal entanglements that happened in therapy.

It is common to assume that the words people use to articulate their inner states are an accurate representation of them. At the same time that words are varied, and allow us to express so many things, words also have a specificity that constricts meaning, while movements are more free of definition. Research shows (Kita, 2000) that people become more articulate when they are encouraged to use hand gestures – bodily expression, supports verbal expression. These movements come out spontaneously as words come out from a person’s mouth. Even if they are not planned, or used as a strategy, retrospectively one can come to understand their meaning. As such, bodily process in psychotherapy can enrich the understanding of patient’s struggles, challenges and strengths.

## **Awareness of the Verbal Bias**

Moving not only helps to organize one's thought process but also allows one to create a common space where worded and wordless voices can coexist. Therapists by working with their bodies and their patients' bodies have a chance to integrate feelings and memories that have been previously discarded, isolated or not fully digested (Wallin, 2007). However, because language is so powerful and so much of patients' and therapists' self-concepts are built around words, to really appreciate the nonverbal part, the therapist has to constantly check for bias in their clinical work. Eldredge and Cole (2008) stress that the "talking cure" can minimize certain crucial aspects of the clinical situation, especially those that cannot yet be put into words. When that happens the wordless voices remain unheard. It is worth the struggle to hold them in tension instead of swinging on a verbal- nonverbal seesaw. When discussing Tina's case, this writer made a point to underscore that the therapy would have not progressed if it wasn't for the attunement to what is not expressed in words. The preverbal struggles of patients can be best accessed when looking for bodily, rather than verbal cues to understand the patient.

## **Bodily Process as a Process in Its Own Right**

Psychodynamic and body-based theory can inform one another to benefit clinical practice and provide a more comprehensive framework for patients. Beebe and Lachman (2002) show that there is never an actual silence in the consulting room. What is worth underscoring is that the nonverbal process can not only enhance the communicative power of words (as described in the preceding section) but also can be an important phenomenon in itself. Bodily phenomena can be shared between the therapist and the patient. This bodily process is not necessarily an immature form of communicating that awaits to be verbalized; it can be perceived as an occurrence that shapes therapy without words (Stern, 1997).

There is a growing interest in the psychodynamic community (Aron, 1998; Stern, 1997, Beebe, Lachman, 2002; Petrucelli, 2014) in issues related to the embodied manifestations in psychotherapy. Coming on the footsteps of infant research, implications for adult treatment are drawn and nonverbal attunement is presented as a phenomenon across the lifespan. Bodily sensations both in the patient and in the therapist do not need to be transposed into the verbal language: that is where the heritage of body-based therapies can become so important in clinical practice.

### **Reclaiming of the Therapist's Body as a Source of Clinical Information**

Another area in which body-based therapies contribute to a richer understanding of the clinical practice is using the therapist's bodily sensations as a source of information about the countertransference, unexpressed feelings and other facets of the therapeutic process. The prominence of those symptoms while working with patients who experienced trauma (Van der Kolk, 2014) has been widely discussed, however those processes are present when any given therapeutic pair meets. They are not reserved for working with particular patient populations, but operate as an inseparable part of therapy. The therapist's ability to attune to them and use them is essential. Therapists can note shifts in their breathing pattern, muscle tension or gestures, to understand better their reaction to the content of the session. Comparably to primarily verbal therapy this insight doesn't always have to be shared with the patient, but once the therapist is aware of it, it can help her guide her interventions.

### **Bodily Techniques – Summarizing Thoughts**

In this dissertation a clinical case was used to share possible ways in which nonverbal attunement, somatic countertransference, mirroring and embodied use of language could contribute to bridging the gap between the worded and wordless. Those therapeutic interventions

that are coming from the field of body-based therapies, could be used in verbal approaches to contribute to a fuller understanding of the therapeutic process. Once again, what is to be underscored is that the body and its movement, shouldn't be seen as purely expressing the conflicts of the mind, but rather as a source of information, a channel of communication and another (apart from words) gate to the unconscious.

Chodorow (1999) used a metaphor from *The Odyssey* to illustrate the value of expressive movement and nonverbal attunement. In the story, Menelaus captures the sea god Proteus to ask him an important question. Proteus is elusive, and constantly shape -shifting, turning himself into a lion, dragon, snake, running water, or tree. But Menelaus keeps holding him. It is Menelaus' perseverance in not letting go, and staying close to those ever changing expressions that leads him to an answer to his question. The capacity to attend to the body, while impulses emerge as physical actions, may be analogous to the story of how Menelaus held on to Proteus. It is through conscious awareness of our movements that their meaning is ultimately revealed to us, which happens both for patients and their therapists.

## References

- Ainsworth, M., D. (1979). Infant-Mother Attachment. *American Psychologist*, 34 (10), 932-937.
- Aron, L. (1998). The clinical body and the reflexive mind. In L. Aron & F.S. Anderson (Eds.), *Relational perspectives on the body* (pp.3-37). Hillsdale, NJ: The Analytic Press.
- Aron, L. (2001) Narrative, Affect, and Therapeutic Impasse. In Petrucelli, J., Stuart, C. (2001). *Hungers and Compulsions, The Psychodynamic Treatment of Eating Disorders and Addictions*, Northvale: NJ: Jason Aronson INC. (135-147).
- Anzieu, D. (1989). *The Skin ego*. Yale, CT: Yale University Press.
- Arend Furestein, L. (1997). The “Tell-tale Heart”: Responding to Patient’s Somatic Language. in Shumacher Finell, J. (1997) *Mind-Body Problems, Psychotherapy with Psychosomatic Disorders*. Jason Aronson INC., NJ: Northvale. P.161-185.
- Atlas, G. (2016). *The Enigma of Desire, Sex, Longing and Belonging in Psychoanalysis*, New York, NY; Routledge.
- Bach, S. (2002). Sadomasochism in Clinical Practice and Everyday Life, *Journal of Clinical Psychoanalysis*, 11, 225-235.
- Barth, D., F. (2001). Thinking, Talking, and Feeling in Psychotherapy with Eating – Disordered Individuals, Petrucelli, J., Stuart, C. (2001). *Hungers and Compulsions, The Psychodynamic Treatment of Eating Disorders and Addictions*, Northvale: NJ: Jason Aronson INC. (41-53).
- Becker, B. (1997). Dance Movement Therapy with People Over 55, Differences, Similarities, Surprises. *ADTA Proceedings*, Nov, 122- 126.
- Beebe, B., Lachmann, F. (2002). *Infant Research and Adult Treatment, Co-constructing Interactions*, NJ: Hillsdale, The Analytic Press,.

- Beebe, B., Lachmann, F., Jaffe, J.(1997). Mother – infant interaction structures and preymbolic self and object representations. *Psychoanalytic Dialogues*, 7, 133-182.
- Bion, W., R. (1959). Attacks on Linking. *International Journal of Psychoanalysis*, 40, 308-315.
- Block, B., & Kissell, J. L. (2001). The dance: Essence of embodiment. *Theoretical Medicine*, 22, 5-15.
- Bloom, K. (2006). *The Embodied Self. Movement and Psychoanalysis*. London: Karnac.
- Boadella, D. (1996). Embodiment in the therapeutic relationship: Main speech at the First Congress of the World Council of Psychotherapy, Vienna, 1–5 July 1996.
- Bollas, C. (1987). The expressive uses of the counter-transference, In *The Shadow of the Object*, London: Free Association Books.
- Bowlby, J. (1951). *Maternal care and mental health*. World Health Organization Monograph.
- Bresler, J.(2010). I Know Something About You. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 297-303). London, UK: Karnac.
- Breuer, J., Freud, S. (1891). *Studies on Hysteria*. New York: NY Basic Books Inc.
- Bromberg, P. (1996). Standing in the Spaces: The Multiplicity of Self and The Psychoanalytic Relationship. *Contemporary Psychoanalysis*, 32, 509-535.
- Bromberg, P., M. (2010). The Nearness of You: Navigating Selfhood, Otherness, and uncertainty. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 23-44). London, UK: Karnac.
- Brown, L. (2009). Assessment of Attachment and Abuse History and Adult Attachment Style. In C. Courtois & J. Ford (Eds.), *Treating Complex Traumatic Stress Disorders An Evidence –Based Guide* (pp.104-128). NY: The Guilford Press.

- Bucci, W.S. (2010). The Uncertainty Principle in the Psychoanalytic Process In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 203-214). London, UK: Karnac.
- Carlson, V., Barnett, D., Cicchetti, D. , Braunwald, K., (1989). Disorganized/Disoriented Attachment Relationships in Maltreated Infants. *Developmental Psychology*, 25 (4),525-531.
- Castle, D.J., Phillips, K. (2002). Disorders of Body Image. Philadelphia, PA: Wrightson Biomedical Publishing LTD.
- Chace, M. (1993). *Foundations of Dance/movement Therapy: The Life and Work of Marian Chace*. Marian Chace Memorial Fund of the American Dance Therapy Association. MA: Columbia.
- Chefetz, R., A. (2010).Life as Performance Art: Right and Left Brain Function, Implicit Knowing, and “Felt Coherence”. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 225-224). London, UK: Karnac.
- Chiarandini, I.C. (1999). Does the Body Speak?: Teresa Bolaños. *Psychoanalytic Quarterly*, 68,150-151.
- Chodorow, J. (1991). *Dance Therapy and Depth Psychology*. London: Routledge.
- Chodorow, J. (1999). Dance Therapy and the Transcendent Function. In P. Pallaro (Eds), *Authentic Movement, Essays by Mary Starks Whitehouse, Janet Adler and Joan Chodorow* (p.236-252). London: UK, Jessica Kingsley Publishers.
- Cornell, W.F. (2015). *Somatic Experience in Psychoanalysis and Psychotherapy*, New York, NY: Routledge.

- Corrington, R., S. (2003). Wilhelm Reich: Psychoanalyst and Radical Naturalist. Farrar, Straus and Giroux.
- Davis, M., Hadiks, D. (1990). Nonverbal behavior and client state changes during psychotherapy. *Journal of Clinical Psychology, 46*, 340-351.
- Deutsch, F. (1952). *On the Mysterious Leap: From Mind to the Body*. New York, NY: International Universities Press.
- Descartes, R. (1984). *The Philosophical Writings of Descartes*. Cambridge: Cambridge University Press.
- Diamen, M. (1998). Polyglot bodies: Thinking through the relational. In *Relational Perspectives on the Body*. Hillsdale, NJ: Analytic Press.
- Doctors, S.R. (1999). Further Thoughts on “Self-Cutting”: The Intersubjective Context of Self-Experience and the Vulnerability to Self-Loss. *Psychoanalytic Review, 86*, 733-744.
- Dosamantes-Alprerson, E. (1987). Transference and countertransference issues in movement psychotherapy. *The Arts in Psychotherapy, 14*, 209-214.
- Dosamantes-Beaudry, I. (1997). Somatic Experience in Psychoanalysis. *Psychoanalytic Psychology, 14*, 517-530.
- Eckberg, M. (1998). Shock Trauma: Case Study of a Survivor of Political Torture. In D.H Johnson & I.J. Grand (Eds.), *The Body in Psychotherapy, Inquiries in Somatic Psychology* (pp.17-43). Berkeley, CA: North Atlantic Books.
- Ehrlich, M.P. (1970). The Role of Body Experience in Therapy. *Psychoanalytical Review, 57*, 181-195.
- Eldredge, C., Cole, G. (2008). Learning from work with individuals with history of trauma: some thoughts on integrating body-oriented techniques and relational psychoanalysis. In F.S Anderson (Ed.), *Bodies in treatment. The unspoken dimension* (pp.79-103). New York, NY: The Analytic Press.

- Ekman, P., Levenson, R., Friesen, W. (1983). Automatic nervous system activity distinguishes among emotions. *Science*, 221, 1208-1210.
- Field, N. (1989). Listening with the Body: An Exploration in the Countertransference. *British Journal of Psychotherapy*, 5, 512-522.
- Fonagy, P., Sacco, F., & Twemlow, S. (2008). Embodying the mind: Movement as a container for destructive aggression. *American Journal of Psychotherapy*, 62(1), 1-33.
- Fonagy, P., Target, M. (1997). Attachment and reflective function: their role in self-organization. *Development and Psychopathology*, 9, 679-700.
- Ford, J., Courtois, C. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. Courtois & J. Ford (Eds.), *Treating Complex Traumatic Stress Disorders An Evidence –Based Guide* (pp. 13-31). NY: The Guilford Press.
- Freud, S. (1893) Some Points for a Comparative Study of Organic and Hysterical Motor Paralyses. Standard Edition1: 157-172, 1966.
- Freud, S. (1892-1894) Preface and Footnotes to Charcot's Tuesday Lectures. Standard Edition, 1: 131-143, 1966.
- Freud, S. (1895) On the Grounds for Detaching a Particular Syndrome from Neurasthenia Under the Description “Anxiety Neurosis.” Standard Edition, 3: 87-115, 1962.
- Freud, S. (1900) The Interpretation of Dreams. Standard Edition, 4 & 5, 1953.
- Freud, S. (1905) Fragment of an Analysis of a Case of Hysteria. Standard Edition, 7: 31-22, 1953.
- Freud, S. (1905b) Three Essays on the Theory of Sexuality. Standard Edition, 7: 125-243, 1953.
- Freud, S. (1920) Beyond the Pleasure Principle, Group Psychology and Other Works. Standard Edition, 8: 1-283, 1955.

- Freud, S. (1923). The Ego and The Id. Standard Edition,9: 1-308, 1961
- Freedman, N., Barroso, F., Bucci, W., Grand, S. (1978). The bodily manifestations of listening. *Psychoanalysis and Contemporary Thought, 1*, 156-194.
- Geuter, U. (2015). The History and Scope of Body Psychotherapy. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.22-40). Berkley, CA: Noth Atlantic Books.
- Grand, I. J. (1998). Psyche's Body: Towards a Somatic Psychodynamics. In D.H Johnson& I.J. Grand (Eds.), *The Body in Psychotherapy, Inquiries in Somatic Psychology* (pp.171-195).Berkeley, CA: North Atlantic Books.
- Grand, I. J. (2015). The Embodied Unconscious. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.209-219). Berkley, CA: Noth Atlantic Books.
- Greene, A.U. (2001). Conscious mind: Conscious body. *Journal of Analytical Psychology, 46*, 565-590.
- Grossmark, R. (2012). The Unobtrusive Relational Analyst. *Psychoanalytic Dialogues, 22*, 629-649.
- Goodill, Sh., W. (2005). An Introduction to Medical Dance/Movement Therapy: Health Care in Motion, Philadelphia: Jessica Kingsley Publishers.
- Gottwald, C. (2015). Neurobiological Perspectives on Body Psychotherapy. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.126-148). Berkley, CA: Noth Atlantic Books.
- Gubb, K. (2014). Craving Interpretation: A Case of Somatic Countertransference. *British Journal of Psychotherapy, 30, (1)*, 51-67.

- Hadar, B. (2001). The Therapeutic Approach to the Body in Psychoanalysis and its Relation to Movement Therapy and Bioenergetic Analysis. *Journal of American Academy of Psychoanalysis*, 29, 483-490.
- Harms, T. (2015). Body Psychotherapy with Parents, Babies, and Infants. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.776-787). Berkley, CA: Noth Atlantic Books.
- Harris, A. (2007). Dangerous Liaisons: Introduction. *Studies in Gender and Sexuality* 8, 45–47.
- Heckler, R. A, Johanson, G. J. (2015). Enhancing the Immediacy and Intimacy of the Therapeutic Relationship through the Somatic Dimension. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.471-479). Berkley, CA: Noth Atlantic Books.
- Heller, M., Haynal, V. (1997). A doctor's face: Mirror of his patient's suicidal project. In J. Guimond (Ed.), *The body in psychotherapy*. Basel, Switzerland: Karger.
- Hien, D., Cohen, L., Litt, L.C., Miele, G., Campbell, A. (2009). *Trauma Services for Women in Substance Abuse Treatment an Integrated Approach*, Washington, DC: American Psychological Association.
- Holifield, B. (1998). Against the Wall/Her Beating Heart: Working with the Somatic Aspects of Transference, Countertransference and Dissociation. In D.H Johnson& I.J. Grand (Eds.), *The Body in Psychotherapy, Inquiries in Somatic Psychology* (pp.59-85).Berkeley, CA: North Atlantic Books.
- Hitchcock Scott, E. (1999). The Body as Testament: A Phenomenological Case Study of an Adult Woman who Self-Mutilates. *The Arts in Psychotherapy*, 26, (3),149-164.

- Hurvich, M.&Simba-Alpern, A. (1997). Annihilation Anxiety in Psychosomatic Disorders. in Shumacher Finell, J. (1997) *Mind-Body Problems, Psychotherapy with Psychosomatic Disorders*. Jason Aronson INC., NJ: Northvale. P. 57-95.
- Johnson, D.H., Grand, I.J. (1998). *The Body in Psychotherapy, Inquiries in Somatic Psychology*.Berkeley, CA: North Atlantic Books.
- Johnson, D. H. (2015). The Primacy of Experiential Practice in Body Psychotherapy. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.117-126). Berkley, CA: Noth Atlantic Books.
- Jung, C. G. (1993). *Psychologia przeniesienia. Psychology of countertransference*. Warszawa: Sen.
- Kernberg, O. (1987). Discussion of Betty Joseph's paper. In J. Sandler (ed.) *Projection, Identification, Projective Identification*, London: Karnac.
- Kita, S. (2000) How Representational Gestures Help Speaking. In. D. McNeill (ed.) *Language and Gesture*,(pp.162-186). London: Cambridge University Press
- Klein, M. (1946). Notes on Some Schizoid Mechanisms. *The International Journal of Psychoanalysis*, 27, 99-110.
- Kramer, S. (1992). Nonverbal Manifestations of Unresolved Separation- Individuation in Adult Psychopathology. In S. Kramer & S. Akhtar (Eds.), *When The Body Speaks, Psychological Meanings in Kinetic Clues* (pp.1-21). Northvale: NJ: Jason Aronson, INC.
- Kuriloff, E. (2001). The Destablizing Dyad: Psychoanalytic Affective Engagment and Growth. In Petrucelli, J., Stuart, C. (2001). *Hungers and Compulsions, The Psychodynamic Treatment of Eating Disorders and Addictions* (pp.125-135). Northvale: NJ: Jason Aronson INC.

- Kurtz, R. (2015). The Experiencing Body. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.419-429). Berkley, CA: Noth Atlantic Books.
- Laban, R. (1956). *Laban's Principles of Dance and Movement Notation*. 2nd edition edited and annotated by R. Lange. London: MacDonald and Evans.
- Lavender, J. , Sobelman, W. (1995). „I Can't Have Me if I Don't Have You": Working with the Borderline Personality. In F. J. Levy (Ed). *Dance and Other Expressive Arts Therapies* (p.69-82), New York, NY: Routledge.
- Lemme, A. (2015). *Minding the Body. The Body in Psychoanalysis and beyond*. New York: NY, Routledge.
- Levenson, E., A. (2010). The enigma of the transference. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 3-21). London, UK: Karnac.
- Lewis Bernstein, P. (1981). *Theory and Methods in Dance-Movement Therapy*, Kendall/Hunt Publishing Company, Debuque: IA.
- Lewis, P. (1979). *Theoretical Approaches in Dance-Movement Therapy, Vol. 1*, Dubuque, IA : Kendall/Hunt.
- Lowen, A. (1967). *The Betrayal of the Body*, The MacMillan Company: New York.
- Marlock, G., Weiss, H. (2015). Preface: The Field of Body Psychotherapy. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.1-20). Berkley, CA: Noth Atlantic Books.
- McDougall, J. (1989). *Theaters of the Body: A Psychoanalytic Approach to Psychosomatic Illness*, W.W. Norton & Company, New York.

- McLaughlin, J. T. (1992). Nonverbal Behaviors in the Analytic Situation: The Search for Meaning in Nonverbal Cues. In S. Kramer & S. Akhtar (Eds.), *When The Body Speaks, Psychological Meanings in Kinetic Clues* (pp.131 -163). Northvale, NJ: Jason Aronson, INC.
- McLaughlin, J.T. (2005). *The healer's bent: Solitude and dialogue in the clinical encounter*. Hillsdale, NJ: The Analytic Press.
- Meekums, B. (2005). *Dance/Movement Therapy*, London: SAGE Publications.
- Meekums, B. (1999). A Creative Model for Recovery from Childhood Sexual Abuse Trauma. *The Arts in Psychotherapy*, 26, (4), 247-259.
- Meissner, W.W. (1997). The Self and the Body Image. *Psychoanalytic Contemporary Thought*, 20, 419-448.
- Mitchell, S., A. (2002). *Can love last? The fate of romance over time*. New York:NY, W.W. Norton &Company.
- Miller, J.A. (2000). The fear of the body in psychotherapy. *Psychodynamic Counseling*, 6, (4),437-451.
- Modell, A., H. (2010). The Unconscious as a Knowledge Processing Centre. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 45-61). London, UK: Karnac.
- Ogden, T. (1989). *The Primitive Edge of Experience*, NJ: Northvale, Jason Aronson Inc.
- Ogden, T. (2001). *Conversations at the Frontier of Dreaming*, Northvale, NJ: Jason Aronson.
- Ogden, T., H. (2014). Fear of Breakdown and the Unlived Life, *The International Journal of Psychoanalysis*, 1-19.
- Orbach, S. (1978). *Fat is a Feminist Issue*. London: UK, Arrow Books.

- Pallaro, P. (1996). Self and body-self: DMT and development of object relations. *The Arts in Psychotherapy*, 23(2), 51-57.
- Pacifici, M.,P. (2008). The coconstruction of “psychoanalytical choreography” and the dancing self: working with an anorectic patient. In F.S Anderson (Ed.), *Bodies in treatment. The unspoken dimension* (pp.103-127). New York, NY: The Analytic Press.
- Payne, H. (2004). *Dance Movement Therapy: Theory, Research and Practice*, New York, NY: Routledge.
- Petrucelli, J. (2008). When a body meets a body. The impact of the therapist’s body on eating-disordered patients. In F.S Anderson (Ed.), *Bodies in treatment. The unspoken dimension* (pp.79-103). New York, NY: The Analytic Press.
- Petrucelli, J., Stuart, C. (2001). *Hungers and Compulsions, The Psychodynamic Treatment of Eating Disorders and Addictions*, Northvale: NJ: Jason Aronson INC.
- Petrucelli, J. (2001). Cloce Encounters of the Regulatory Kind: An Interpersonal? Relational Look at Sel-Regulation. Petrucelli, J., Stuart, C. (2001). *Hungers and Compulsions, The Psychodynamic Treatment of Eating Disorders and Addictions*, Northvale: NJ: Jason Aronson INC. (97-113)
- Petrucelli, J. (2010). Things That Go Bump in the Night: Secrets After Dark. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 135-149). London, UK: Karnac.
- Perin, E. (2011). *The conscious body: psychoanalytic exploration of the body in therapy*. Washington, DC: American Psychological Association.
- Plato (1997) *Complete Workd of Plato*. Indianapolis: Indiana, Hackett Publishing Company.

- Pulver, S.E. (1992). Gestures, Emblems, and Body Language: What Does It All Mean? In S. Kramer & S. Akhtar (Eds.), *When The Body Speaks, Psychological Meanings in Kinetic Clues* (pp.163-179). Northvale, NJ: Jason Aronson, INC.
- Quinodoz, D. (2003). *Words that touch: A psychoanalyst learns to speak*. London:Karnac.
- Reich, W. (1982). *The Bioelectrical Investigation of Sexuality and Anxiety*. New York: Farrar, Straus and Giroux.
- Röhrich, F. (2015). Body Psychotherapy for Severe Mental Disorders. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.704-717). Berkley, CA: Noth Atlantic Books.
- Röhrich, F., Priebe, S. (2006). Effect of Body – Oriented Psychological Therapy on Negative Symptoms in Schizophrenia: a Randomized Controlled Trial. *Psychological Medicine*, 36, 669-678.
- Ross, M. (2000). Body talk: somatic countertransference. *Psychodynamic Counseling*, 6, (4), 451-468.
- Rothschild, B. (2004). The physiology of empathy. *Counseling and Psychotherapy Journal*, 15, (4), 11-15.
- Sandel, S. L. (1993). The Process of Empathic Reflection in Dance Therapy. In S. Sandel, S. Chaiklin, A. Lohn (Eds.), *Foundation of Dance/Movement Therapy: The Life and Work of Marian Chace* (p.98-111). Columbia, MD: American Dance Therapy Association.
- Santostefano, S. (2008). The Sense of Self Inside and Environments Outside: How the Two Grow Together and Become One in Healthy Psychological Development. *Psychoanalytic Dialogues*, 18, 513-535.

- Schmais, C. (1985). Healing Processes in Group Dance Therapy. *American Journal of Dance Therapy*, 8, 17-36.
- Schoop, T. (1971). Philosophy and Practice, *American Dance Therapy Association Newsletter*, 5, 3-5.
- Schoop, T. (1974). *Want You Join the Dance?* Mayfield, CA: Mayfield Publishing Company.
- Schore, A., N. (2010). The Right Brain Implicit Self: A Central Mechanism of the Psychotherapy Change Process. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 177-202). London, UK: Karnac.
- Siegel, E., V. (1984). *Dance-Movement Therapy, Mirror of Our Selves, The Psychoanalytic Approach*. New York: NY, Human Sciences Press, INC.
- Slavin, J.H & Rahmani, M. (2016) Slow Dancing: Mind, Body, and Sexuality in a New Relational Psychoanalysis, *Psychoanalytic Perspectives*, 13(2), 152-167.
- Smith, E., W., L., (1985) *The Body in Psychotherapy*. Jefferson, NC: McFarland&Co, Inc., Publisher.
- Sloate, P.L. (2008). From Fetish Object to Transitional Object: The Analysis of a Chronically Self-Mutilating Bulimic Patient. *Journal of American Academy of Psychoanalysis*, 36, 69-88.
- Silverstein, B. (1985). Freud's Psychology and its Organic Foundations: Sexuality and Mind-Body Interactions. *The Psychoanalytic Review*, 72, 203-228.
- Sperling, M. (1973). Conversion hysteria and conversion symptoms: a revision of classification and concept. *Journal of American Psychoanalytic Association*, 21, 745-771.
- Stanton-Jones, K. (1997). *An Introduction to Dance Movement Therapy in Psychiatry*. London: Routledge.

- Stark, A., Aronow, S, McGeehan, T. (1989). Dance/Movement Therapy with Bulimic Patients. In L. M. Hornyak, E. K. Baker (Eds.), *Experimental Therapies for Eating Disorders* (121-141). New York, NY: Guilford Press.
- Stawarska, B. (2006). Introduction: Intersubjectivity and embodiment. *Phenomenology and Cognitive Sciences*, 5, 1-3.
- Stein, A. (2010). Shooting in the Spaces: Violent Crime as Dissociated Enactment. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 65-77). London, UK: Karnac.
- Stern, D. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Hillsdale, NJ: The Analytic Press.
- Stromsted, T. (1998). The Dance and Body in Psychotherapy: Reflections and Clinical Examples. In D.H Johnson& I.J. Grand (Eds.), *The Body in Psychotherapy, Inquiries in Somatic Psychology* (pp.147-171).Berkeley, CA: North Atlantic Books.
- Stone, M. (2006). The Analyst's Body as Tuning Fork: Embodied Resonance in Countertransference. *Journal of Analytical Psychology*, 51, 109-124
- Tantillo, M. (2004). The therapist's use of self-disclosure in a relational therapy approach for eating disorders. *Eating Disorders, Spring;12(1)*, 51-73.
- Tinter, J. (2010).The Incredible Shrinking Shrink. In J. Petrucelli (Eds.), *Knowing, Not Knowing and Sort-of- Knowing, Psychoanalysis and the experience of Uncertainty* (pp. 281-293). London, UK: Karnac.
- Tischner,I. (2013).*Fat lives. A feminist psychological exploration*. NY: Routledge, NY.

- Tonella, G. (2015). Body Psychotherapy and Psychosis. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.717-724). Berkley, CA: Noth Atlantic Books.
- Tortora, S. (2006). *The Dancing Dialogue: Using the Communicative Power of Movement with Young Children*, Baltimore: Paul H. Brookes, Publishing.
- Trautmann-Voigt, S. (2015). Dance Therapy. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.849-863). Berkley, CA: Noth Atlantic Books.
- Tronick, E.Z., Weinberg, M.K. (1997). Depressed mothers and infants: Failure to form dyadic states of consciousness. In L. Murray & P. Cooper, (Eds.) *Postpartum Depression and Child Development* (pp. 54-85). New York: Guilford.
- Van der Hart, O. (2009). Treating Dissociation. In C. Courtois & J. Ford (Eds.), *Treating Complex Traumatic Stress Disorders An Evidence –Based Guide* (pp.145-166). NY: The Guilford Press.
- Van Der Kolk, B. (2014). *The Body keeps the Score. Brain, Mind, and Body in the healing of Trauma*, New York:NY, Penguin Books.
- Wallin, D., J. (2007). *Attachment in Psychotherapy*, New York: NY, Guilford Press.
- Weiss H., Harrer, M. (2015). The Body and the Truth. In G. Marlock & H. Weiss, *The Handbook of Body Psychotherapy and Somatic Psychology* (p.255-264). Berkley, CA: Noth Atlantic Books.
- Winnicott, D.W. (1966). Psycho-Somatic Illness and its Positive and Negative Aspects. *International Journal of Psychoanalysis*, 47, 510-516.
- Winnicott, D., W. (1969). The Use of an Object. *International Journal of Psychoanalysis*, 50, 711-716.

Winnicott, D.W. (1988). *Human Nature*. London: Free Association.

Winters, A., F. (2008). Emotion, Embodiment, and Mirror Neurons in Dance/ Movement

Therapy: A Connection Across Disciplines. *American Journal of Dance Therapy*, 30, 84–105.

Woods, J. (1988). Layers of Meaning in Self-Cutting. *Journal of Child Psychotherapy*, 14, 51-60.