Bodies in Treatment

The Unspoken Dimension

Edited by
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At a Loss for Words and Feelings

A Psychoanalyst Reflects on Experiencing Bodywork

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It was peony season last year when I committed to write this chapter. It is peony season again, as I struggle to finish. Monday's tightly compressed buds, the size of pink cotton balls, have become Thursday's 13-inch, effusive, exuberant, multilayered wonders, and they're still expanding. Last year, I was in a full-bloom self-state while planning this book. As soon as I tried to use words to describe ineffable, imagistic experiences in bodywork, I tightened into an apprehensive, defiant, compressed-bud state: I was afraid I could not convey what I needed to in narrative form. It seemed like an overwhelming project, and I discovered that I did not want to work so hard. All year, I have felt like one of those oppositional buds that never opens. You know the ones I mean: They have such potential. You can wait forever but they never open. I felt as if I would never open. But I did. What I wrote during the year was self-conscious and stilted, too studious, dead. What helped me open was taking in the beauty and wonder
of the peonies, staying with the feelings they evoked, and starting to write from that place.

I have a highly conflictual relationship with words compared with my relationship with imagistic mentation (Fossagh, 1997). I respond readily to color, texture, form, movement, facial expression, and posture and to the pitch, volume, rhythm, inflection, and intonation of spoken language. I grew up in a family who did not graduate from high school. They had native intelligence and abundant common sense but a limited vocabulary and only rudimentary grammar. They seldom put thoughts and feelings into words. I remember a lot of silence: Most family communication was through what was not said — through facial expression, gesture, and posture. When they did speak, I relied on intonation and inflection to discern what they really meant. I knew more than I could ever articulate, and I longed for the words to capture and convey my experiences.

I was, and still am, in awe of and envy people who seem to be able to articulate concepts and feelings effortlessly, fluidly, eloquently. I experience an unbridgeable gap between my introspective, propoceptive, and kinesthetic experience and what I can convey about those aspects of experience in words. Often I cannot find the links between what Bucci (1997, 2001, 2003, this volume) calls the subsymbolic mode of experience and verbal and nonverbal symbolic representations of those experiences. (I often use visceral to refer to what she calls the subsymbolic mode.) Despite many years of formal education and evidence of mastery in some areas, I still feel at a loss when I confront dense, highly conceptual verbal and quantitative material. In contrast, when I meet someone for the first time or consult with a new patient, I “know” a lot immediately, even though I cannot always articulate what I “know” in my body. I rely heavily on subsymbolic and nonverbal symbolic modes of processing as an analyst and often find it difficult to articulate the complexity of my awareness in discussions with colleagues and when writing.

I resonated recently with a New York Times article, “Being Joan Didion” by Campbell Robertson (2006), in which he discusses the ways Ms. Didion and actress Vanessa Redgrave are collaborating on Ms. Redgrave’s role as Joan Didion in a play based on Ms. Didion’s book, The Year of Magical Thinking. The book is a gripping account of the impact of the sudden death of her husband, concurrent with the life-threatening illness of their only child. He quotes Ms. Redgrave, “I’m thinking about a lot of things in a lot of different ways.... I don’t like to put it into words.” Ms. Didion supplied, “It freezes it” (p. E2). David Hare, the British playwright who will write the script, contrasts Ms. Redgrave and Ms. Didion as follows: Ms. Redgrave “is the most emotionally expressive actor about a certain kind of extreme feeling.... And one of Joan’s extraordinary qualities is this glacially perfect prose which contains fantastic feeling underneath a formal surface” (p. E2). There’s my challenge — I wish to be emotionally expressive about extreme feeling in glacially perfect prose.

My difficulties in the realm of verbal communication, discovered in my personal analysis and in my treatment of people in pain, together with my discoveries about personal trauma through body-work modalities, are the sources of my passion for integrating verbal symbolic, nonverbal symbolic, and subsymbolic modes of processing. Writing from my perspective as a psychoanalyst reflecting on 30 years of experiencing body-based treatments, I hope to illustrate how I discovered experience that is difficult to represent in words but that I symbolized in images and eventually integrated into my biographical narrative. I also attempt here to identify conditions that can facilitate accessing feelings when the narrative lacks a connection with the subsymbolic realm. Finally, I wish to convey what I have learned about the advantages and limitations of verbal and nonverbal modes of treatment and how we can build bridges between self-states elicited in each.

The Beginning of My Quest

What began as an intellectual, academic pursuit became a passionate personal journey, fueled by each discovery I made along the way. My quest began in 1975, after I had finished my dissertation, received my doctoral degree, and completed my clinical psychology internship. I joined the psychology staff at my internship site—Rusk Institute of Rehabilitation Medicine at NYU Medical Center—diagnosing and treating children and adults with progressive neuromuscular diseases and doing research on sexuality and neuromuscular disease (Anderson, Bardach, & Goodgold, 1979). I have elsewhere described the impact of working as an analytically oriented clinician in physical rehabilitation medicine, where the material body dominates
the physical environment and is the focus of one's work every day (Anderson & Gold, 2003).

Eager to learn, I began studying in a private group with a psychologist, Camilla Kemple. She was renowned for diagnostic acumen and a creative approach to the interpretation of projective techniques—figure drawings and the Rorschach, among others. Having studied with Flanders Dunbar, a prominent figure in the field of psychosomatic medicine, Camilla had developed distinctive ideas about the relationship between mind and body, psychosomatic medicine, and how the Wechsler scales and projective tests could be used to detect difficulties in these areas. I had serendipitously found in Camilla someone from whom I could learn more about the mind-body connection, an interest dating back to my first undergraduate course in psychology. I first heard about “bodywork” from Camilla. She knew a seasoned Alexander teacher, and I, who had always been a very serious academic student, was ready to learn in a completely different modality. Thus, in 1976 I began to experience bodywork out of intellectual curiosity.

I chose to begin Alexander lessons without doing research on the technique; I relied only on Camilla’s descriptions. I wanted to enter from a place of curiosity, open to discovery, not from my “head.” Being goal oriented and practical, however, I found myself justifying the lessons: I knew that the Alexander technique focused on improving one’s posture, so I decided that I needed to correct my posture. That is where the trouble, and the unanticipated discoveries, began.

What was wrong with my posture? All I knew was that as far back as I could remember, Aunt Sadie had made harsh criticisms of it, such as, “What’s wrong with you? Hold your shoulders up.” Or, “Don’t slouch. You look like your daddy when you do that.” I continue to deal with the emotional reverberations of her critical voice, still audible within and capable of making me cringe as I write this. Having learned to avoid further castigation from her by being compliant, I never considered asking her to explain what she meant. Being precociously resourceful, I determined that I should lift my shoulders straight up to my ears. I hoped that would correct my problem, please Aunt Sadie, and literally get her off my back. Well, no matter how hard I tried to be perfect in order to avoid her criticism and to get her approval, my shoulders did me in. I just couldn’t remember to “hold them up” every single moment.

Thus, I brought my “poor posture” and “slumping shoulders” to my Alexander teacher, Patricia, fully intending to correct it. The sessions were about an hour long, and I was fully clothed. My first discovery was that, unlike my teacher, I was impatient with the painstakingly slow pace at which we worked. I had always taken pride in being diligent and patient. The body awareness Patricia required was very subtle and precise. Two thirds of each one-hour session was spent standing, turning, and bending, very slowly, with keen attention to doing it correctly. I quickly suppressed my feeling that this exercise was very tedious, boring, and, to my surprise, infuriating. I was angry that I had to be so conscious of every movement—what happened to spontaneous movement? What about the majority of people who never heard of Alexander lessons and seemed to be just fine without them?

The last part of the session, I lay on my back on a massage table, fully clothed, with my head off the table, supported only by my teacher’s hands. This posture was absolutely wonderful. I had never experienced anything like it. Her supporting my head was blissfully soothing. For about 3 years, I went for a class once a week, enduring the first part in order to get to the second part so that I could experience her holding my head. I had no idea why that was so important, and I never asked for the rationale for that part of the lesson.

I made two discoveries about myself that I had not yet made in my talking treatment: 1) I was very impatient and silently furious about having to work hard, in contrast to my conscious pride in being able to endure and persevere without complaint no matter what I had to do, and 2) it was very important for me to let go, to allow myself to be held, to be soothed; I hadn’t been aware of wishing for or needing that. These self-states, accessed first through “hands-on” body treatment, would prove to be fundamental in my process of integration and self-healing, to echo Krystal (1988). Neither my analyst nor I understood the significance of these self-states.

Treating Pain, Finding Myself

In 1979, I began working with a psychiatrist, John E. Sarno, MD, at Rusk Institute, NYU Medical Center, treating people with chronic musculoskeletal pain. He was the only mainstream physician who

My patients were exquisitely attuned to pain sensations in their bodies. Before long, I became aware of my own somatic sensations. I had hardly noticed them before, or I had paid scant attention to them if I did. Family and cultural norms had constrained and devalued bodily experience. I grew up on a working farm in the South, where we used our bodies for manual labor to make a living. We gave little thought to taking care of the body, except to feed it properly and to rest so that we could work. We had no concept of soothing the body, nor a concept of pleasure or leisure. My family also required Fundamentalist religious training, in which I was taught that the body was to be used to work and to do good deeds. I had much to learn about the body.

In the pioneering years of collaborating with Dr. Sarno, we treated people who had usually been suffering with pain for years. Many had had numerous unsuccessful medical procedures, including surgeries and injections. They had come to him as a last resort, placing great faith in and pressure on all of us who treated them. In the rehabilitation medicine field, they were thought of as “difficult,” even “untreatable,” except by the use of cognitive behavioral techniques to “manage,” not cure, the pain. That attitude prevails today, even though Dr. Sarno’s approach has gained national and international attention. My patients were not easily soothed; it was difficult to get them to talk about anything but their bodily pain, and they usually could not speak easily about their emotions. I was fascinated with the challenge of helping them but had no idea how much I had in common with them and how profoundly I would be affected by working with them.

As I worked with my pain patients, I began to feel that I needed a different kind of bodywork. Perhaps the Alexander technique had helped my posture, but more important were my discoveries that I hated working tediously at correcting my posture and that I craved the time I spent on the table “letting go.” I was eager to learn more about letting go through hands-on bodywork and in the talking situation.

What do I mean by letting go, recommended in many kinds of bodywork and meditation? Let me return to Monday’s peony buds. If you don’t know peonies, imagine a tight new rosebud. Can you locate within yourself the visceral experience of the tightly compressed buds? Here I use visceral to refer to sensory information from the internal organs of the body that reaches the brain by way of the spinal cord and to refer to our verbal concept of “gut feeling.” A technical term for this awareness is interoception. What do you sense in your body when you try to find that closed, compressed-bud self-state? Imagine the tightly compressed bud and notice what happens in your body. I call that the OPPOSITE of letting go. Now, imagine Thursday’s 15-inch peonies, or a voluptuous rose, and notice what you feel in your body. What sensations, images, feelings, and thoughts arise when you try to access your peony/rose-in-full-bloom self-state? I call this a form of letting go, or opening up—a process that took my peonies about a week.

The “open” state that happens when we “let go” comprises cognitive, emotional, imagistic, and visceral elements difficult to convey precisely in words. Another image of letting go is to imagine holding a small rubber ball that will fit in the palm of your hand so that you can wrap your thumb and fingers around it. Imagine squeezing that ball very tightly, as tightly as you can, and notice all sensations, images, feelings, and thoughts that arise as you “hold on” very tightly. Now imagine suddenly letting go of the ball, suddenly releasing it—I call that letting go. What do you feel in your hand and in the rest of your body now that you have “let go”? Can you express in words what you feel in your body?

In 1979, I knew that my pain patients could not let go. And working with them forced me—allowed me—to discover that letting go was difficult for me also. Continuing to seek methods of experiencing feelings I could not access in talking treatment alone, I worked with a woman, Samantha, trained as a psychomotor therapist, focusing on how the body moves. I hoped to be able to discover how I could feel free to move and also understand what psychological processes interfered with moving freely. I also hoped that moving freely would generalize to feeling free to move cognitively and emotionally as well.

As I had anticipated, the work with Samantha was much more active than the Alexander lessons had been. It involved a lot of stretching and breath awareness while I was fully clothed. Some of it was done standing and some lying on the floor. I loved my teacher—she was warm, had a great sense of humor and a lovely voice, and was remarkably patient. I felt good being in her physical presence. I was
amazed that, unlike Aunt Sadie, she did not criticize me or pressure me, even though I was not being a good student.

When I first wrote the preceding three sentences, I felt embarrassed, like a child in grade school talking about her favorite teacher. Awareness of feeling ashamed alerts me to recent writing by Schore (1994, 2003a, 2003b) and Bromberg (2003, 2006) about the significance of shame regulation in the development of trauma and in its treatment. My feeling ashamed that I had expressed loving feelings toward my teacher indicates that I still have dissociated shame about spontaneous expressions of affection that must have origins in what Bromberg (2006) calls "the early failure of responsiveness by the mother or father to some genuine aspect of the child’s self." This "nonrecognition" or "masked withdrawal from authentic contact" with the child can lead to a "structural dissociation of a part of the self," which may interfere with the "early attachment process and in the capacity for mutual regulation" (p. 139). Other analysts (e.g., Corrigan & Gordon, 1995) have drawn on and elaborated Winnicott’s (1960) formulation of a false self, which unfolds to make possible the survival of what Bromberg (2006) has referred to as nonrecognition. I could easily identify with this form of developmental trauma.

I see now that I needed Samantha’s warm, accepting attitude because I was still very impatient with my body’s limitations and deficiencies: I was still carrying around images of my “bad posture,” and I felt physically inept, not well coordinated, and weak. I felt like a failure—I was not perfect and, for a child in my family system, being perfect was a survival strategy. I did not acknowledge to Samantha the importance of this relational dimension of the treatment. It was implicit; but my explicit recognition of it as I was writing evoked embarrassment, indicating that I still have dissociated shame around spontaneous, authentic expressions of self-experience.

In the sessions, I quickly discovered that I did not want to do the exercises, just as I had felt during the Alexander lessons. I rarely did my homework. This time, I was acutely aware that I wanted my teacher to “fix” me. “I need fixing and I don’t want to have to do it myself!” This wish was not explicit, but we were enacting it in the sessions. Clearly, the transference and countertransference are vitally important in bodywork. Much is enacted and not understood as such because the frame does not allow it. I knew that I had been searching for a treatment arrangement that would help me to process psychologically my need to let go and my wish to be fixed. With Samantha, I was aware of this wish as I never had been in my talking treatment. There was something about her "presence" that facilitated my experiencing these feelings.

Years later, I realized that I was experiencing at a visceral level what Krystal (1988) and McDougall (1980, 1985, 1989) identified as common fantasies in people who have somatic symptoms and addictions. They speak about the fantasies as resistance to “owning” one’s body in the belief that the body belongs to a powerful other such as God or Mother. In their view, these difficulties arise from developmental trauma in the relationship with the primary caregiver, severe trauma in adult life, or both. Prior to participating in bodywork, I had not “known” that I had such fantasies and resistance. At the time of the sessions with Samantha, I did not think of myself as having experienced trauma, so I was very puzzled by my “resistance to self-care.”

I worked with Samantha for about 6 years. My posture changed—I was able to keep my chest open by lowering my shoulders and moving them backward. I learned, finally, that what my family had really been critical of was my natural tendency to curl my shoulders forward. Aunt Sadie could not criticize me any longer. I gained an intimate appreciation of how one’s image of one’s body parts becomes entwined with relationships with authority figures: I am still self-conscious of where my shoulders are resting, and I am very attuned to where other people’s shoulders are positioned.

As I worked with Samantha and my analyst, I searched the analytic literature to locate help in treating my “difficult” patients—and found myself. A colleague who knew about my work with pain recommended one of Henry Krystal’s early papers on alexithymia (1982/1983). His conceptualization validated my experiences with my patients who could not speak in words about their emotions and who often could not recognize that they had feelings. I realized that I had similar difficulty, although most people would never guess that I did. Winnicott’s (1960) concept of false-self development pertained to the experiences of many of my patients. His understanding of the formative impact of the facilitating environment on the infant’s development was richly supportive (Winnicott, 1965). I read all his work that I could find. Playing and Reality (1971) became a transitional object, given to me by my analyst to use during her two-and-a-half-month summer vacation.
I was particularly intrigued by Winnicott’s (1949a) statement that infants remember every second of the birth process and by his description of the significance of the pressure on the head, and the need to relive that process in analytic treatment. I thought of the story my mother had told many times as I was growing up about her 48 hours of labor before I was delivered. I don’t know if forceps were used. I thought of the comfort I felt in having my head held. I began to feel that I needed to have my head held, to feel pressure on my head, as Winnicott described. Discussing the impact of prolonged labor, he stated, “There can very easily be delay at a time when there is constriction round the head, and it is my definite view that the type of headache which is clearly described as a band round the head is sometimes a direct derivative of birth sensations remembered in somatic form” (1949b, p. 186).

My analyst, Dr. L, and I were working with the feelings of constriction that I experienced emotionally. In the fifth year, she broached the subject of how stuck we were and suggested that I consult with other analysts with whom I might more easily access my feelings, in particular, my negative feelings toward her and others. I was resistant for some time because I felt like a failure and I still idealized her. I was barely aware that I envied her, but we never dealt with my envy. I consulted with two male analysts she recommended, chose one, and we set a termination date for the end of that fifth year.

I was eager to have a termination dream. We had worked with dreams productively, she valued them, and I had come to value them. The night before my last session, I dreamed that I found a mutilated, murdered body hidden underneath my multigenerational family’s dining room rug. I was trying to discover the identity of the body, a man, and to learn who had murdered him. I was stunned, perplexed, and disappointed by my dream. I felt that it revealed that I had failed in the analysis.

Over the years, I have come to appreciate the richness of that dream. Daily meals at my family’s dining table were accompanied by long silences interspersed with harsh, gossipy critiques of all members of the extended family who were not present. At times, they would lash out at one another as well. Everyone was afraid of and utterly dependent on my stern, maternal grandmother, the family matriarch. I rarely said a word. Rather, I listened carefully to calculate exactly what I needed to do, or not do, to prevent such criticisms of me. Viscerally soaking up the aggression, I became a supersaturated sponge, as I sat silent, unmoving, and afraid.

I was shocked at the way my termination dream blatantly depicted my long-standing, compliant, goody-two-shoes adaptation, which I had refined so as to survive and, eventually, escape from my family circumstances. Dr. L and I “knew” the narrative very well: I was still hiding my murderous rage at my family for their aggression toward one another. I remained a supersaturated sponge. We had tried hard to bring that directly into our relationship.

As I learned more about trauma and its impact on the body, I realized that I was reflexively using my shoulders to protect myself from those tension-filled dynamics. My shoulders seemed to be curving forward as if to ward off those dangerous verbal assaults I had witnessed in family interactions and that I sought to avoid at all costs. My sympathetic nervous system was conditioned to respond reflexively to aggression, and my right shoulder is still hypervigilant. I have an exaggerated startle response as well, which I now understand as a response to sensory and emotional overstimulation at an early developmental stage.

The dining room rug in my dream belonged to my analyst; it was out of place in my family’s dining room, which was covered with linoleum. She and I agreed that we had been unable to destabilize what Dr. Sarno refers to as “goodist,” “people pleasing,” perfectionistic behaviors that cover feelings of inferiority, fear, rage, and other threatening emotions. Together, Dr. L and I had hidden them under her Oriental rug, just as I had hidden “not nice” feelings from my family to avoid their disapproval and criticism. I ended the analysis feeling grateful for how much she had helped me, yet feeling that I had failed to learn how to tolerate and regulate my aggression. Nor had I touched on the envy underlying my idealization of her. I have found myself in Dr. L’s shoes many times with my patients and appreciate how difficult a challenge I was to her.

Many years later, I met Dr. L in the lobby of a building while I was on my way to an appointment. We greeted each other amicably, and she asked how I was doing. I gave her a sketch. Then, to my surprise, she asked, “Are you still holding yourself so tightly?” as she scrunched her shoulders into the position I had worked so hard to change! Her question revealed that she had been very affected and regulated by my posture, but we had never discussed it. We had not
created a space in which we could welcome my protective armor masquerading as slumping shoulders into the talking situation. I have had similar reactions to aspects of my patients’ posture and have not always been able to bring these reactions into our relationship.

Developing a Somatic Symptom

By 1983, I had developed a symptom—tension headaches. Until then, I had not had somatic symptoms. I could remember only one headache in my life—a vivid memory. It occurred during my junior year of high school when I made a less-than-perfect score on a chemistry exam. I relied exclusively on my academic performance to escape the clutches of my insular family system and repressive Southern culture. I had always had the highest GPA in my class, and I intended to keep it that way. But the chemistry instructor had given an exam that had nothing to do with the material covered in class. Unable to feel furious, I was devastated; I could not stop thinking about my poor grade and the lost opportunities it heralded. I felt an endless loop playing in my head. Two days later, I got a headache that required a family member to take me home from school, a first. I was nauseated and extremely sensitive to light. It was probably a migraine, but I was not given a diagnosis and no one knew how upset I was about my bad grade.

The life context in which I gradually developed a pattern of headaches was fraught with similar dynamics: Like many of my pain patients, trying my best to do a “perfect job,” I was putting extraordinary pressure on myself in a situation that placed objective external limitations on what I could accomplish. I knew I was furious but was not able to use my anger effectively enough to have an impact on the system in which I was working. After a few years, I chose to leave the situation, a move that relieved my symptoms for a few months. I took my perfectionism and its companion, rage, with me, however. My headaches returned as I created more and more impingements.

In my new analysis with Dr. W, recommended by Dr. L, I quickly developed an idealizing father transference—he was very smart and must have all the answers. Certainly he could “fix me.” The analysis was intense but my emotions were still difficult to access. I looked for a “more powerful” bodywork to complement the talking process. I wanted to have bodily experiences that would give me easier access to my feelings.

A friend recommended her bodyworker, Monique, who combined bioenergetic techniques with kundalini yoga breathing to open areas of “energy” blocked by emotional “holding” in different areas of the body (see Bass & Newman, this volume, regarding the concept of energy). I did not know what all that meant, but I wanted to try it, hoping that this mode of experiencing would enhance my talking analysis. I made a point of not researching bioenergetics and kundalini yoga beyond the basics I already knew because I wanted to enter the work openly, still trying to counter a tendency to overconceptualize, to have everything already worked out in my “head.”

Monique was quiet and calm. Her voice was soothing and her hands were remarkable—surprisingly small, powerful, and boundary are the best descriptors I can find. She worked as I lay on my back on a massage table, wearing only underpants. She would have treated me fully clothed but explained that it was easier for her to see my breathing and changes in blood circulation if I wore fewer clothes. Her explanation made me feel comfortable working this way. She directed my breathing into different areas of my body where she sensed that energy was blocked. She was the authority about what was happening in my body. I hated the breathing. In fact, I did not want to breathe. I complied, however, because I always felt better after a session. The last 10 minutes or so of each session, I could breathe naturally while she worked on my head as she listened to sounds in my belly with a stethoscope. She was aiming to stimulate normal peristalsis in the lower gastrointestinal tract. I never asked her why this method worked nor why it was important. This was my favorite part of the session.

After three sessions, I had a dream that contained disturbing, vivid body imagery. I remember it as clearly as if it had happened last night. I still get chills if I tell it. Although Monique encouraged me to work with dreams and incorporate talking in the sessions, I did not tell her the dream because she was not trained as a therapist. Dr. W and I worked on the dream but with little success.

The emotional impact of the bodywork with Monique, in the context of an intense, idealizing transference to my analyst, proved unmanageable. Specifically, my idealized analyst became openly exasperated with me in reaction to my constant complaints about insurmountable limitations in current primary relationships, including
my relationship with him. I was appalled that I was becoming a “difficult” patient, much more openly than with Dr. L.

We conceptualized what was happening as my “acting out.” I think of it now as an “enactment” that was unfolding, like a screenplay. His open, verbal response of being fed up was much like my mother’s when I pressed her too hard to get what I wanted. With my mother, I felt guilty. With my analyst, I felt criticized. For the first time, I reacted by being a “bad girl,” both inside and outside the treatment. I was breaking rules, defiantly—something I had never done. I was reacting to feeling unrecognized and misunderstood by him and by significant people in my life. I was certainly feeling more intensely than ever, but my analyst did not recognize the hurt, disappointment, and rage that I barely disguised by my rebellious behavior. After 8 months of combined treatments, I ended both. I felt that the bodywork was too intense and unboundaried; I was afraid of what might emerge next. I felt jarred and disillusioned with psychoanalysis. My idealization of Dr. W was shattered, and I lost hope and trust that he could “fix” me. We could not repair the rupture in our relationship, although we tried.

Looking back, I can see that Dr. W and I had entered what Bromberg (1998) has referred to as the “messy” part of the analytic relationship. While writing this chapter, I thought of a conversation I had a couple of months ago with Bromberg on the topic of being “difficult.” He is comfortable with being difficult and likes to work with difficult patients. I found myself saying, “Philip, I aspire to tolerate being thought of as difficult!”

I have come a long way since the enactment that disrupted my analysis in 1985. For the next several years, in the same month I had had that powerful dream, I had a dream with the same theme, which I have come to articulate as “Learning to stay in the room when something dreadful is happening.” (More about this dream later.) On two occasions, I awoke from the dream unable to move because of pain in my lower back. Eight years later, when I began to study the impact of emotional and physical trauma on the mindbody system, I came to think of the dream as containing information about trauma and dissociation. In the dream, the body images represented trauma—“The body keeps the score” (van der Kolk, 1994)—just as my dream about the mutilated murdered body under my family/analyst’s carpet was conveying information about traumatic affect that could not be easily regulated and integrated into family, interpersonal relationships, and my relationship with my idealized analyst.

After I ended that analysis, for the next couple of years I tried to figure out what had happened in the chemistry of my idealizing analytic transference and the bodywork. Trusting that I would find my way, I read voraciously, had consultations with analysts of varying orientations, and paid a lot of attention to my dreams. For a while, I thought I was incapable of being analyzed. I now think of this period of solo exploration as one of building a sense of agency. I continued to look for literature to help me treat my patients who had chronic pain, and I continued to puzzle about my headaches. When I discovered Joyce McDougall’s (1980) work, I felt understood and relieved as analyst and patient. She describes an enactment in which she and her patient became mutually exasperated and hopeless. Her patient lashed out at her. This rupture opened her patient up to previously inaccessible feelings. It shed some light on what had triggered the enactment with Dr. W.

As I read more, I felt hopeful again because of what Dr. McDougall had to say about how experiencing and not experiencing affect was related to the development of somatic symptoms. I consulted her for a referral to an analyst, Dr. G, with whom I began treatment. I continued to study in supervision with Dr. McDougall. I was fascinated with the psychoanalytic concept of affect as a link between mind and body and used Krystal’s (1988) information-processing model of affects in my discussion of the psychoanalytic treatment of pain (Anderson, 1998).

Affect regulation has become a key construct in understanding the development of the mindbody system (Shore, 1994, 2003a) and the impact of trauma (Shore, 2003b; van der Kolk, 1994; van der Kolk, McFarlane, & Weisaeth, 1996). This literature gave me a new perspective on my own development and symptom. Through the lens of trauma, I could now begin to answer a question I had posed to my analyst, “Why do I have somatic symptoms?” I didn’t experience developmental trauma severe enough to be affecting me somatically.

Prompted by the literature on attachment trauma, I asked my family for details about a traumatic separation that they had always mentioned casually, even matter-of-factly, as I was growing up. The narrative was that I had been separated from my mother in a marital dispute when I was about a year and a half old. No one could remember how long the separation had lasted or how it had affected me or them.
As I was gathering details about this calamity, my mother mentioned that, again in the context of a dispute between my parents, I had been separated from her, against her will, when I was about 10 days old. As she told me the details, I remember getting chills, then feeling frozen, and suffering a strong visceral sense of dread. I wanted and yet did not want to know more (Laub & Auerhahn, 1993). She could not remember how long the separation had lasted but said that, when we were reunited, “Everybody was worried about you. All you did was sleep. You didn’t move.” I was stunned. I tried to ask some questions, get some details, but she could not remember how long I was in this separation-induced traumatized state.

A year prior to getting this information from my mother, I had spent several months on the analytic couch, four sessions a week, feeling like “petrified wood,” not wanting to move, not feeling anything, not wanting to speak. Dr. G tried every possible way to engage me, but without success. We could not make sense of my unreachable state. As soon as I heard my mother’s answers to those questions about my developmental trauma, that period in my analysis began to make sense. I gained a new appreciation of the concept of “ownership” of one’s body. I understood better the deficits that interfere with ownership and the resistance to ownership I had experienced in bodywork, in analytic treatment, and in trying to take care of myself.

On reflection 15 years later, I feel that I was reliving what I think of as a “layering” of traumatic states in an enactment with my analyst: birth trauma, infantile trauma in the second week of life, and separation trauma when I was about 18 months old. She tried very hard to reach me but she failed. I remember that the “petrified wood” period had been triggered by my feeling that I could not make her understand why I had felt so keenly “abandoned” in an important relationship. I gave up and lapsed into an unmoving, unreachable state. Eventually she told me that she had become aware of a traumatic experience she had survived that she thought contributed to her difficulty reaching me. It was not her theoretical orientation to elaborate further, and I was not assertive enough to ask her to tell me more. I eventually began speaking and continued in the analysis without our understanding the significance of the “petrified wood” state.

I believe that it was inevitable that traumatized states, which I had been contacting in bodywork, would emerge in my analytic relationship. The bodywork facilitated their emergence. The vivid dream I had in 1985 in the context of bodywork and an intense transference now began to make sense. The dream contained an image of an alive but immobilized preadolescent girl who was being physically traumatized as I watched. Her pale, unmoving body, frozen in a protective reaction to traumatic stimulation, carries information about residues of trauma that can still cause the cognitive and affective paralysis I experience, so aptly described by Laub and Auerhahn (1993). The traumatized preadolescent body, along with the narrative of the infantile traumatized state I experienced in the early weeks of life when I “didn’t move,” have helped me understand why I can become exhausted, immobilized, and frozen, conceptually and somatically, in response to sensory, emotional, and cognitive stimulation. For instance, it sheds light on the constricted, compressed-bud, cognitive state I described at the beginning of this chapter. I have come to realize that I can easily be overstimulated when I have overworked, and that I usually need a period of prolonged, silent rest, preferably meditation or bodywork, in order to recover. Bodywork and meditation, combined with analysis, have made it possible for me to make contact and gradually integrate dissociated frozen, unmoving, immobilized states. I am still learning how to self-regulate in order to feel restored and revitalized. The willingness to do so is slowly developing. I am still processing the images in that dream as I continue learn about the lasting impact of developmental trauma.

Additional Bodywork Experiences

In the past 15 years, I have continued to explore different kinds of bodywork/treatment. For example, having read about biofeedback as treatment for a variety of physical symptoms, I decided to experience it. The practitioner monitored tension in my forehead muscles and the temperature in my index finger. I could easily change the tension and temperature by using an image of my deaf cat, Herzog, resting on my chest while my yoga teacher, Alicia, sat behind me and held my head.

This was an impressive demonstration of the power of “relational” imagery to regulate internal, visceral states. Specifically, my emotional relationship with Herzog was based entirely on communication through visual and tactile cues. My husband and I referred to him, affectionately, as our “healing” cat because of his ability to seek us out when were feeling despondent or ill and soothe us with
his presence. In the image I created in the biofeedback session, I placed Herzog on my chest and recalled an incident 20 years earlier when he had "healed" me. Herzog had found me weeping in bed, inconsolable because of a distressing phone call from my husband, hospitalized for several weeks due to postsurgical complications. I was lying on my back when Herzog jumped on the bed and climbed onto my chest. Aligning himself perfectly along the midline of my chest, he rested his nose on my chin. He remained there long after I had stopped crying. This is the most powerful bodywork experience I have ever had.

I returned several times to do bodywork with Monique. Noting that she had to work very hard to get my energy to flow, she observed many times during the sessions that it was "sluggish." I did not tell her that I felt criticized and ashamed—I did not work with her in that way, even though she was open to doing body-oriented psychotherapy (versus only bodywork; see Cornell, this volume). In the sessions, she could always help me change my somatic/emotional state. I always felt better after the session. I craved that release. The problem was that I could not, or would not, do it for myself. I felt completely dependent on her, which made me feel ashamed, helpless, and furious. She gave me exercises to do on my own, but I still did not want to have to self-regulate.

I was stunned when she announced that she was retiring, giving only 2 months' notice. I felt abandoned and desperate. Fleeing from these feelings, I tried another kind of treatment I had heard about from friends—craniosacral therapy (see Bass, this volume). I consulted the practitioner, Janine, whom they had highly recommended. One friend had been recommending her for more than a year. I had called Janine for an appointment several times but never left a message because her voice seemed closed and dismissive. Now I felt desperate, so I made an appointment. When I saw her, I had a sinking feeling about the expression in her eyes. That, combined with her restrained manner, which was consistent with her voice quality and intonation on the phone, made me wary. I went forward with the session anyway. She took a developmental history and reported that she could see evidence of birth trauma during the prolonged delivery in my face and head. This was on target and gave me hope.

She conducted the hands-on treatment as I lay on a massage table wearing underpants. Gently holding and moving different parts of my body, she focused a great deal on my head—wonderful! A skilled practitioner, she could take me into states of "letting go" that I had never experienced. In these open states, I found myself sharing associations and images with her, disclosing details that made me feel ashamed immediately because of her perfunctory, dismissive response. My longing to be taken care of was awakened again, and I started to feel acute dependency on her to change my state, despite my negative reactions to her nonverbal cues. She did not consciously invite dependency in the interpersonal realm. In fact, she seemed to discourage it.

I was in a bind: I felt invited to let go and open but felt unsupported and rejected when I accepted the invitation. We did not create a safe, contained space in which I could integrate what the bodywork was unleashing. Unfortunately, I left the sessions disoriented, ungrounded, longing, craving more sessions, and feeling very dependent on her to change my state. I started to feel angry and had to find a way to dissociate it in order to continue the work. Once, after a particularly powerful session, I tripped on the sidewalk a couple of blocks down the street from her office, barely escaping serious injury. This kind of event can happen to anyone, anytime, anywhere, but I am convinced that it happened because I had not made a transition to an alert, awake, grounded state. I realized that I did not feel safe enough to continue to work with her.

Boundaries in Bodywork

Explicitly, boundaries can be particularly difficult to define when one is working in an area where words cannot easily be used as markers, as limit-setters. In contrast to the talking situation, where "Do not touch" is explicit, in body-focused treatments I have experienced, I relied on the implicit, usually unarticulated, judgment of the bodyworker. When the work is "hands-on," the bodyworker's judgment is particularly more important because he or she may not be able to verbalize what is being done and why. Such an unbounded space can "open" the patient to dissociated self-states that the patient is not prepared to integrate. The bodyworkers' conscious and unconscious intention, as well as their skill, becomes very important. Often it is unacknowledged or addressed because the bodyworker has not been trained to incorporate this dimension of the treatment.

For example, take my right shoulder, which prefers to curve in slightly, after all these years. Every bodyworker I have consulted has
noted it immediately and tried to get it to open, usually without asking "permission" (see Bass, this volume). I remember a session with a highly skilled massage therapist and bodyworker, recommended by a trusted friend. She incorporated a variety of hands-on techniques in her treatments. Consciously, I was ready to participate in this session, even though there was something about her nervous laugh that had unsettled me from our first conversation on the phone. I had taken a group workshop with her and felt unsettled there as well, for the same reason. In the individual session, when I was open and disclosing, she made lighthearted, joking remarks, which were jarring. I experienced her as pushing me away, and I felt bad about myself. Her hands-on work was excellent, however. She worked very gently with my shoulder, almost not touching it. My shoulder cooperated—she was able to take it into an open, properly aligned position that I never recall having attained. I "felt" very open and amazed that such a state was possible. I rushed from the session back to my office. Within half an hour my right shoulder had rebounded into a position far tighter than ever, and I had a severe headache. I, the patient, had participated willingly in the treatment, which had nonetheless produced a result that neither of us had anticipated. I have had similar experiences with practitioners of other modalities, for example, bioenergetic therapy.

What we did not do in the session I just described was inquire about why my shoulder seems to need to be in the curved in position all the time. I have not worked with a practitioner who inquired about what my shoulder is communicating through its preferred position. Rather, I have given over my body to the authority of the bodyworker. In the talking situation, we might think not of my shoulder as "resisting" but as the body expressing an unsymbolized, or subsymbolic, self-state in reaction to traumatic overstimulation—an embodiment that has become chronic and unmoving. My study of the impact of trauma on the mindbody system has helped me appreciate how my body was affected by my family's emotional violence manifested in their harsh critiques around the dining table. Unfortunately, my bodyworker did not have this information about me. In the talking frame, it is the therapist's job to respect and inquire about a bodily state such as this before trying to change it. That was not my experience in the bodywork modalities I have described. This omission led to some of the intense reactions I experienced, e.g., the pronounced opening of my right shoulder followed quickly by its retraction once the session was over. In the new body-based talking therapies, such as Somatic Experiencing (Levine, 1997, 2005; Eldredge & Cole, this volume) and Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006), the practitioner, respecting my shoulder's position, would recognize the possibility that it had assumed this chronic "poorly aligned" position as a protective response to trauma of some kind. The practitioner would inquire in detail about my sensory experience of my shoulder before collaborating with me to make interventions to change its position.

Another consideration regarding bodywork interventions is that changes in the body's position and movement can quickly evoke affect-laden self-states that neither the practitioner nor the patient may be able to regulate adequately. For example, I worked in individual sessions with a yoga teacher, Alicia, mentioned earlier. I had had an instantaneous positive transference from the moment I heard her voice on the phone. When I saw her, I felt completely open, filled with hope and longing to be soothed and healed by her. Her calm, focused attention to breathing work on the floor, without touching me, "held" me in a way I had never experienced. At the end of our first session, when we did a brief silent meditation, she was simultaneously completely silent and fully present in a way no one else ever had been.

I was in bliss when we worked on the floor. As soon as I had to stand, to our surprise, I became overwhelmed and would start to cry. Neither of understood what was happening. She instinctively suggested that I move into "child's pose" (kneel, sit on your heels, fold your torso forward to rest it on, or between, your thighs, hands on the floor alongside the torso with palms up) on the floor. She sat beside me, rested her hand on the middle of my back, and left it there until I stopped crying. What had happened? I knew a good deal about what was unfolding, but we did not have a way to integrate the "meaning" of this emotional experience in our treatment relationship. I was looking for an integrative experience that she was not trained to provide.

Those examples, among others, have led me to realize that it is crucial to choose carefully when and with whom to open, and how far to open. This discernment is particularly important for people who know that they have a history of trauma. When I began bodywork, I
did not “know” about the developmental traumas I had experienced. I knew that some of my experiences had been challenging but I had no idea how challenging. Choosing a bodyworker is as important a decision as choosing an analyst.

I cannot emphasize strongly enough how important the transference and countertransference are in bodywork. I tell people who ask for recommendations that they need to check their gut reaction to the bodyworker. I tell them to ask themselves, “When I think of X, what do I feel in my body? Do I feel like opening up or closing down? What is it about X that makes me feel that way?” Feeling like opening up may not necessarily be a good thing, unless the practitioner is prepared to work with eruptions of affect and help the patient regulate and integrate it. Feeling like you are closing down is usually not a positive indicator: Why would you put yourself in a treatment situation where opening is usually a goal when your visceral sense is, “No, don’t go there.”

I now give the same recommendations to people when they are choosing an analyst. At the end of the initial consultation, I invite patients to be aware of and to feel free to share their visceral reactions to me—to my body, to my voice, to my office. When I teach physical therapists, yoga teachers, and other bodyworkers about pain, trauma, and the treatment relationship, I focus on the significance of the transference–countertransference configuration and the importance of openly setting up communication about boundaries.

Conclusions

When I was at a loss for words and feelings, I sought experiences in the nonverbal, subsymbolic realm to help me find words for what I could not speak about and to access feelings that I could link with the words in my verbal narrative. In the world of moving and breathing—the sensory, motoric, and visceral domain—I made contact with what Winnicott (1960) referred to as the true self, the source of the spontaneous gesture. I conceptualize these experiences as authentic self-states, dissociated long ago in an effort to survive.

Transferences to my bodyworkers proved more affective-laden than transferences to my psychoanalysts. The physical presence of the bodyworker and the immediacy of body contact, without the boundaries provided by words and interpretations, activated previously unconscious feelings of longing to be held, soothed, healed, and fixed. My understanding of Bucci’s (1997) model is that this treatment modality quickly engaged the affective core of emotion schemata, the prototypic images of the self interacting with others: “The emerging image of the caretaker is the crucial, enduring prototypic symbol about which the emotion schemata are organized from the beginning of life” (p. 162). The affective core is dominated by sensory, motoric, and visceral elements, and in normal emotional development, these must be integrated into the emotion schemas.

Bodywork, combined with traditional analysis, helped me discover developmental trauma at a visceral and affective level, through transferences to my bodyworkers and analysts and through imagery in dreams. My tranferences to bodyworkers opened the portal to intense experiences evocative of birth trauma and separation trauma, previously dissociated. In two instances—my mother’s prolonged labor and the separation from her when I was a year and half—the traumatic events were part of my narrative, but I did not have affective connections with the narrative. In another instance, a separation in the second week of life, I did not know the narrative of the event but discovered that I had been carrying the residues in somatic memory. The residues in bodywork manifested in my attitude of not wanting to “do my homework” and in wanting to be “fixed,” “soothed,” and “healed.” In an enactment with my analyst, a residue was my feeling like “petrified wood” and not moving or speaking.

Bodywork can be a powerful adjunct to psychoanalysis. The unbounded space of bodywork can, however, enable access to affect-laden self-states that are alarming and difficult to regulate and integrate. Such self-states elicited in the bodywork domain often are not easily accessed in the analytic frame, which makes it difficult to integrate them. Both bodyworker and psychoanalyst need to be prepared to collaborate in these instances. When the analyst and the patient “know” about trauma, they need to carefully consider the type of bodywork, and the bodyworker needs to be aware of the narrative. Ideally, bodyworkers need training about psychological mechanisms, trauma, transference, and countertransference. Psychoanalysts need to know more about the body and to experience bodywork themselves to expand their awareness of the complexity of the mindbody system. I hope that our efforts in this volume will stimulate interest in learning from each other.
References


