Infant Research & Neuroscience at Work in Psychotherapy
EXPANDING THE CLINICAL REPERTOIRE

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facial musculature, thereby experiencing the emotion in him- or herself. One might hypothesize that a baby with a depressed (sad) mother actually experiences, through her own facial musculature, the same sadness when she is with her mother. In adult psychotherapy, Pally (2001) suggests that there might be different brain systems that read and interact with these nonconscious communications that are expressed through the subtle facial musculature. Patient and therapist in face-to-face interactions are implicitly reading and communicating to each other.

Whereas Tomkins and Ekman used traditional research paradigms to develop and verify their theories, neuroscientists rely more on the use of high-tech imaging machines. When these technologies emerged in the late 1980s and early 1990s, neuroscientists began contributing more fully to the discourse on emotions as bodily based experiences. From all sources (Damasio, A.M.; LeDoux, J.; Panksepp, J.) there seems to be overwhelming consensus that body–brain–mind are interwoven.

The case of Andrew, contributed by my colleague Elly Huber, provides a literal depiction of the mind–body connection. Patients like Andrew carry the majority of their relational conflicts in their bodies, through various somatic illnesses and complaints. Because their feelings and relational conflicts remain primarily bodily based experiences, they can be frustrating and challenging patients for a psychodynamic therapist. Prior to becoming a psychoanalyst, Elly was trained as a mind–body practitioner in the Rubenfeld synergy method. With this special training, Elly is unusually attuned to body experience and to facilitating a translation from somatic to linguistic language with her patients. She has found ways to integrate her knowledge of how the body speaks into mainstream psychodynamic psychotherapy. Using the body as a portal for exploration, in the case of Andrew she demonstrates how speaking to and with his body, she helped to facilitate the translation of a narrative that emerged from Andrew’s body into words. In this process she helped Andrew transform his relational configurations and conflicts. The case is presented in the first person, with “I” being Elly Huber.

**Andrew: Embodied Relational Conflict**

Andrew, a 30-year-old professional, came for therapy for treatment of his fibromyalgia. He had made many attempts to heal his symptoms, but he remained chronically symptomatic. Andrew heard of my somatic orientation to psychotherapy and hoped that I could help to alleviate the chronic symptoms of his fibromyalgia: pain, fatigue, cognitive disorganization, and depression that accompanied all of the above. Fibromyalgia is a poorly understood disease. Although considered a legitimate disease, it is nevertheless considered by many in the medical community to be purely psychosomatic. To date, little has been successful in treating the pain, discomfort, and other symptoms that patients suffer.

Based on my bodywork training, I subscribe to the belief that emotion itself is a somatic experience and that grounding a person in his or her body can sometimes help him or her develop greater access to feeling states. I began the psychotherapy with Andrew from this perspective. Immediately, as I explored his reasons for therapy, it became clear that he had very little awareness or experience of his own body. He was aware of pain, though. And, if he didn't feel pain, he ex-
experienced himself as "numb." "I don't know what I feel," he said, and he seemed confused when I tried to elicit other bodily areas of experience. Over time, it became clear that for Andrew, the only way of feeling his body was through pain.

Using the principle of starting with where the patient is psychically, I inquired about the parts of his body that were in pain, and asked him to describe the pain in as much detail as possible. I used this detailed questioning to get a better picture of his self experience. In describing his pain, he used words such as squeezed, pushed, pressed, poked, and prodded. From his associations to these harsh words and the images they evoke, Andrew's body slowly revealed his relational history. Beyond the pain, it was difficult for Andrew to come up with much experientially. When I asked him about parts of his body that were not overtly in pain, he had no answer. Because Andrew had so little awareness of his body, I started with the basics in order to help orient him to his body. I asked him about his awareness of his heartbeat, his breathing, and his temperature. This was difficult for me. I experienced the work as painstakingly slow and very constrained, and Andrew expressed frustration at this line of questioning. Awareness of his body did not come easily to him.

Through the process of trying to orient him to his body, a relational dynamic emerged that I labeled the "right answer" theme. It became apparent that Andrew had so much trouble focusing on and exploring his body because his primary attention was focused on me. He was trying to puzzle out the "right answer" to my questions. He was convinced that there was a right answer and that he was unable to "figure it out." He was vigilantly monitoring me in order to "ferret out" what he thought I wanted to hear.

As we explored the "right answer" theme, details about Andrew's early relationships began to emerge. Andrew, the youngest of four boys, grew up in a highly ambitious family. All four sons were expected to meet high intellectual, athletic, and social expectations. Whereas the three older boys seemed to comply easily with these expectations, Andrew felt pressed, pushed, prodded, and squeezed to conform and measure up. He was relentlessly compared with his highly successful brothers, and he always felt that he came up short. The competitive sparring in the family was often in the form of debate and intellectual dominance. Andrew felt unsuccessful or overwhelmed in this environment and was often ridiculed by his family. He was filled with shame. As this relational configuration emerged, I acknowledged that I did indeed want something from him, but what I wanted was to share in an exploration of his inner world and his self experience. Despite this explanation and reassurance, Andrew was convinced that I knew something that he was supposed to figure out; he was panicked and frozen because he kept coming up blank. Thus frozen was expressed in his body: It was devoid of any and all feelings because he expressed his fear through freezing.

Slowly, Andrew became aware of the anxiety that accompanied self-exploration. If he felt something that he deemed was wrong, he feared I would shame and ridicule him. Historically, he experienced this very shaming in his family when he offered himself up in an unwanted or incorrect way. Exploring one's feelings or felt sense was anathema to him and to what his family prized. His focus on others as the source of the right continues today. It shows up in his dependence upon his partner and his parents. He relies on both to
direct the important decisions in his life, as well as his ongoing search for some professional to heal him.

A second self experience emerged when I asked Andrew to experiment with gently moving his knees and ankles to explore some tension he described there. He responded either “They won’t move” or “I can’t move them.” The tension in these parts seemed to orient around an unwanted feeling of being “pushed, directed, or forced.” His response was to tighten all his muscles. Despite my suggestions that he come up with imagery that might soften the experience of the various joints, he couldn’t. Thus a second component of his relational configuration emerged. He felt pushed or prodded by me. He was afraid to soften and let go of the muscles, not knowing what would happen. He was afraid of feeling lost and not knowing where to go. This led to increasing anxiety and fear, which he experienced in his chest as rapid movement and a racing heart, the classic physiological expressions of anxiety. While he didn’t like the feeling of pain and tension in his joints, that now-familiar sensation was preferable to the experience of loss of control. Loss of control made him feel nauseated, wobbly, and weak.

Not surprisingly, I often experienced myself in a power struggle with Andrew. He had a way of changing, in some nuanced way, everything I said. If I said “You seem sad,” he might say, “Well, I’m not sad, I’m frustrated” or “It’s not really difficult, it’s more exhaustion.” This reflexive “no” was constant enough that I made a connection to the struggle in his body over releasing tension in the muscles. I pointed out that there seems to be a parallel. I interpreted to him that he feared having his experience co-opted, and thus he tries to take control by stating it exactly in his own words.

Andrew’s internal struggle over being controlled showed up in other patterns. While he was exhaustive in his search for healing from his symptoms from all kinds of practitioners and healers, he has also developed a sense of himself as a challenging and frustrating patient—the patient who outfoxes and defies any attempt to heal. In this way, he maintains control. Andrew developed a feeling of strength and power in being able to thwart and control the healing process. He longed for his suffering to be seen and attended to, yet he also derived some satisfaction in being able to say “You can’t help me.” This ambivalence toward being helped served other functions as well. It served to contain his fears of letting go and getting to know his body (his self) out of fear of further wounding.

As we explored Andrew’s issues around control, he revealed that he had been pushed rather relentlessly to succeed in many areas by his very controlling, anxious mother. She placed a high premium on looking attractive, on social status, and on professional success. Andrew often did not measure up to her high standards, and his mother freely showed her disapproval and frustration. In relation to these demands Andrew developed all sorts of somatic complaints—headaches, body aches, chronic sickness—all of which were dismissed as essentially unimportant or, at worst, fabricated. He received very little understanding, empathy, or support. In fact, his physical symptoms seem to have frustrated his mother and stimulated her anxiety. When I expressed empathy for his pain and distress, he rejected these words. It was as if he had internalized his mother’s attitudes toward soothing and comfort and couldn’t let himself receive it.

As our work progressed, Andrew came to identify more
readily the tension and stiffness in his body as it related to the feeling of being pushed. He was exquisitely sensitive to any experience of force or agenda on my part, and he could articulate that he felt pushed. If he sensed I had an agenda, he became frustrated and sad. As he learned, very slowly, to release his muscles, concomitant emotions emerged. He became soft-spoken and sometimes teary. He equated this place of vulnerability with the earlier sensations of weak and wobbly. As the two states were held together in our awareness—weak and wobbly and vulnerable—he was able to talk more and more about how endangered he felt throughout his childhood because of his vulnerability. He now guards any access to this vulnerability through body tension and armoring.

As the treatment progressed, Andrew developed much greater body awareness and was able to move quickly and spontaneously from his somatic experience to a conscious feeling state. He translated tension building in his chest to an awareness that he was in an emotionally charged situation. He began to connect the sensation of his throat tightening to feelings of hurt and sadness. Slowly, he allowed the various feelings to arise. In one session he felt some heat in his body as he discussed an anticipated conversation with his partner in an attempt to set a boundary. He was able to stay with the heat and from this somatic place, to state his boundary, in so doing he connected to a sinking feeling in his stomach. He interpreted this feeling as a sense of futility and turned the heat image into a feeling of power. This grounded him and gave him confidence to proceed.

By helping Andrew connect to himself through his body, many aspects of his self-experience changed. Primarily he gained access to his psychic pain and sadness. This affective/emotional experience was an experience that existed separate and apart from the pain in his body through the fibromyalgia. He is now more willing to share these painful, vulnerable feelings with me and with intimate others. I would parallel this softness with relaxation and greater flexibility of his muscles. He yields emotionally and physically.

Andrew has shown significant growth in developing self-reflective capacities. He is curious about valuing himself as a challenging patient and about how his behavior relates to the pushing and prodding. He tolerates not having the answer, and his need to control the interaction and create distance with corrections, negations, or wordy explanations has abated. Most importantly, Andrew has become less preoccupied with the bodily pain of his fibromyalgia, more patient with it when it does flare, and more accepting of the limitations the pain causes. At the same time, because he is less preoccupied with his pain, there is more “space” for him to inhabit his body in a more complete and engaged way. He seems more energetic, and he no longer takes antidepressant medication.

I believe that exploring somatic realities with Andrew afforded entrance into his self-experience in a way that working solely with the narrative, on the explicit level of discourse, might not have allowed. Because fibromyalgia is a condition that expresses itself somatically, it proved fruitful and therapeutic to bypass the more usual psychodynamic, narrative work and go directly to the source of the pain: his body. I was able to use the body to help Andrew interpret its messages in
a language that he both spoke and understood. It gave him access to himself in a way that words alone did not seem able to provide.

Because feelings start as bodily based experiences, it is essential to integrate this knowledge into one's clinical repertoire. The value of working with the body exists along a continuum. Patients such as Andrew speak primarily through their bodies. When the body is the primary language, working with that language can facilitate an effective therapeutic process. Other patients, such as Willa, also speak through their bodies as one of their languages but not the only one. A therapist who attends and attunes to the body will find his or her practice enhanced with these additional tools.

CHAPTER FOUR

The Fear System

Working with Anxiety, Panic, and PTSD

OF ALL THE EMOTIONAL systems described in the previous chapter, the fear system is the most studied and researched. The fear system has particular relevance to psychotherapy as it is part of generalized anxiety disorders, phobias, trauma, and a variety of other relational and personal difficulties in which underlying anxiety contributes to the problem. In this chapter I discuss the fear system, as described by neuroscientists, from a subcortical perspective. Humans developed a higher brain system, the neocortex, which affords them better regulatory capacities to manage the fear system and to make decisions and judgments despite the fear(s). Nevertheless, the subcortical systems that become active in humans when they feel different forms of fear (anxiety, panic, etc.) operate in similar ways in other mammals. Understanding fear from the subcortical perspective alerts the clinician to the importance and nature of triggers, to many of the bodily changes that occur in fear, to its relationship to memory, and to its enduring nature. This understanding provides additional pathways for working with various permutations of anxiety, panic, and possibly trauma. Understanding the fear