

Projective Identification Revisited

Listening with the Limbic System

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(I will use the masculine pronoun in this paper for convenience sake)

Last year I read a paper at this conference (psychotherapy conference, Mount Sinai/NYU Medical Center) entitled "Trauma and the Body". This year my paper is entitled, "Projective Identification Revisited- Listening with the Limbic System". The topic of both papers basically concerns the use of nonverbal material in a psychotherapy process. Last year the bulk of my talk was taken up by clinical vignettes. There was a brief experiential exercise and a limited discussion. As most of you know, I myself, in addition to the general practice of psychiatry, have a special area of interest that I call body-oriented, or somatic psychotherapy.

Both last year and today, the spirit of my presentations is in exploring whether there can be meaningful, even mutually enriching dialogue, in spite of profoundly different vocabularies and underlying assumptions, between mainstream verbal and body-oriented psychotherapy.

Actually, the experiential exercise last year was not supposed to be brief. What I asked was that while I read the vignettes which detailed my work with patients' nonverbal sounds and physical movements, including my physically touching them- that the group focus on its inner-visceral, sensate, emotional reactions to my report. I found that almost no one of the dozen or so present reported the sensate-emotional experience they had had during my presentation of the patients' painfully traumatic material and my- to say the least- controversial interventions. While this may have been in part because I was not skillful enough in structuring our exchange, I think it was largely due to the difficulty we as therapists, no matter what our orientation, have in dealing with traumatically based, non-verbal material - in ourselves and in our patients. Projective identification, a big topic and a poorly understood phenomenon, is one way we have of trying to describe, understand and work with this not linguistically encoded, often unconscious material.

My talk today is about alternative, or perhaps even complementary ways of working with the challenge of non-verbal material. In doing so, I am attempting to apply the broader definition of projective identification as a ubiquitous mode of reciprocal communication occurring throughout life between infants and caregivers, lovers, and, last but not least, between therapists and patients. Melanie Klein herself, Bion, Schore, and many others have noted that positive, adaptive aspects of ourselves are also communicated via this mechanism, that it goes on all the time, largely outside of our offices and, for that matter, outside of our conscious awareness. Current research for instance, is documenting split-second real time in which nonverbal emotional expression is imbedded in facial and prosodic stimuli (Blonder et al. 1991).

Last year, although I realize that none of you signed up for an experiential workshop with me, I was attempting to tap into this broader definition of projective identification as a mode of communication, or perhaps the phenomenon described by Searles (1965) in which the supervisor experiences what the supervisee has experienced with his (the supervisee's) patient. What happened, very briefly, is that one person felt that my touching my patient in one of the vignettes was simply the humane, compassionate thing to do, given the situation. While I always appreciate the implication that I am at times humane, we seem to have skimmed over the question as to whether my touch was a crucial bridge in the encoding into spoken language of what had until then been unspeakable for this patient—a bridge that was worth at least a thousand words or, more to the point, a bridge that could not have been accessed via the spoken word alone. Then Hillel shared his thoughts about the relatively infrequent situations in which he would touch his patients, i.e., put a hand on their shoulder, etc. – and I raised the question as to whether this kind of touch was an inherently healing agent which many therapists, because it is a departure from the “book”, use only in circumstances in which it can be forgiven, such as when the patient is terminally ill, etc. The other memorable moment was when one colleague in his congenially adversarial fashion, shared his nonverbal experience, or perhaps it was his judgment that my physical touch had been incorporated by the patient into her masturbatory fantasies. Given the timing and details of the clinical material, this seemed quite implausible to me, but my colleague uttered it with a sense of conviction...and, perhaps after all, it was not a judgment, but something he felt in his body.

All of which leads me to temper my enthusiasm about clinical vignettes. They have a tendency to provide us with data to support what we already believe. So, I thought that I would spend some time today detailing not just what I do, but what people on the more mainstream side of things seem to be doing in the nonverbal realm. From Freud's time on, it has been a bedrock part of the frame of analytically oriented therapy that patients were to lie still on the couch, or sit still in the chair. They were to remember- not re-enact. To move physically was to act out (or in), to discharge impulses, to gratify instincts, etc. The notion was not available that a patient's bodily movements were the most adequate or perhaps the only way he had to remember something that had never been verbally or imaginably encoded by him.

Now, a century later, even though much has changed, judging from recent articles by Jacobs, Dosamantes, Schwaber and others, analytically oriented therapists are still, perhaps wisely, but nonetheless powerfully constrained by the “book” that Freud wrote for them.

Allen Schore, at the University of California at Los Angeles School of Medicine, is attempting to integrate Freud's “book” with current studies on infant-mother emotional communication, attachment behavior and developmental neuroscience. He invites us to look at the clinical implications of a psycho-neurobiological model of projective identification. He defines projective

identification as a process used throughout the life span involving rapid, fast-acting, nonverbal, spontaneous emotional communications within a dyad (Schore, 1994, 1997a). Its healthy use allows the infant to project valued parts of the self into the mother. Borrowing a phrase from Buck (1994), Schore (2003) describes both healthy and disturbed patterns of emotional regulation in the early dyad as “conversations between limbic systems” (p. 49). When the dyadic conversations involve significant dysregulation and mis-attunement, a defensive use of projective identification becomes imprinted into the maturing limbic system. Schore is talking here about a preverbal, bodily-based dialogue. The relevant point for my paper, and the main thrust of Schore’s richly referenced work is that, as with the empathic mother who matches her infant’s internal state, it is the *clinician’s body* which is the primary instrument for psychobiological attunement. Since feelings and emotions are psychobiological phenomena and the self is bodily-based, projective identification represents not linguistic but rather mind-body communications. Indeed most of us listen for the music behind our patients’ words, and Schore, with Bion, Jacobs and others is urging us to *expand the range of data to which we attend with our “evenly hovering attention”*.

But what do you do when the prosody, the music becomes cacophonous? How do you allow the sensory-motor, chaotic, diffuse traumatic experience of the patient to invade your body, so that you can help them to better tolerate it? How do you not, Schore asks, defensively shift out of the right brain state into a left dominant state, thereby cutting off your empathic connection to your own and therefore to the patient’s pain?

Schore and others stress images as a bridge from other modes of perception to something to which words can be put. They urge us to hold on to the visceral state long enough until “sensoriaffective images” come to our aid. (i.e., visual, auditory, tactile, kinesthetic, and olfactory) I suspect that images are overstressed because they are more acceptable, i.e., less anxiety provoking for verbally-oriented therapists than more diffuse, perhaps developmentally earlier forms of sensory experience. Auditory or tactile, or motoric experience, for example, often occurs without accompanying imagery.

In the following vignette, Dr. Richard Gartner, the analyst who spoke to us last year at this conference, was admirably equal to the task:

For example, one day as I worked with Patrick, I noticed that as he reached for the words to recall early abuse he kept making a constricted “khh-khh-khh sound. It sounded like coughing, and I wondered if he were ill. He continued making this guttural vocalization, and then I had a sudden insight about this sound. Dry and strangled, it sounded as though he were gagging, and I abruptly wondered whether it was a reenactment of his choking attempts to accommodate his father’s penis during fellatio at age three. I immediately felt enraged at Patrick’s father, but also experienced disgust and nausea. I began to dissociate from my own thoughts and feelings, and....I could not breathe easily. At the same time I began to think Patrick was being histrionic, that this could not

have happened. Aghast and appalled, I was experiencing both the symptoms and doubts that Patrick himself felt. Only with pain and difficulty could I allow myself not to interrupt, neither to deflect Patrick from this topic nor to railroad him into a too-quick acceptance of my insight. I forced myself to remain silent, and a few sessions later he began to voice a similar nearly unbearable recognition of what his choking sound must have meant. (p. 258)

But, lest we get too unreal here, consider the following area of concern from Theodore Jacobs ('93):

... the nonverbal behavior of both patient and analyst is an aspect of the analytic situation that receives comparatively little attention either in supervision or in the teachings of technique. With the exception of those colleagues who have a special interest in this area, it is uncommon for supervisors to regularly inquire about, or for students to regularly report on, the nonverbal behavior of their patients ... In the training analysis, too, the nonverbal dimension of communication is often overlooked. Many senior analysts though highly experienced in other aspects of analysis, have had comparatively little experience in the decoding and interpretation of nonverbal data ... As a consequence, communications that are conveyed through posture, gesture, movement, and other bodily means often go unrecognized.

Jacobs, who submitted this paper for publication eight years ago, continues:

When such a situation occurs in the analysis of a candidate, the minimization or omission of material from the nonverbal realm has wide reverberations for the young analyst's technique. Having experienced little understanding and effective interpretation of his own nonverbal communications in analysis, and having been exposed to little teaching about the subject in supervision or in courses on technique, he can be expected neither to appreciate the importance of the nonverbal dimension in analysis nor to develop competence in working with it. The result, all too often, is that in his clinical work the candidate uses his ears to the virtual exclusion of his eyes, focuses single-mindedly on the verbal material, and sooner or later develops a scotoma for material expressed in bodily language or through other means. In this way a significant deficiency in analytic technique is transmitted from one generation of analysts to the next. (p. 742)

Jacobs goes on to note that the nonverbal experience of our infantile years is inherently threatening to us. Additionally, he says that understanding nonverbal communication is a demanding art that he likens to grasping the message in the apparently random movements and vocalizations of an infant.

(Let me pause here, to underline Jacob's last point with something that happened last year at this conference. Although I have been practicing the skill for over thirty years, I managed to misread the facial expression of perhaps the one person in the room who was unconsciously giving me the very kind of nonverbal reaction I explicitly had asked for. When I confusedly asked her what she was smiling about; she told me that whatever I saw on her face, she was feeling intense pain at the material in my vignette.)

Again, to support Jacob's observations, let me note that it should not be surprising that such movements and vocalizations exist also in adult patients as part of their core bodily sense of self ... which self, as Daniel Stern has pointed out (1985), once it comes into existence, is never fully or adequately subsumed by the verbal self. In concluding, Jacobs notes:

It is that way in learning to decipher the movements, gestures, vocalizations and enactments of analytic patients. At first one sees little and understands little. In time, however, a novel world begins to unfold- a world in which the hands, the head, and the body speak. Sometimes they complement what is being said. Sometimes they contradict it. Often they comment on, add to, or amend the spoken word... (p. 749)

Concerning Jacobs' comment on learning to understand the language that the hands "speak", I have learned over the years to attend to what patients do with their hands. At times their hands seem to embody the object in transitional space, behaving, for instance, in a soothing, sheltering or attacking manner towards themselves. The hands may have a "not me" and yet "not-not me" quality. They may express the patient's inner states in his external near space. One patient, for instance, a complexly dissociated survivor of a violent, alcoholic home, seemed too fractured and frozen to even register my physical touch. Then, one day, while he was overcome by feelings of anguish and humiliation, his hand began to stroke and sooth his forehead; the words he attached to this gesture were, "we understand." He seemed to be sculpting a soothing and holding presence ... which could then become part of his inner world.

And then there was Emily, in last year's vignette, whose hands began to "tell" her about the secret they had literally held for decades. She reported at the beginning of the session that both hands felt completely cut off from the rest of her body. All sensation stopped above her wrists. She had never felt anything like this before. Emily was sitting in a chair silently...looking furtively at her hands, as they stretched and moved. She tried to hide them behind her back and then sat on them. This went on for perhaps ten minutes. Suspecting that some very specific kinesthetic, tactile, state-dependent memories were at work, I encouraged Emily to not hide her hands, but to keep looking at them and feeling them as they moved. The word "perpetrator" came to her. It seemed to be about her and her hands. When she did speak, her words were in very-slow motion.

She then asked for a blanket, and covered herself, creating a private space for herself for another ten or fifteen minutes. She later said that while under the blanket she was unable to say the words which swelled inside her body. Finally, uncovering and looking at her hands, she said: "I feel I must have touched- fondled someone's genitals". *From a sensate anesthesia and via movement and focal attention*, Emily had found inner words and then spoken words. Her body's memory had begun to become part of a linguistic narrative from a time and place in her life.

In his final paragraph Jacobs says that the situation he describes is not likely to change. His paper was accepted for publication in 1993. Assuming that Jacobs is somewhat prescient, eight years later it may still not be that easy for analytically-trained therapists to process nonverbal projective identifications by expanding the range and types of material to which they attend with their analyzing instrument, (Balter et al., '80) their "evenly hovering attention".

But let me lift our spirits here, by citing again, and quoting Allan Schore, who inspired the title of my paper "listening with the limbic system." Schore feels and documents extensively (as do other researchers) that we are extremely well equipped neurobiologically to bring the body's messages (specifically, the autonomic nervous system and limbic mediated sensory-motor experiences which traumatically abused patients bring to therapy) to the spoken word. Schore cites extensive research indicating that it is the right orbitofrontal cortex, sitting at the 'hierarchical apex of the limbic system and acting as the "senior executive of the emotional brain" (R. Joseph, '96), which should bring the therapeutic use of projective identification within the grasp of any of us- that has a brain, that is.

But how to use theory and research when you are dealing with the disorganized and chaotic somatic components of dys-regulated biologically 'primitive emotions" that are often involved in projective identification –we mean here, raw arousal, excitement, elation, mutilating rage, terror, disgust, shame and hopeless despair. It bears repeating that among the things a therapist is likely to do when invited by the patient to resonate with such material, is to attempt to restore his (the therapist's) equilibrium by too quickly, abruptly shifting out of the right brain state into a left dominant state, thus cutting off his empathic connection to his own and therefore to the patient's pain. A somatically oriented psychotherapist is specifically at risk for getting too active, for fleeing into interventions of one kind or another. I would suggest that a verbally oriented therapist is at risk for, in one way or another, trying to rush the excruciatingly slow process in which vague, disorganized sensory-motor fragments of experience are, in felt dialogue with the therapist, gradually raised to an inner word and then a spoken word.

Let us look again at the "evenly hovering attention" which Freud recommended early on. While the therapist was attending in this special way, the patient was, to the best of his ability, "reporting to the analyst without exception whatever thoughts came into his mind and refraining

from exercising over them either conscious direction or censorship” (Brenner, '57, p. 8). In a somatic psychotherapy this fundamental rule of psychoanalysis *has been explicitly extended to include pre-symbolic sounds vocalizations, bodily sensations and movements*. In my paper I am suggesting that this broadens the clinical options for working with the material transacted in the unconscious, nonverbal mechanism of projective identification.

For instance, my patient Anne, a 50- year old woman, was one of two surviving children of parents whose own parents had been either incarcerated or murdered by the Nazis. Lying on my somatic psychotherapy couch, she put her hand over her solar plexus, where she said she was experiencing a burning, pressured sensation/feeling. The patient and I were able to directly explore what her bodily sensation was expressing about her inner state. Putting aside for the moment the question of how much my attention and interventions are influenced by mutual projective identifications, this patient had consciously, explicitly and verbally called my attention to the burning feeling around her upper abdomen. I watched her breathing. Her respiratory wave, as it moved along the front of her body, was shallow. She was pursing her lips, and swallowing frequently. I encouraged her to breathe into and sense with her hand the area of her body to which she had called our attention. Over some five or ten minutes, the burning sensation moved up into her throat, as her breathing deepened. I asked Anne if she heard an inner sound or words or sensed any tone in her burning throat. She was uncertain. I suggested she sound her exhalation, allowing anything to come out that wanted to. She then emitted a very high-pitched, far away sound...it cut off after several seconds. She then described it as “weird”, and said it made her feel “inhabited” as if by some kind of “poltergeist”. We waited. I was sitting next to her. She felt both frightened and intensely curious. After several minutes, the burning over her solar plexus became more intense, and another wave of feeling moved up the front of her body, culminating in another high-pitched, extremely difficult for me to listen to, wail, for which Anne, moments after, used the word “horror”. She then said, in a horrified tone, “it’s an old woman...it’s my father’s mother’s voice...he carried it, and now it’s in my body”. The history was that her father alone had survived. The Nazis had shot his entire family.

I am suggesting that with some patients, at certain phases of their process, it may not be necessary to first contain their material by accepting their projective identification. Why not, in other words, on the way toward communicating inter-subjectively, but on a core bodily level (Stern, '85), allow the patient with your explicit support to experience directly the not yet verbally- encoded or otherwise highly charged material in his own body, his own organism? Evelyne Schwaber urges something similar in stressing that we pay attention to our patient's “state”. Her definition of state includes, once again, the music by which words are understood, and the sense of how the patient is in the room in his body – that is, his level of arousal and energy level, his motor activity, posture and mannerisms, his rate, volume and pitch of speech. Schwaber’s vignettes describe receiving otherwise inaccessible information from her patient's gait and tone of voice. How different is this

actually, from Wilhelm Reich's discovery in 1930 that the tone and tension and physical attitude with which his patients spoke was often more revealing than the content of their words? Unfortunately, as Jacobs states, Reich's work fell under a cloud, which contributed to analysts shunning the nonverbal realm for many years. On the other hand, Reich, and somatically oriented psychotherapists have been freer during these decades to observe how their patients move...Schwaber, presumably could only note her patient's gait on the way to and from the couch. Schwaber's emphasis on bodily state reminds me that the above vignette with my patient Anne, in which we were both surprised by her grandmother's voice, was not really representative of the work-a-day nonverbal work we did. At our initial session, Anne had explained her reason for entering therapy with me: She wanted to explore her youthful manner and appearance...that belied her almost 50 years of age. Both Reich, and Schweber and, I hope all of us, would have noticed that Anne said this in the tone of voice of a young girl. Anne had been in psychoanalysis for close to fifteen years before she got to me. She had grown immeasurably during this time, but still feared to more fully assert her creativity, independence and authority. Her sessions often began with the burning or other physical sensation over her solar plexus or throat, for instance. When encouraged to be with the sensation and see what happened, Anne's bodily "state" would change. Sounds and movements came out of her and moved through her; not those of a murdered grandmother, but rather those of a hitherto hidden, private self. At times the room would fill with a level of energy, arousal and vitality and sound many times that of the 50-year old woman with the little girl's voice. At other times Anne would tell me she felt a band of tension cutting off her voice and breath at her solar plexus and/or throat. She would ask for help and I might put a hand on her body where she felt the tension. I do not know what limbic to limbic communication between us determined (A) whether I touched her on a given occasion or (B) how Anne experienced the touch. At times my touch seemed to reduce a physical restriction and/or to support an inner resonance which then came close enough to the surface of Anne's being to enter her consciousness as a sound she could hear and a movement she could think about. Anne was renegotiating her issues on the level of core bodily self. She felt exuberant and terrified, ferocious and loathsome as she came to more fully embody the fifty-year-old woman that she was. At times I was her lethally narcissistic mother in the transference, as Anne was overcome with shame and barely able to believe that I could tolerate eye contact with her after she had delivered herself so vitally into the room with me.

This vignette may be reason enough to explain why the split that began seventy years ago when Wilhelm Reich began to study the physical form and motility of his patients' self-expression ... why this split is based on such different basic assumptions that fruitful dialogue across the abyss rarely occurs. If it is not sufficient, in a rather daring paper entitled "On knowing what one knows" ('97, p. 239), Donald Marcus explains the powerful impulse to keep what happens in the session in the realm of thought and words. Marcus cites the adult patient who has been molested as a child and who now must re-experience the molestation in the transference in order to fully work it through.

In the case of a woman patient with a male analyst, says Marcus, this means that the analyst must experience a desire to have sex with his patient and the patient must know that her analyst has that desire. For this to be safe enough so that it is not re-traumatizing, Marcus states that the experience must remain in the realm of thought.

This is a compelling argument, but after you have heard Marcus' vignette, I am interested in whether you believe that he has succeeded in keeping his patient's experience in the realm of thought:

Vignette #2: During the course of a "good session," a young woman was able to express her feelings freely. I noticed her face, and she seemed very pleased. In my mind I heard her say " I love you." It felt like an interference, so I put it out of my mind. After another few minutes of silence I had an image of my patient getting up from the couch, coming over to me, and kissing me on the cheek. The image was very sharp and impossible to dismiss. After another minute or two I asked her what was going on in her mind. She said she did not want to tell me. I asked if there was some action she would like to take. She hesitated, making it clear that she was too embarrassed to tell me what it was. After a while she asked me what I thought. Rather than engage in a struggle, I told her that I had an image of her kissing me. She said "no," and then after a pause she added, "but I did have a fantasy of kissing you on the cheek." I replied that that was what my image was. She then added that prior to that fantasy it had occurred to her to tell me that she loved me. In this instance I can understand that I had seen a lot in her face and had correctly interpreted it, but the exactness of my image and the words I heard, I find to be quite fascinating. I am no longer startled, however, since I have come to believe that it is an aspect of what is called intuition. Intuitive understanding always raises the question as to which person is generating the feelings, and this is an especially sensitive matter when the feelings are sexual. An intervention based on intuition must be made with tact and an awareness that it could be saying more about the analyst than about the analysis. (p.231-2)

It is safe to say that we tend to promote what reflects well upon us, and while I can tell you that Dr. Marcus' other vignettes, are at least as exciting, all worked out really well. Many of us, four years later, still might not dare to publish, let alone work in this fashion. As he himself notes, the need to provide safety, forces Marcus to confine the encounter to the realm of thought and words. However, although he is not physically touching his patient, there would seem to be a lot more than thought and words moving between them, as he attempts to distinguish what part of his subjective, nonverbal bodily experience is part of his story and what part is that of the patient. At times, for instance, in his other vignettes, he was processing not just images of the patient kissing him, but genital sensations of sexual arousal. What I take issue with in this paper is not his work as presented, although it does seem to me that such an intuitive approach in less gifted hands could easily be experienced by a patient as a kind of molestation that was actually traumatizing.

What I object to, perhaps just because the therapeutic enterprise is so complex, and so inadequately understood, is Marcus' apparent conviction that there is only one way to go. He concludes, for instance:

What needs to be communicated is un-mentalized or raw experience, what Bion calls beta particles and Bollas (87) the un-thought known. These have never been worked on by alpha process so they cannot be thought about and can only be communicated by projective identification and not by words. *It is only the analyst's unconscious mind that can receive the message.* (my emphasis) (p.236)

As you have gathered by now, in attuning to, and being present for the patient's breathing, general level of arousal, sexual feelings, quality of eye contact, etc., I am working in another way with beta particles, with the un-thought known. What is similar in my way of working is that I, too, am helping my patients to identify this frightening material, to contain, metabolize and make it fit for human consumption. When I sit with my patient and direct his attention to his tone of voice, or any of the above qualities of his bodily state, my own bodily state, my way of being present with him, is "holding" his unconscious, somato-sensory or otherwise un-integrated material...with Winnicott, at times this "holding" and thereby helping the patient to better contain and integrate unspeakable things, involves actually physically touching the patient. For instance, consider my patient Emily, mentioned earlier, whose hands "informed" her that although her hands had held her father's penis, she was not really the perpetrator. Prior to the session in which this occurred, she had once again gone into the altered state which I had experienced with her many times in which she screamed and writhed and flailed her arms helplessly and choked on what later tasted like semen. This session, however, for some reason, while she was still in her altered state, I took her flailing arms in my hands and held them firmly for some seconds, and then told her to hold my arms in her hands similarly. I believe that the helpless, purposeless quality of Emily's arm movements was the immediate stimulus to my intuitive physical intervention. I had certainly felt helpless to move Emily towards some mastery of this experience and its reenactment may even have been digging its neurochemical grooves more deeply. I think it quite possible that my right brain understood the sensori-motor schema in her flailing arms. It told me that while she was still in her overwhelmed, disorganized state, she needed sensori-motor help in organizing and regaining control of part of her body. Parents intuitively hold and physically help to contain and organize their children when they are overwhelmed with excitement and emotion. Contemporary analytic thinking increasingly views the therapeutic reworking of inevitable reenactments in the therapeutic relationship as critical to healing. Telling a patient whose father may have put his penis in her hands or told her to take it in her hands...telling such a patient to touch me certainly qualifies as an enactment. I think it also qualifies as helping Emily towards meaningful mastery via a projectively identified right cortico-limbic safe touch.

Finally, regarding different approaches to beta particles and the un-thought known, Dosamantes-Beaudry ('97) presents the case of Ellen in her article on Somatic Experience in Psychoanalysis. Her paper is particularly fascinating in that by training and temperament Dosamantes-Beaudry was able to offer Ellen therapy experiences on both sides of the mind-body divide. Her paper raises questions for me that speak to the arbitrariness of the rituals into which our patients often must fit themselves. Quoting briefly from her richly nuanced history:

Ellen is an attractive white woman in her mid-fifties. I first met Ellen within the context of a movement therapy group. Before entering psychoanalytic treatment, the patient had participated briefly in a movement psychotherapy group conducted by the author at a university. In this context, I observed that she preferred to move alone and to create a physical barrier around herself that followed the boundaries of her body. She would lie on her back, close her eyes, and focus intensely on the sensations that her slow-rocking motion from side-to-side generated. In retrospect, I realize that what Ellen was showing me during these moving moments was an aspect of herself that she later in her analysis referred to as her "wounded I". Her spontaneous movement statement provided me with an opportunity to become aware of the autistic and isolated state of her psychic existence.

Five years passed before I saw Ellen again. She phoned me at my office to inquire whether I would be willing to work privately with her as a psychoanalytic patient. She hoped that I would be able to help her "find the words" with which to adequately describe her private experience. (p. 523)

Dosamantes-Beaudry writes this paper approximately six years into the analysis, during which time many things happened. I find it interesting that one thing that apparently never happened was another "spontaneous movement statement" such as Ellen had made during her participation in the movement psychotherapy group. Indeed, it is not often that a patient gets a chance to experience a movement psychotherapy group and a psychoanalysis from the same therapist. Her therapist summarizes the six years as follows:

Initially, the intensity of Ellen's nonverbally enacted rage put me in touch with the depth of her infantile frustration and envy. As I became better attuned to her nonverbal mode of affective relating, she became more trusting of the analytic surround and permitted herself to regress to the autistic encapsulated state that she called her "wounded I." As she shared her "wounded I " with me, together we created a merged sensation-oriented state that seemed free of all outside intrusions. Feeling safe in this state, Ellen began to integrate fragments of herself

she had previously projected out, and increasingly she became better able to describe her experience in words.

I am not doing justice to Dosamantes-Beaudry's rich paper which details six years of a complex psychoanalysis, but in the spirit of inquiry suggested by Jacobs' paper, questions come to me which might further clarify the mind-body enigma. (1) Was it the patient's natural inclination to wait five years to put words to her "spontaneous movement statement" or did she wait until she knew that her former movement therapist had become an analyst? (2) What was the specific nature of the "merged sensation-oriented state that seemed free of all outside intrusions? (3) One also wonders, during the two therapies, what the differences in explicit and implicit instructions were as to the allowable self-expression in the patient's "free associating" to her inner states. (4) What was conveyed to be legitimate material in the two different forms of therapy?

As I read the case history, Dosamantes-Beaudry gave Ellen a great gift in struggling with her through her intense nonverbal issues until they could be contained in their relationship, thought about and given words. However, had there not been an earlier movement psychotherapy, would both Ellen and her analyst have been deprived of the great gift of the "spontaneous movement statement" that illuminated and gave meaning to so much of what they later lived through in the psychoanalysis?

As we all know, therapists tend to do more in the relative privacy of their offices than they will put in print, or even talk about, especially when they feel they are departing from Freud's "book", to which I referred earlier. But note that Jacobs and Schwaber and other contemporary analysts are focusing on and writing about the analysand's physical state, his bodily movements and vocalizations as providing crucial information. I therefore find it quite likely that soon, perhaps even as we sit here today, it will be possible for a patient such as Dosamantes-Beaudry's to have an opportunity within an analytic therapy, perhaps a movement psychoanalytic therapy, to explore her "spontaneous movement statement". This fortunate patient would be free to rock her body or otherwise sculpt and intone her inner being in her analyst's presence and directly facilitate the shared "sensation-oriented state" out of which both she and her therapist could find the inner and then outer words.

However, I am going to end on a sober note about the power of Freud's "book" to make us feel guilty even to the point of taking leave of our senses. This is the only explanation I can find for a conclusion that Dosamantes-Beaudry comes to regarding a painful incident with her patient Ellen. She says:

Frequently during this period I experienced her as physically intrusive. For example, during one session when I felt a particularly intense pinching sensation

in my left breast and responded to the pain by exclaiming “ouch,” she blurted out that she was visualizing me as a “breast’ and herself as “a baby sucking on it and clamping on it.” (p. 523)

Dosamantes-Beaudry goes on to say that such experiences, as intense as they seem to be, should not be taken as literal reality by the analyst, but as metaphoric phenomena. Such is the complexity of the mind-body relationship that Dosamantes-Beaudry would have us believe that the intense pinching sensation in her left breast, which caused her to exclaim “ouch” in the session, was a metaphor. These are the kind of metaphors which hurt, whether they land on your toe or impact your breast, and that Dosamantes-Beaudry invokes them strikes me as an attempt to wrap the very alive bodily incident, the immediate physical experience, in cerebral saran-wrap- to keep it in the safe realm of abstract thought. There are some things that we cannot explain very well. Projective identification is one of them. The nonverbal world is another. Ted Jacobs refers to it as “a relatively uncharted area, one that requires new ways of observing and new ways of thinking about what we observe.” (p.61)

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