

From one body to two bodies: psychoanalytic perspectives on the  
therapist's body as the analytic object. A hermeneutic literature  
review

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## **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature

Pautia Crowe

Date

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## **Abstract**

Interpersonal and intersubjective ideas have expanded traditional psychoanalytic theory to consider the subjectivity of the therapist in the therapeutic encounter, including the therapist's body. Theorists from the relational and intersubjective schools view bodies as intersubjective and embedded in relational context. In the intersubjective therapeutic relationship, the therapist's and client's bodies are seen to be attuned – picking up on and contributing to each other's experience. Body development is viewed as a process of attunement and incorporation between the mother's and infant's bodies which is influenced by cultural patterning. These early experiences are seen to create a base structure for which future bodily experience builds on. Care and handling that is consistent and empathically attuned is seen to instill a sense of stability and vitality in the infant's body while care that is inconsistent or lacking in empathy is seen to lead to distress and fragility in the body, and ongoing body difficulty. In view of the relational development of the body, it is proposed that the therapist's body represents the maternal body in the transference-countertransference relationship and is evocative of primitive projections and associations. Examples of how therapists have experienced their body as meaningful to the therapeutic encounter are discussed using psychodynamic theories, including Winnicott, the relational school and the intersubjective school. It is suggested that in a culturally-aware, containing, intersubjective relationship with the therapist's body, clients' can incorporate new bodily experiences, develop subjectivity, and improve bodily distress.

This dissertation uses a hermeneutic literature review to look at predominantly female psychoanalytic perspectives on the therapist's body as clinically meaningful and uses the concept of the analytic object to do this. The research question asked is: What are the current perspectives in psychoanalytic psychotherapy on the therapist's body as the analytic object and what are the ways it is worked with in practice?



## **Chapter 1: Introduction**

Perhaps like most women, I grew up feeling self-conscious about my body. Consumer culture normalises body surveillance, self-denial, and objectification of women's bodies and my self-concept was influenced by this. Measuring, comparing and contrasting myself against other bodies, I sought to determine whether I was acceptable by current trends and standards. Interestingly this body surveillance revealed distortions in my self-perception, where my subjective bodily sense could alter depending on the circumstances I was in. This included internal senses like security, definition, animation, fragility, or density. It also included aspects of my body image and behaviour such as the size and shape of my body, and how gracefully, awkwardly or expansively I took up space. Traditional psychoanalysis is built on the Cartesian theory of mind where the psychological system is independent of external forces. In this view intrapsychic forces are seen to determine affect (Stolorow & Atwood, 1996). I initially interpreted my bodily changes along these lines, seeing them to be generated from within and to be purely informative about me.

However, clinical experience revealed that my body felt different depending on whom I was with. For instance, with some clients my body felt awkward while with others it felt anxious and reactive, and with others there was not much affective charge at all. This did not appear to be an objective phenomenon; rather there was a fantasy or intersubjective element to what I was experiencing where my body image, form and affect were mediated by relationships. Contemporary psychoanalytic perspectives regard personal experience to occur within a continuous and reciprocal intersubjective system (Stolorow & Atwood, 1996). Affective processes, rather than residing in the mind, are inseparable from social life and interpersonal interaction (Dunn, 1995). This perspective led me to wonder if the dysmorphic phenomena I was experiencing reflected elements of my own and others embodied experiences; prompting my interest in the intersubjectivity of bodies in psychoanalysis.

Psychoanalysis has a long history of finding meaning in the body, starting with Freud's famous aphorism "the ego is first and foremost a body ego" (1923/1961, p. 25), and his theory of hysteria (Breuer & Freud, 1893/1955). However, psychoanalysis has its roots in the Enlightenment, dualism and medical empiricism (Shapiro, 1996), and bodily symptoms have often been interpreted as mental drama (McDougall, 1974), rather than

subjective, interpersonal, or intercorporeal processes. Orbach (2004) argues that the subjective experience of the living body in the social world is missing in psychoanalytic theory. She states that subjective bodily experience is relevant to psychoanalysis because, once checked, there are numerous people who demonstrate difficulty in their ability to dwell in their body, and that this is expressed through bodily distress, instability or symptomology (Orbach, 2003). These ideas made me wonder about the levels of distress and disconnection that can be felt in the body and what of the client's experience may be missed by interpreting such as intrapsychic conflict. In other words, I was interested in looking at bodily experience in terms of the body, rather than related to the mind.

Psychoanalysis also has a long history of using the therapeutic relationship to explore clients' interpersonal experiences and engagement. A central tenant of psychoanalytic theory is the transference-countertransference relationship, where the therapist comes to symbolise the primary object to the client (Jacobs, 2004). Theorists formulate body development to occur as an interpersonal process between the infant's and primary caregiver's bodies combined with cultural patterning, and disruptions in development can lead to problematic experiences of the body (Orbach, 2003; Wrye, 1993). Conceptualising the body as an outcome of relationships brings its relevance into the clinical setting, leading me to wonder about the role that the therapist's body plays in the therapeutic encounter. For instance, how is the therapist's body experienced in the transference-countertransference relationship, and are clients' perceptions of the therapist's body influenced by their past experiences with significant others' bodies? Further, can experiences with the therapist's body contribute to healing or repair of past ruptures that occurred with other bodies?

Consumer culture objectifies bodies, encouraging body control, dissatisfaction and modification, and these messages affect clients and therapists alike (Daly, 2014). Feminist theorists' state that these cultural messages are internalised and that people form object relationships with dominant cultural symbols (Baker-Pitts, 2007; Daly, 2014). These ideas made me wonder about how cultural messages about bodies impact the therapeutic relationship: for instance, how do cultural norms and values influence the interaction of the client's and therapist's bodies; what assumptions are made about the other's body experiences; how is sameness and difference tolerated between bodies; and how is the anxiety related to the discussion of bodies managed?

In summary, it was through a combination of personal and clinical experiences that I came upon my topic, the therapist's body as the analytic object. I am particularly interested in the meaning and associations that clients have to the therapist's body and how these may be worked with in practice. I wonder why clients' perceptions of and relationship to the therapist's body do not feature more in the therapeutic discourse when clients recurrently see and engage with the therapist's body. Further, I wonder if my dysmorphic responses are signs that my body is featuring in some way for clients that is for some reason, not able to be verbalised. My aim is to develop an overall understanding of how the therapist's body can become meaningful to the therapeutic encounter and how it can be worked with in practice, thus I have framed my question as follows: What are the current perspectives in psychoanalytic psychotherapy on the therapist's body as the analytic object and what are the ways it is worked with in practice?

### **Definition of Terms**

#### **Therapist's body.**

The therapist's body refers to the therapist's objectively and subjectively perceived body. The therapist's body that is objectively perceived (by the client or the therapist) includes the therapist's size, shape and appearance. It also includes how they gesture, move and inhabit space. The therapist's body that is subjectively perceived (by the client or the therapist) includes the therapist's sense of boundary, stability, and density. It also includes vitality, desirability and capacity to desire.

#### **Analytic object.**

According to Green (1975) the analytic object exists in the mutual in-between unconscious space between the therapist and the patient. It is neither strictly internal, that is, part of the client's internal object relations world, nor strictly external, that is, an object in reality. Green defines the analytic object as, neither on the patient's side nor on the analyst's, but in the meeting of these two communications in the potential space which lies between them, limited by the setting which is broken at each separation and reconstituted at each new meeting" (1975, p. 12).

Ogden also uses the idea of the analytic object, referring to it as that which becomes “a carrier of psychological meanings that had not existed prior to that moment” (1994, p. 75). It is a co-created object that comes out of the intersubjective space (Ogden, 1994).

### **Intersubjectivity.**

Intersubjectivity in psychoanalysis refers to the continuous and reciprocal interaction of the therapist’s and client’s subjectivities. The therapist and client occupy different roles however both individuals influence the interaction and are “constantly in multiple, interpenetrating, mutually transforming engagement, [which is] largely unconscious” (“Intersubjectivity,” 2006). Inferences about the client’s subjective and unconscious experiences are made based on the therapist’s interpretation of the intersubjective relationship (Ogden, 1994). The recognition of the therapist’s subjectivity is a relatively new development in psychoanalytic theory with modern perspectives viewing the intersubjective relationship as a vital and mutative feature of the therapeutic process (Schoore & Schoore, 2008).

### **Intersubjective body.**

The intersubjective (or co-created) body is an individual’s subjective experience of their body in the intersubjective relationship (Burka, 1996). As subjectivities interact in the intersubjective relationship, elements personal to each individual will influence the experience of the other’s subjective body – making ones experience co-created. Examples of subjective body experience that may be affected by the intersubjective relationship include perception of body image, somatic and sensory experiences, gesture, movement, use of space, and affective responses. As unconscious processes interact in the intersubjective space, the intersubjective body has elements of fantasy and reality to it (Burka, 1996). In the therapeutic relationship the therapist may use their own subjective body experience to make inferences about the client’s body experience (Burka, 1996). Subjective body experience may be differentiated from somatic countertransference where the subjective body refers to the person’s total and continuous subjective response (Dunn, 1995) while the countertransference refers to only part of this response.

**Transference.**

Transference refers to the transfer of feelings originating in past relationships onto the experience of the relationship with the analyst ("Transference," 2002). As human relationships are dynamic and complex, the transference can manifest every type of feeling and can occur in brief or longstanding ways (Jacobs, 2004). Jacobs (2004) points out that transference occurs in all human relationships, however it is regarded as particularly useful in the therapeutic relationship as elements of the client's past and current relationships can be brought into the here and now setting of the therapy for exploration.

**Countertransference.**

Another dimension of the therapeutic relationship is the therapist's responses to the client. Countertransference is described as "*a jointly created phenomenon*", made up of features from both the client and the therapist's subjective experiences (Gabbard, 2001, p. 984). Gabbard goes on to say that the "patient draws the therapist into playing a role that reflects the patient's internal world, but the specific dimensions of that role are colored by the therapist's own personality" (2001, p. 984). In this way countertransference is both the *counter* to the client's transference as well as the therapist's personal responses. This intrapsychic and interpersonal experience is unique to each therapeutic couple. It is clinically useful because it provides the therapist with a lived experience that may be indicative of the client's interpersonal life (Jacobs, 2004). The therapist's task is to reflect on these feelings and to find ways to make sense of them in terms of the client (Gabbard, 2001). Because the countertransference involves aspects of the therapist's conscious and unconscious awareness, it is possible for the therapist to respond or act on their responses without fully reflecting on them (Gelso & Hayes, 2007). This process, called enactment, is considered an inevitable and potentially useful part of the therapeutic process.

**Somatic countertransference.**

Somatic countertransference refers to the somatically-based responses which particular individual qualities of the client arouse in the therapist (Gubb, 2014). Like general countertransference these responses may be indicative of elements of clients' internal and interpersonal life. Somatic countertransference responses may be identified internally by the therapist, for instance feeling dull or sexually

aroused; or they may be identifiable to the client, for instance, crying, blushing, stumbling, or feeling sleepy. The somatic countertransference contains elements personal and unconscious to the therapist and it is therefore analysed in terms of the client's dynamics as well as the therapist's (Gubb, 2014).

## **Overview of Chapters**

Chapter two describes the qualitative methodology and methods used for this dissertation. Chapter three looks at what the literature says about the impact of the therapist's physical body on the clinical encounter. Except in cases of major physical change it finds a paucity of literature. It goes on to review how intersubjective ideas have expanded psychoanalytic theory from one-person to two-person perspectives, bringing the person of the therapist into the room and creating a space to consider the impact of the therapist's body. Chapter four looks at body development from a contemporary psychoanalytic perspective, seeing it as a contextual, relational, and intersubjective process. I argue that viewing body formation as an outcome of relationships implicates the bodies of the client and therapist in the therapeutic setting. Chapter five uses clinical examples to describe and illustrate how the therapist's body can become the analytic object and evocative of rich associations, unconscious phenomena, and interpersonal processes. Chapter six discusses the literature using ideas from Winnicott, the relational school and the intersubjective school. Limitations of the review and future directions for research are also identified. Chapter seven provides concluding comments.

## **Summary**

This chapter has looked at how the topic of the therapist's body as the analytic object was chosen and why it is relevant to psychoanalytic clinical practice. Key terms were defined and the chapters were outlined. In the next chapter the methodology and methods are presented and discussed.

## **Chapter 2: Methodology and Methods**

This dissertation uses a qualitative methodology and a hermeneutic literature review to guide the research process. The chapter begins by looking at the use of evidence-based practice and empirical research in health-care development and how this has been applied to psychotherapy. The empirical approach to research is contrasted with research using a qualitative paradigm which is found to be a better fit for the aims and qualitative data of this dissertation. Last, the methods of gathering, reviewing and interpreting the literature are presented.

### **Aim**

This dissertation aims to develop an understanding of how the therapist's body as the analytic object is currently perceived and worked with in psychoanalytic psychotherapy. Because psychoanalytic psychotherapy contains multiple theorists and perspectives I have framed my question in the plural, as follows: What are the current perspectives in psychoanalytic psychotherapy on the therapist's body as the analytic object and what are the ways it is worked with in practice?

### **Evidence Based Practice**

Evidence based practice (EBP) aims to combine research evidence with professional practice to improve health care services (Hamer & Collinson, 2005). EBP seeks to standardise practice with proven, safe methods in order to minimise risk, harm and malpractice (Hamer & Collinson, 2005). The evidence of EBP has its roots in empirical science and this mode of inquiry tends to be considered 'best' (Dickson, 2005). Incorporating research evidence into clinical practice is highly valued in current health care models such as medicine, and there is an expectation that practitioners continually update and modify their practice (Dickson, 2005).

### **Systematic Reviews**

Systematic reviews are literature reviews which gather and synthesise large quantities of data and are commonly used to inform EBP (Dickson, 2005). Systematic reviews follow strict scientific methods in order to limit bias, and traditionally use randomised controlled trials and quantitative data to achieve this (Pearson, 2004).

## **Evidence Based Practice and Psychotherapy**

The principles of EBP have been applied to psychotherapy. However, Totton (2008) and Milton (2002) argue that the aims and methods of empirical research, such as standardising treatment, creating symptom checklists, and reducing the effect of the professional relationship, fail to account for the subjective and relational factors central to psychotherapy. As this dissertation aims to get an overall understanding of the therapist's body as the analytic object, a literature review is a fitting approach; however the empirical requirements of a systematic review are not well-suited to psychotherapeutic inquiry and development.

## **Modified Literature Review**

### **Qualitative research.**

Pearson (2004) states that systematic reviews can be modified to include other sorts of data to inform different contexts. This is relevant in the field of psychotherapy where the data tends to be written by clinicians about the clinical encounter, placing it in the qualitative field (Milton, 2002). Further, Smythe and Spence (2012) state that the data needs to match the methods. While the quantitative data of systematic reviews is suited to empirical methods of analysis, qualitative data looks at human processes and calls for interpretive methods to make sense of the complex, dynamic phenomena. As my topic relates to the therapeutic relationship, the bulk of the data I use will be written by clinicians about the clinical encounter. Likewise, in order to improve my knowledge and practice as a psychotherapist I will use psychodynamic concepts to interpret the findings. Thus, while a literature review is a fitting approach for this dissertation, aspects need to be modified to reflect the type of data being looked at and the methods of data interpretation.

### **Hermeneutics in qualitative research.**

The hermeneutic perspective is a mode of engaging with and interpreting qualitative research. It derives from hermeneutic philosophies which have existed for centuries, originally concerned with understanding biblical and sacred texts (Diesing, 1991). Current hermeneutic thought derives from the works of Heidegger and Gadamar which look at methods of understanding in the human sciences (Smythe & Spence, 2012).



In research the hermeneutic perspective sees phenomena to be context-specific and understanding develops through the subjective dialogue between the researcher and their focus (Smythe & Spence, 2012). Unlike empirical research, hermeneutic research challenges the idea that the focus of study can be reduced to a single truth or understanding (Smythe & Spence, 2012). The aim in hermeneutic research is to “provoke thinking” rather than to present truth (Smythe & Spence, 2012, p. 14). This does not mean that arguments are not stated in hermeneutic research, but that they are more open and generative than the definitive arguments of traditional research (Smythe & Spence, 2012).

### **Hermeneutics and psychoanalysis.**

Diesing (1991) links the hermeneutic approach to psychoanalysis. He describes how the meeting of transference and countertransference in the clinical encounter is similar to the meeting of subjectivities of reader and text in hermeneutic research (Diesing, 1991). Diesing (1991) also talks about how the aim of interpretation in psychoanalysis is to make meaning, unlock new thinking and deepen self-understanding which is analogous to the generation of new thinking in hermeneutic research. As the hermeneutic approach takes context and researcher subjectivity into account it is a good match for the literature and methods of this dissertation.

### **Limitations.**

A hallmark of hermeneutic research is the subjective dialogue between researcher and text (Smythe & Spence, 2012). Stepping away from the objective stance of empirical research is traditionally seen as a limitation (Evans & Pearson, 2001). However Smythe and Spence (2012) state that the idea of the detached observer is misleading as people always bring knowledge and bias from their personal, biographical and cultural experiences. Other critiques of the hermeneutic approach include that it lacks structure, that it emphasises text over lived experience, and that it is unclear when the process of interpretation ends (Myers, 2013). For these reasons a hermeneutic approach is not suitable for all types of research. However, it is a good match for the qualitative inquiry of this dissertation because both hermeneutic methodology and psychoanalytic data are based in similar paradigms.

## Hermeneutic Literature Reviewing Process

### Sourcing texts.

The aim of a literature review with a hermeneutic approach is to locate data that interests the researcher and generates new thinking (Smythe & Spence, 2012). Unlike a systematic method of data searching, hermeneutic research uses the subjectivity of the researcher to identify relevant and engaging material. It recommends reading widely from different and diverse sources, including different disciplines and time periods. The researcher's task is to bring an open and curious attitude to the various texts in order to identify those that they "incline towards" (Smythe & Spence, 2012, p. 17).

In my search I looked for literature that resonated with me and provoked my thinking. Searches included systematic and non-systematic strategies. I conducted a search of AUT databases in a similar manner to that of a traditional literature review. This helped to identify relevant academic books, articles and authors.

Below is a table of the databases that were searched showing the results of the most relevant searches. The search terms which returned the most relevant results were "embod\*" AND "therapeutic relationship". Complete lists of key words, search terms, and database searches are found in Appendices A, B and C.

Table 1  
Results of Database Searches Undertaken May-July 2014.

Database	Number of hits	Relevant
Psychoanalytic Electronic Publishing (PEP)	769	20
OVID PsycINFO	67	8
EBSCO Psychology and Behavioural Sciences Collection	12	3

Non-systematic searches included reading reference lists of articles and chapters, a manual search of the AUT library shelves, and looking at information from unpublished sources such as dissertations, theses and conference proceedings. I discovered that philosophical, sociological, and feminist traditions have written about the intersubjectivity of bodies, which provided context to my topic and these sources have been included. Further, I found an abundance written about the subjectivity of bodies in literature and poetry, which brought my topic to life and helped to integrate my thinking; however these are not necessarily included in the final dissertation.

### **Inclusion and Exclusion.**

The processes of inclusion and exclusion were determined by my subjective responses to the literature as outlined by the hermeneutic approach (Smythe & Spence, 2012). This means that my views, biases, background and cultural experiences have influenced what data was used. I was drawn to contemporary theorists from the relational and intersubjective schools who write about intersubjectivity, as this material spoke directly to my question and resonated with my approach to practice. I was attracted to works by psychoanalytic social workers and feminist psychoanalysts who combine psychoanalytic ideas with social constructionist ideas, perhaps because their approaches reflected my feminist philosophical position. I was drawn to the authors who wrote about the subjective body rather than the objectified body as the latter seemed idealising, pathologising or pejorative. I excluded works from the mind–body school, body therapists, or non–psychoanalytic psychotherapies as my interest is in developing my knowledge in psychoanalytic psychotherapy; further the size of this dissertation required that I establish some limits. I excluded texts with a particular client group, such as trauma, as I wanted to get an overall perspective of the phenomenon, however eating disorders proved to be one of the few areas where my topic had been considered and these texts have been included.

### **Presentation and interpretation of findings.**

The hermeneutic circle is a way of coming into understanding. The hermeneutic circle is pictured as a spiral to demonstrate how the ongoing engagement with the text leads to a more integrated understanding (Myers, 2013). The process involves moving back and forth between the parts and the whole of the text in

order to identify ideas, challenge preconceptions, revise hypotheses and integrate thinking (Diesing, 1991). I engaged with the literature in this dialogical way, paying particular attention to how the material fit with (or did not fit with) my existing knowledge of the topic, my expectations of the findings, and my personal values and philosophical beliefs. Because I would like to inform my practice as a psychotherapist I have used a psychodynamic framework to interpret the findings, including concepts from Winnicott, intersubjective psychotherapy, and the relational school of psychoanalysis. Overall, using a variety of therapeutic and non-therapeutic texts and reviewing them in this interactive way has facilitated a thought-provoking exploration of the topic.

### **Summary**

This chapter has identified the aims of my dissertation as well as the methodology and methods used to address it. The longstanding preference for empirical methods in health care research was contrasted with principles of the qualitative approach which was found to be a better fit for the data and interpretive methods used this dissertation. Last, the review process and techniques for gathering and organising the data were described.

### **Chapter 3: From One-Person-One-Body to Two-People-One-Body**

*When a body meets a body, no formal introductions are made...As therapists we focus on words but our bodies also speak...Yet most accounts of therapeutic process mention very little of what the bodies mean to each other (Petrucelli, 2008, p. 237).*

This chapter provides an overview of what has been said in psychoanalytic literature about the impact of the therapist's physical body on the clinical encounter. Except in the cases of major physical change such as illness and pregnancy, I find a paucity of material on the topic. I consider whether the one-person model of early psychoanalysis made exploration of the therapist's body problematic for client and therapist alike. I then look at how intersubjective ideas have expanded psychoanalytic theory to two-person models, which have brought the person of the therapist more into the room. Despite these major developments, I argue that the therapist's body remains outside of the room and of psychoanalytic theory as a whole.

#### **The Therapist's Body in the Psychoanalytic Literature**

Gubb (2013) states that little has been written about the therapist's physical body in psychoanalytic literature except for the instances where the therapist's body changes in a dramatic way, such as illness or pregnancy. In these cases recognition of the therapist's body seems unavoidable, as significant physical change occurs or adjustments to the frame may be required to support the therapist's needs. Theorists writing about the impact of the therapist's illness (Galatzer-Levy, 2004; Pizer, 1998) or pregnancy (Paniagua, 2004; Whyte, 2004) discuss how such events disclose the therapist's mortality, sexual activity, and/or existence of external relationships to the client which can significantly impact the work. Theorists state that intensification of the transference is common and that the themes of change and impermanence tend to come to the fore (Galatzer-Levy, 2004; Paniagua, 2004; Whyte, 2004).

#### **Illness.**

Theorists who write about illness in the therapist discuss dilemmas that the therapist may face, such as the ethics of self-disclosure, absences, or discontinuing work, and there is little emphasis on the unique meaning that clients make of the changes to the therapist's body (Gubb, 2013). Galatzer-Levy (2004) suggests that therapists deny their mortality and avoid discussing illness

with clients, and that clients can correspondingly collude with this denial. In such cases, the therapeutic couple misses the opportunity to work through the impact of the therapist's illness (Galatzer-Levy, 2004). Galatzer-Levy (2004) states that therapists are not sufficiently trained or prepared to process illness with clients suggesting there is a more widespread denial of therapist mortality in the psychotherapy profession.

### **Pregnancy.**

The therapist's pregnancy was first talked about in psychoanalytic literature in 1949 and it continues to draw the attention of theorists (Whyte, 2004). In general, theorists state that clients will respond to the therapist's pregnancy according to their particular dynamics (Whyte, 2004). Theorists also suggest general themes emerge, such as infantile conflict, sibling rivalry and Oedipal issues (Whyte, 2004), identity and sexuality issues (Paniagua, 2004) and anxiety and envy around the plasticity of women's bodies (Balsam, 2012).

### **Reflections**

These cases identify how significant visible change in the therapist's body can influence transference dynamics and destabilise the therapeutic frame. Both pregnancy and illness create turbulence within the therapist which in turn impacts the therapeutic relationship. However I wonder what sense can be made of the more subtle aspects of the therapist's body that clients pick up on in the emotionally and physically intimate space of the therapy room. My searches have not returned much material about these subtle features or how they affect the therapy. Ferenczi (1928/2002) talks about the importance of clients' observations of the therapist's appearance, stating that they may reveal critical thoughts towards the therapist. Ferenczi also states that clients will not volunteer these observations and that therapists must invite clients to express them: "every patient, without exception notices the smallest peculiarities in the analyst's behavior, external appearance, or way of speaking but without previous encouragement not one of them will tell him about them" (1928/2002, p. 93). Ferenczi speaks to the difficulty of raising topics personal to the therapist, and the body is surely one of these. The absence of literature on the therapist's body suggests that his comment continues to hold true, despite it being nearly a century old. Gubb (2013) talks about the roots of psychoanalysis in drive theory and that the legacy of some elements of this model, such as therapist neutrality, may contribute to a difficulty clients and therapists appear to

have in acknowledging the impact of the therapist's body. The following paragraphs review the evolution of psychoanalysis from one-person to two-person paradigms, and how relational theories have brought the subjectivity of therapist into the clinical encounter. In the end my findings suggest that despite major developments, the therapist's body remains outside of the room and of psychoanalytic theory as a whole.

## **One-Person Paradigm**

### **Overview.**

The drive model of classic psychoanalytic theory was developed by Freud, and draws on the Cartesian idea that an individual's psychological system is self-enclosed and separate from that of others' (Orange, 2001). In psychoanalysis, the idea of psychic determinism comes from this "Cartesian mind", where thought, affect and behaviour are traced back to instinctual drive and defence (Orange, 2001, p. 281). In other words, subjective experience is seen to be determined by intrapsychic forces rather than contextual or interpersonal processes (Aron, 1990; Stolorow & Atwood, 1996).

### **The body.**

In drive theory the body is seen as a biological system with libidinal drives that link to psychic processes (Aron, 1998b). Freud is famous for linking the soma and psyche in this way, suggesting that psychic conflict can manifest physical symptoms (for instance, in conversion syndrome) and that bodily impulses can manifest psychic conflict (for instance, in the repression of sexual impulses) (Breuer & Freud, 1893/1955). Infant development is seen to occur via the psychosexual stages and, as with the mind, the body is viewed as independent of contextual and relational factors. However, critics state that without a theory for a line of subjective, corporeal development, the subtle and varied levels of bodily experience are not taken into account (Shapiro, 1996). Further, contemporary theorists argue that drive theory overlooks the body's intersubjective, perceptive, and communicative qualities. Viewing the body as a closed biological system rather than a relational entity minimises the role of the therapist's body, which may account for the paucity of literature about the impact of the therapist's body on the therapy encounter. The term one-person psychology is used to describe this model of psychoanalysis which focuses on

the mind and the biological body of the individual rather than contextual or interpersonal factors (Aron, 1990, 1998b).

### **Therapeutic relationship.**

In classical psychoanalysis the transference is a central component; however it is conceptualised as a phenomenon manifesting within the mind of the individual, rather than as an interpersonal event (Aron, 1990). Therapists' facilitate the emergence of the transference by assuming a neutral and abstinent stance, minimising their individuality to avoid contaminating the transference (Aron, 1990). Countertransference - identified later – is thought to reflect the therapist's unresolved conflicts that have been triggered by the client's transference (Gelso & Hayes, 2007). Like other personal factors, the countertransference is considered a hindrance to be minimised (Gelso & Hayes, 2007).

It is noteworthy that in the theory of transference the therapist comes to symbolise the primary object to the client (Jacobs, 2004). And it follows that the therapist's body will represent the maternal body to the client, and evoke maternal associations (Burka, 1996). However, it does not appear that traditional psychoanalytic theory followed this line. Gubb (2013) states that the therapeutic frame in traditional psychoanalysis emphasises verbal, aural and mental interaction over bodily and non-verbal interaction. She states that this has the effect of depersonalising and disembodimenting the therapist, which clients react to by seeking out the therapist's personal self (Gubb, 2013). In drive theory this behaviour is likely to be considered resistance or enactment (Aron, 1998b). However, contemporary theorists suggest clients may, in fact, be in search of a body to relate to (Baker-Pitts, 2007; Connolly, 2013; Daly, 2014; Orbach, 2004).

### **Influences.**

Critics regard drive theory as limited, stating that it reduces personal experience to biological impulses and fails to account for contextual and interpersonal factors (Shapiro, 1996; Wrye, 1996a). However, Shapiro (1996) states that Freud was a man of his time, and that he was influenced by the post-Enlightenment, Cartesian, and patriarchal views of the day. She also points out



that Freud was trained as a doctor and that he sought to align psychoanalytic theory with the medical establishment, which was embedded in biology, empiricism and Cartesian dualism (Shapiro, 1996). Considering his background and the socio-cultural environment of the time it is understandable how Freud's drive-based, one-person psychoanalysis was developed. Further, Freud's approach would have seemed entirely normal for the time as alternative ideas, such as the social construction of experience and intersubjectivity were not part of mainstream thought (Shapiro, 1996). For this reason, the cultural climate will have influenced both sides of the therapeutic exchange – Freud's theorising and practice, as well as the ways that clients experienced and presented their symptoms (Shapiro, 1996).

### **Example 1: Illness in the therapist.**

Margaret Little (1901-1994), a physician and psychoanalyst writes about her experience with an aging analyst in deteriorating physical health (1985, 1990). Little's observations of the analyst's physical condition were met with silence or interpreted as transference, which left her feeling frustrated, angry and silenced (1990). Little felt to be in a double bind, where she was invited to bring all thoughts and feelings into the room and at the same time found this was a topic that she could not approach:

Always on the couch reality had to be set aside, including observations of her age and her health, and specifically of her heart condition. It was not only my "prerogative" to say whatever came, I was bound by the "analytic rule," so I spoke of what I could not have failed to recognize as signs of longstanding heart disease, cyanosis and clubbing of the fingers. She made no reply, so I knew this must be secret and forbidden, and in making a 'personal remark' I was automatically being "rude" (Little, 1985, pp. 15-16)

Little's analysis was cut short due to the analyst's sudden death, proving her observations correct. Little's analyst appears to derive from the drive theory paradigm where free association is treated purely as unconscious and internally-generated (Aron, 1990). Correspondingly, Little's experience of her analyst's body was interpreted in terms of intrapsychic conflict. Doing so had a negative

impact on Little where she felt that her analyst did not connect with the reality of her experience: “instead of empathy there had been a confusion of tongues” (1990, p. 37). Sullivan, who developed an interpersonal conceptualisation of the therapeutic process, suggests that free association encourages the client and therapist to indulge in “parallel autistic reveries” which interfere with interpersonal communication (cited in Aron, 1990, p. 480). Sullivan states that clients’ behaviour cannot be understood independent of the interpersonal relationship and that the focus of the therapy should therefore be on the therapeutic interaction (Conci, 2011). Little appears to view her experience along the same lines as Sullivan, where her associations were influenced by real features of her analyst’s body and that she needed to engage with her analyst on a more personal level in order to feel empathically understood.

## **Two-Person Paradigm**

### **Overview.**

The relational theory of mind regards human behaviour to be organised around relationships, referred to as object-seeking (Aron, 1990). This is in contrast to drive theory which regards human behaviour to be organised around drives and libidinal relief (Aron, 1990). In the relational view, an individual’s experience cannot be understood independent of the social environment, making the interaction with the therapist an essential and informative feature of the therapeutic work. According to Aron (1990), early relational models of psychoanalysis, such as British object relations theory, American interpersonal theory and self-psychology arose in response to the one-person paradigm which drive theory implies.

### **The body.**

Aron (1998b) states that initially interpersonal models did not recognise the significance of the body. In reaction to the emphasis on the biological body in drive theory, those using interpersonal approaches de-emphasised the body in general (Aron, 1998b). Consequently, appreciation of the therapist’s body as a meaningful object did not feature in early two-person models. However, as theories have developed, more diverse conceptualisations of the body have emerged. For instance, interest has increased in the subjectivity of the client’s

body, as well as the role of the therapist's body as a perceptive instrument through the use of somatic countertransference (Shaw, 2004).

### **Therapeutic relationship.**

As the therapeutic interaction is examined in two-person perspectives, the transference and countertransference are seen as inevitable and useful parts of the therapeutic process. The transference-countertransference dynamic is viewed as a co-created process where elements personal to both client and therapist interact (Aron, 1990). In practice, therapists use their own responses to make inferences about the client's interpersonal life. Somatic countertransference is increasingly explored by theorists in the two-person paradigm. It has traditionally been considered to reflect client's dynamics or to be a way of perceiving that is unique to the therapist (Gubb, 2014). However, contemporary models are beginning to look at somatic countertransference in terms of the intersubjective relationship.

### **Influences.**

There were numerous influences on the development of a two-person paradigm in psychoanalysis. Mid-century changes in social, political and intellectual thought challenged and deconstructed long-established views of human lived experience. In particular, philosophy, feminism, and the human sciences argued that human experience is socially constructed rather than purely biological, challenging the view of the "Cartesian mind" (Dimen, 2000). Post modernism and the ideas of Foucault brought about questioning of the scientific and positivistic aspects of classical psychoanalysis (Balsam, 2012). And the concept of embodiment expanded views on the body from a closed biological entity to a site of culture, perception and subjectivity (Dimen, 2000). As a result, ideas that unconscious, intrapsychic, and interpersonal processes were socially and environmentally informed became more integrated into psychoanalytic theory.

### **Merleau-Ponty (1908-1961).**

Merleau-Ponty, a philosopher from the French phenomenological school, significantly influenced views on interpersonal relationships and the role of the body in psychoanalysis. Merleau-Ponty criticised the one-person perspective of academic psychology seeing that internal life overlapped with others' internal

lives rather than residing in a closed psychic system (Merleau-Ponty, 1964). This idea parallels the concept of intersubjectivity which regards psychic processes to be embedded in a relational matrix (Dunn, 1995). Merleau-Ponty also criticised the Cartesian view of the body, seeing the body as the site of perception, subjectivity and interpersonal engagement, and seeding ideas about body intersubjectivity in psychoanalysis (Diamond, 2001; Harris, 1998).

### **Example 2: Illness in the therapist.**

The previous example discussed Little's analysis with an aging analyst. After this analysis ended, Little (1985) started therapy with another analyst whose health was also at times compromised. Unlike before, when Little enquired after her analyst's health he answered her directly, validating what she saw. Little (1985) found this a positive and helpful experience which facilitated a deepening of the analysis. In this example Little's analyst appears to derive from the two-person paradigm where he is aware that aspects personal to him influence the therapeutic relationship (Aron, 1990). This is not to say that all therapists who derive from the two-person paradigm will be self-disclosing, but that the impact of the therapist's individuality is considered and will inform the responses of the therapist.

### **Current Trends**

Overall, traditional views that saw the body and mind in isolation are moving towards more complex formulations. Two-person perspectives place more emphasis on the interpersonal relationship, countertransference, and the person of the therapist than the one-person model of traditional psychoanalysis (Aron, 1990). New ways of understanding the body are more widely recognised, seeing it as diverse, fluid, socially constructed, and intersubjective (Dimen, 2000). These developments suggest that the therapist's body would represent a significant object and subject to the client in the therapeutic encounter. However, Shaw states that this is not reflected in the psychoanalytic literature: "the emphasis within the literature is to study the body of the client; the therapist's body is largely absent...as though there is only one body in the consulting room" (2004, p. 272). It appears then that despite significant shifts in the therapist's position, as well as in the understanding of bodies, the role of therapist's body continues to be unexplored (Dimen, 2000; Gubb, 2013).

Contemporary theorists, particularly from the relational and intersubjective traditions view the body as a vital component of subjective and intersubjective life (Harris, 1998; Orbach, 2004). They conceptualise a line of body development to occur through interactions with significant others' bodies and that the nature of these interactions lay the foundation for individuals' ongoing experiences of their own and others bodies (Diamond, 2001; Orbach, 2004). Viewing the body as constructed in relationship and connected to other bodies through the intersubjective relationship implicates the therapists' body in the therapy encounter. The following chapter looks at the idea of an interpersonal development of the body and the ways that disturbance in this development can manifest anxiety and defence formation at the level of the body.

### **Summary**

This chapter has reviewed what has been said about clients' interest in the therapist's physical body in psychoanalytic literature. Material was only found in terms of major physical change. The one-person and two-person models were used to make sense of how reflecting on the therapist's physical body may be problematic for client and therapist alike. The following chapter looks at contemporary thinking around the relational development of the body.

## **Chapter 4: The Relational Development of the Body**

*The subjective experience of having a body is not inherent or natural but is arrived at as the outcome of a series of interactive events with the material, social psychic environment (Harris, 1998, p. 42).*

*There is...no such thing as a body, only a body in relationship with another body (Orbach 2003, p. 11).*

Body development, as a contextual, relational, and intersubjective process is explored in contemporary psychoanalysis, particularly in the relational and intersubjective schools. This chapter looks at these ideas, beginning with an overview of how the relational and intersubjective schools situate philosophically. It then looks at body development as a process involving holding, attunement, and internalisation within the primary relationship as embedded in a cultural context. It goes on to look at how significant disruptions can create anxiety and defense-formation at a bodily level. Linking the body to maternal provision and regarding the body as relationally embedded implicates the therapist's body in the therapy setting and this clinical relevance is also identified.

### **Contemporary Psychoanalysis: Relational and Intersubjective Traditions**

Contemporary theorists from the relational and intersubjective schools hold a common interest in the phenomenology of lived experience, affective attunement, interpersonal recognition and social construction (Mills, 2005). Both approaches draw from theorists in object relations, self-psychology and interpersonal psychoanalysis to varying degrees, and emphasise relationships as significant to the formation and transformation of self (Mills, 2005). The intersubjective relationship is central to both approaches, recognising the therapist's subjectivity in the clinical encounter (Aron, 1998b; Stolorow & Atwood, 1996). Exploration of unconscious processes is seen to occur within the intersubjective matrix, which builds on a two-person configuration of the therapeutic relationship (Mills, 2005). The interdependence of histories, attachment styles, and unconscious meaning-making between client and therapist makes the clinical situation entirely unique for each therapeutic couple.

An anti-Cartesian stance is a feature among many of the relational (Aron, 1998a; Dimen, 1996, 2000; Harris, 1996, 1998; Orbach, 2003) and intersubjective (Stolorow, Atwood, & Orange, 2002) theorists, who argue for more complex, less reductive

formulations of the body. The concepts of embodiment and intercorporeality describe the phenomenology and intersubjectivity of bodily experience, and are used to replace traditional dichotomous views. However, exactly how embodiment fits into psychoanalytic theory and practice remains uncertain, and Connolly (2013) points out that there is little written about what a corporeal line of development actually looks like. This chapter draws on contemporary theory to describe subjective body development in psychoanalytic terms. I attempt to portray key concepts without fixing the body into any set structure; remaining mindful of the mixed, nuanced and multiple levels of experience which compose subjective life.

### **The Development of Self**

Contemporary theorists view self-development as a process involving early interactive experiences with significant others (for instance, Stern, 1985). Within a sensitive, attentive and attuned relationship, the processes of mirroring, identification and internalisation enable the infant to gather a sense and an image of itself (Stern, 1985). Holding (Winnicott, 1965) and containing (Bion, 1962) are important functions provided by the mother<sup>1</sup> over this period. Holding enables the infant to develop a sense of continuity over time, which Winnicott refers to as going-on-being (1965). The mother's emotional investment – her primary maternal preoccupation – shields the infant from impingements that may impact its sense of coherence, until the infant can provide this function for itself (Winnicott, 1965). Containment, on the other hand is the dynamic emotional interaction between the infant's thoughts and affects and the mother's capacity to tolerate, metabolise and return them (Ogden, 2004). Bion's concept of containment is regarded in contemporary psychoanalysis as an intersubjective process of communication and mutual affect regulation (Ogden, 2004).

These ideas are well-established in psychoanalytic theory; however they are often interpreted to only apply to mental development (Orbach, 2003), reflecting the legacy of dualism in psychoanalytic discourse. The development of bodily form, boundary and integrity may be referred to however it is generally seen as a precursor to mental functioning: the body as a “container” for the mind (Krueger, 2001, p. 239) or as a stage where psychic conflict plays out (McDougall, 1989). This overrepresentation of mental and symbolic functions implicitly negates the unique subjective experience of

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<sup>1</sup> In this dissertation the term 'mother' does not refer exclusively to the biological mother, but to the significant caretaking person.

inhabiting a body in the social world (Shapiro, 1996). Orbach (2003) states that subjective bodily experience is germane to psychoanalysis because there are numerous people who experience difficulty in their ability to dwell in a body. These individuals describe a bodily experience that is conflicted, distressing, dispossessed, unstable or unanimated. In Orbach's words, body instability

is expressed as a kind of void, a not really knowing how one's body is plotted, where it begins and ends, for others, it is experiencing the body as a hated attribute, for still others, it means having this thing, the body, which is out of control. For others it is always just an elusive size away from contentment (2004, p. 148)

If body experience is a basic aspect of subjective reality, it follows that to dismiss it is to overlook a basic tenet of clients' lived experience. Contemporary theorists argue that current developmental theories can be elaborated to describe the body, recognising the intersubjective, culturally-specific developmental line upon which bodies are formed (Connolly, 2013; Diamond, 2001; Orbach, 2003).

## **Body Development**

*"the object is first and foremost a bodily object" (Harris & Chodorow, 2012, p. xi)*

### **Physical holding and handling.**

A sense of self is initially gained through interactive experiences with significant figures, namely the mother (Stern, 1985). In early infancy these interactions are based around the care and management of the infant's bodily needs and functions (Wrye, 1993). Bodily definition, boundary, interior, and exterior form through the somato-sensory experiences of being held, touched, rocked, changed, fed, stroked and soothed (Wrye, 1993). The accuracy and consistency that the infant's bodily needs are met forms the foundation of how coherent and integrated the infant feels in their body (Orbach, 2003). For instance, care that is consistent, sensitive and empathically attuned contributes to a body that feels stable, reliable and inhabitable (Orbach, 2003). Conversely, care that is inconsistent, misattuned, rough or abusive contributes to a body that feels un-bounded, awkward, fragile, or misaligned (Orbach, 2003). These basic bodily ministrings reflect the role of holding (Winnicott, 1965) on the formation of the body, where the mother's body acts both as the holding object – providing vital



functions for the infant's as-yet undifferentiated body; and the holding environment – creating balance and insulation between the infant's body and external impingements, which may interrupt its sense of unity and continuity.

The idea that there are parallels between the primary relationship and the therapeutic relationship is well-recognised in psychoanalytic theory (Jacobs, 2004). In this, the therapist comes to symbolise the primary object to the client through the transference-countertransference dynamic (Jacobs, 2004). Theories of infant development help to inform therapists of how they may be experienced by their clients. The infantile experience of physical holding and handling may manifest in the therapeutic setting by looking at how the therapist holds the client's body. For instance, Orbach says of body holding, "I don't mean my physically holding her but my holding her body in mind, my sensual/psychic taking of her body into my body so that it could nestle in, be protected, and in time experience itself as precious and adored" (2006, p. 103). Here Orbach refers to holding the client through her maternal countertransference. Similarly, Burka (1996) conceptualises the therapist's body as a symbolic womb. She suggests that regardless of age, shape, or gender all clients have maternal associations to the therapist's body and wonder "unconsciously, that there's room for them in there" (Burka, 1996, p. 263). These theorists suggest that the therapist's capacity to allow their body to be used as the maternal object may assist clients to integrate primitive feelings and to incorporate new relational experiences.

### **Use of space.**

Wrye talks about the intimate contact that occurs through the infant's and mother's bodily fluids, referring to body fluids as "conductors" of sensual contact (1993, p. 103). Wrye (1993) also states that the way bodily fluids are managed influences how the infant comes to manage physical and interpersonal space. She describes how wetness and dryness need to be balanced, and that an appropriate balance creates containment: "mother's acceptance of, contact with, and ministrations for her baby in dealings with these fluids may optimally develop a slippery, sticky sensual adhesion in which the infant feels contained" (Wrye, 1993, p. 103). She goes on to say that the security of this containment

contributes to the infant's capacity to trust its environment and to physically inhabit the space in it (Wrye, 1993).

Wrye's depiction of early body-to-body contact illustrates the significance of the mother's physical body in infant development. Wrye's comments about use of space may be applied to the therapy setting by observing the manner that clients negotiate the shared space of the consulting room. The ease or inhibition of their behaviour may reflect elements of early relational experiences with the mother's body. Likewise, one could infer that the therapist's attitude toward the client's physical body may impact how comfortable the client feels to take up space in the therapy setting.

### **Meaning making.**

*The mother knows she must keep alive and allow the baby to feel and hear her aliveness (Winnicott, 1965, p. 71).*

*The therapist's body has great significance for the patient, and the therapist's actual and symbolic physicality plays a very important role in the patient's experience of aliveness and in the vitality of the therapy (Burka, 1996, p. 274)*

Affective attunement facilitates meaning making for the infant (Stern, 1985). Stern (1985) states that attunement is an intersubjective process which involves reflecting back the infant's internal experience. Through attunement the infant learns that its experience can be seen and shared with another, which creates meaning (Stern, 1985). Attunement to the infant's body requires the presence of another receptive body (Orbach, 2004). According to Orbach (2004) the infant needs to have its bodily vitality recognised by another vital body in order to establish a sense of occupying an animated and alive body. Likewise, the infant needs to have sensual and erotic experience recognised in order to take pleasure and enjoyment in its body (Orbach, 2004). The infant develops a sense of agency from the process of attunement through eliciting reciprocal responses from the mother (Stern, 1985). For instance, to the extent that the mother's gaze is waiting when the infant seeks it, or that her manner of handling balances boundary and tenderness, or that the flow and temperature of her feeds suits the infant, instills a sense in the infant that its body impacts her, and that its bodily functions, affects, and needs are manageable (Wrye, 1993).

Krueger (2002) states that body affect that is recognised contributes to psychological integration and symbolising capacity. However, Orbach (2004) cautions the tendency for the body to be translated into mental and psychic terms which can miss its relevance on a bodily level. Orbach (2006) and Connolly (2013) talk about the importance of the therapist offering a present and animated body to the client in order to accurately mirror the client's body. These theorists believe that recognising the body as body facilitates the integration of body affects (Connolly, 2013; Orbach, 2006). Further, as the infant develops a sense of agency from the process of eliciting reciprocal responses from the mother, the therapist's capacity to demonstrate bodily reciprocity while maintaining appropriate boundaries is another feature of the work (Connolly, 2013; Orbach, 2006).

### **Incorporation.**

The infant incorporates the maternal relationship into its sense of self (Orbach, 2006). In other words, the way that the mother relates to the infant informs the infant's core feelings about itself. The mother's history, environmental influences, and psychodynamics influence how she relates to and cares for her infant (Wrye, 1996b). Further, these features influence how the mother feels about and receives her infant's body. To the extent that the mother feels stable and secure in her body, and she is accepting of her infant's body as a dependent yet separate body will engender the same feelings of security in her infant (Lemma, 2009; Orbach, 2003). However if the mother has not established this stability, feels conflicted about her infant's body, is preoccupied, psychotic or depressed, her infant will internalise this experience as its body reality (Connolly, 2013; Lemma, 2009). Therefore, in the absence of consistent, congruent messages, the infant comes to develop uncertainty about its body (Orbach, 2004).

These ideas suggest that just as infants attune to and internalise the maternal relationship and the mother's self-concept, so too will clients pick up on the feelings that therapists have about their (the therapists') bodies and use this to inform their body reality. This is not to say that therapists cannot feel conflicted or ambivalent about their own – or clients' – bodies, but that they need to be

aware of clients' attunement to their bodies and to assess how the constellation of feelings the therapist holds differs from or parallels the client's early experiences (Baker-Pitts, 2007).

### **Cultural patterning and the postmodern body.**

*"What I have been able to understand so far is that the body is made in relationship: to paraphrase Simone de Beauvoir, the body is made, not born" (Orbach, 2004, p. 149).*

Feminist theorists' (Baker-Pitts, 2007; Daly, 2014; Orbach, 2004) point out that the probability of mothers feeling secure in their bodies is unlikely in the current socio-cultural climate where women's bodies are scrutinised, objectified, and marginalised. Cultural attitudes normalise and perpetuate body insecurity, particularly in women, manifesting in women's attempts to monitor, control, and deny their natural bodily expressions (Baker-Pitts, 2007). Daly (2014) states that in the postmodern context, consumer culture is internalised into the object world and that people seek object relationships with dominant cultural symbols. The mother's internal relationship with the dominant culture will occupy the intersubjective space between the mother and infant and influence their interactions (Burka, 1996; Daly, 2014). To the extent that the mother identifies with the cultural mirror and its pressures will influence the ways she unconsciously mirrors and receives her infant's body, potentiating a trans-generational transmission of body distress.

Cultural pressures impact client and therapist alike and just as culture infiltrates the mother-infant relationship, so too does culture infiltrate the intersubjective space of the therapy encounter (Burka, 1996). This means that the therapist's identification with cultural pressures will be picked up on by the client and may reinforce identifications the client has with the mother or the "mother culture" (Daly, 2014, p. 5). As women's bodies are particularly targeted by cultural pressures, the mother-daughter relationship is especially vulnerable to this dynamic (Baker-Pitts, 2007; Daly, 2014; Orbach, 1978). Likewise, female-to-female therapeutic dyads may be particularly vulnerable to dynamics relating to female bodies in consumer culture (Baker-Pitts, 2007).

## Consequences of Inadequate Development

### **The unstable body.**

*“So much of what we see in our consulting room is not the body as a container for unmanageable or painful mental contents, but a body that is literally in trouble, a body that is unstable, fragile, immobile and insecure. A body self that needs the same kind of attention in therapy that we give to the psychological self” (Orbach, 2004, p. 148).*

When the handling and relationship to the infant’s body has been misattuned, inconsistent, neglectful or traumatic anxiety and instability can develop at a bodily level (Connolly, 2013; Diamond, 2001; Orbach, 2003, 2004). This anxiety reflects arrests in the development of body cohesion, boundary, form and image which can create a disturbing sense of rudderlessness, emptiness, ugliness and un-inhabitability in the body (Orbach, 2003). Unintegrated body affects may over-or under-shadow lived experience depending on the individual’s response to the disruption. For instance individuals may be overly aware of their body, feeling awkward, exposed, and self-conscious. Conversely they may feel disconnected from their body, and separated from the vitality, utility and enjoyment they see available to others. Orbach (2003, 2004) suggests that somatic symptoms are expressions of body anxiety, where the body is literally restless, gasping, weeping, erupting or contorting. These ideas recast the way somatic symptoms may be viewed in psychoanalysis, as they have traditionally been seen as an outpouring of un-symbolisable mental conflict (McDougall, 1989) or repressed libidinal drive (Breuer & Freud, 1893/1955).

### **False Body.**

*The spontaneous gesture is the True Self in action” (Winnicott, 1965, p. 148).*

Orbach (1995) extends Winnicott’s (1965) idea of the false self to the unstable body. According to Winnicott (1965), the false self develops when the infant changes its behaviour to adapt to the mother. When maternal provision has been inadequate, the infant interprets that the badness originates from within and begins a process of adapting and concealing parts of itself to suit the apparent needs of the mother (Winnicott, 1965). As a result the infant develops an enduring pattern of withholding ‘true’, spontaneous responses and of modifying

its behaviour in terms of the external relationship. Similarly, when care for the body is misattuned the infant may construct a false body (Orbach, 1995). In this the infant internalises a belief that its body-image, affects or processes are unacceptable to the mother and adapts by only bringing forward the attributes that seem acceptable to her (Orbach, 1995).

After infancy, the need for external confirmation of the body and its qualities (such as aliveness, desire and desirability, continuity, and form) is transferred to other sources and individuals are particularly vulnerable to the cultural pressures of body-obsession and modification (Baker-Pitts, 2007; Daly, 2014). Orbach (2004) observes that cultural practices around control, surveillance and maintenance of the body normalise false body behaviour. For instance, the person that develops a false body in response to the mother is situated in a cultural atmosphere which confirms the messages that authentic body expression is not acceptable, and must be modulated to fit cultural norms.

According to Winnicott, the relational ruptures that give rise to the false self disrupt individuals' sense of continuity, and they create 'emergencies' as a way to confirm their existence. Likewise, Orbach (1995) states that when a bodily sense of continuity is impaired, body-based emergencies such as eating disorders, sex addiction, compulsive shopping, compulsive exercise, or self-harm may be adaptive attempts to connect with a body. Orbach states that "the precarious body gathers a kind of strength from recovering from emergencies. This 'surviving of or recovering' from emergencies provides the individual with the sense that their body exists" (2003, p. 10). Orbach's ideas illustrate the significance of the mother's body to infant development and what may occur if maternal provision is not adequate. She offers a new perspective on the meaning and origins of the body-based behaviours that are commonly seen in the consulting room, and what they may be trying to achieve.

Connolly (2013) talks about the 'false body-self' in terms of the disembodied individual. Disembodied people are those individuals who did not have their vitality tolerated or reflected back in infancy and they experience a great disconnect from their body as a result. The disembodied person experiences their body as dead, inanimate and sexless and the false body-self is constructed

to create the illusion of a more-alive body to offset the disturbing dead feeling (Connolly, 2013). Unlike Orbach's false body construct which is embedded in a relational dynamic, Connolly's false body centers on providing the individual with a material body to identify with – albeit precariously – which they are lacking. The false body-self is a construction that is often based on gendered ideals of masculine or feminine bodies. Various practices such as exercise or action sports for men, or grooming, fashion and make-up for women create sensory experiences that connect the individual with their body (Connolly, 2013). Further, the gender confusion common to the disembodied person may be masked by the construction of an identity that is aligned with accepted gender ideals (Connolly, 2013). Connolly's ideas also offer an alternative view on the meaning and origins of body-based behaviours, particularly those that may be hidden in normalised gendered behaviour.

### **Summary**

This chapter has looked at body development as an inherently relational process embedded in a cultural context. It described how care and attitudes towards the infant's body influence the degree that it comes to form, inhabit, and enjoy its body. The mother's acceptance for and receptivity to the infant's body stands as an integrating influence on development, while care that is inconsistent, misunderstanding, or abusive contributes to body-based distress and instability. I suggest that the role of the mother's body in infant development is recreated in therapy through the transference-countertransference relationship where the therapist's body comes to represent the maternal body. I also suggest that the relational nature of the body points to body-to-body attunement in the therapy relationship. The next chapter looks further at the ways the therapist's body is a significant feature to the client, using the concept of the analytic object to do so.

## **Chapter 5: The Therapist's Body as the Analytic Object**

*“What I am trying to convey is that, in analysis the analyst's body is not entirely his or her own and what it says to him or her is not a message for him or her alone” (Samuels, 1989, p. 164).*

This chapter looks at the therapist's body as the analytic object. It begins by looking at potential reasons why clients may notice and use the therapist's body. It then looks at ways the therapist can engage with this process and make it clinically useful. Examples are used to illustrate topics discussed. Naturally, as clients, therapists, and therapeutic relationships are different and changeable the meaning and purpose of the therapist's body as the analytic object will be unique and un-generalisable; therefore the purpose of this chapter is to draw attention to and generate thinking about this dynamic in the clinical encounter.

### **Why the Therapist's Body?**

Reasons why the therapist's body may be noted or utilised by the client are diverse and unique. Theorists have suggested generalisable themes to emerge when the therapist's body changes, such as Oedipal issues from a therapist's pregnancy (Whyte, 2004), or existential conflict from a therapist's illness (Galatzer-Levy, 2004). However it cannot be assumed that all clients will respond in these ways; nor will the therapist's body only become a feature when it impinges with dramatic change. Gubb (2013) states that the therapist's body becomes a feature to the client for reasons particular to the client's dynamics, which will be subjective, context-specific and influenced by the transference-countertransference relationship. Some theorists (Baker-Pitts, 2007; Burka, 1996; Daly, 2014; Gubb, 2013; Lowell & Meader, 2005; Orbach, 2004) have shared how their bodies have taken on extra meaning in the clinical setting. Their ideas help to contextualise these events and to orientate therapists to an area that has not been explored in great depth in psychoanalysis (Burka, 1996; Gubb, 2013).

### **The Therapist's Body as Mother**

In this dissertation I suggest that that because the body forms out of relational experiences with the mother, clients will notice and associate to the therapist's body in primitive and unconscious ways that link to this early relational experience.



### **A Body to Relate to**

Drawing on the idea that the body forms in a relational context, Orbach (2003, 2004, 2006) and Connolly (2013) state that clients need to engage with the therapist on a bodily level. Individuals who have had inadequate experiences during their body development may experience conflict, distress, deadness or instability within their body. These clients enter therapy with a corresponding desire for another body to process this with (Connolly, 2013; Orbach, 2003).

### **The Dis-embodiment Frame**

The therapeutic frame is an asymmetrical construct (Gubb, 2013). While classical and contemporary perspectives may differ about how opaque or revealing therapists are about their personal selves, the frame is nonetheless set up to focus on the client. The purpose is to create space for the client to share their experience and to allow transference and countertransference dynamics to emerge (Aron, 1990). However, Gubb (2013) believes that a consequence of the frame is that intellectual, oral and auditory engagement is emphasised over the physical body, leading to the depersonalisation and disembodiment of the therapist. Gubb (2013) suggests that as the body reveals the therapist's subjectivity more than other aspects of the frame – such as time and money which can be kept constant – clients can fixate on the therapist's body in the attempt to bring the person of the therapist (including their body) into the room. Therefore, in view of the asymmetrical frame, the revealing nature of the body makes the therapist's body a unique platform for projections and interpersonal dynamics to be explored.

### **How**

There are numerous ways the therapist may realise their body has become the analytic object. The client may introduce their interest through a comment or enactment (Burka, 1996; Gubb, 2013); or the therapist's body may impinge through a change (such as a haircut or weight-loss), transition (such as pregnancy or illness) or enactment of its own (such as, blushing or stumbling) (Tintner, 2009, 2010). When there is not a comment or enactment to identify that the therapist's body has acquired extra meaning, the therapist often picks this up through the somatic countertransference (Burka, 1996; Orbach, 2004).

## **Intersubjective Relationship**

Just because the client regularly looks at the therapist's body does not mean that they will perceive that body objectively, nor can one predict how the client will use the therapist's body unconsciously (Burka, 1996). In the intersubjective relationship both bodies are accessible to each other and – as the transference and countertransference are part of the intersubjective relationship – real and fantasy elements come to be attributed to the therapist's body. As a result, clients' impressions may come uncomfortably close to the therapist's personal experience, or they may differ from the therapist's reality. Burka talks about the inconsistent and changeable ways her body feels in the therapy setting: "sometimes dumpy and self-conscious, sometimes voluptuous and racy, sometimes motherly and nurturing, sometimes shriveled and empty" (1996, p. 263), illustrating how her body changes and responds within the intersubjective relationship.

## **The Analytic Object**

The analytic object is created in the mutual intersubjective space between the therapist and the client. It contains elements of client's and therapist's internal, unconscious, and fantasy lives as well as each person's objective reality (Green, 1975). Burka (1996) states that while both bodies are continuously interacting in the therapy encounter, the therapist's body is not always the analytic object. It is only when the therapist's body takes on meaning that it did not previously hold that it becomes the analytic object (Ogden, 1994) representing an opportunity that the therapeutic couple can make use of.

## **Examples**

**Case A.** Gubb (2013) sees a male client who enquires after scarring to her hand. As she explores the question the client shares that he is not sure if she acquired the injury as the result of being the victim or the aggressor. This leads to further exploration of the client's paranoid dynamics that inhibited his ability to trust the therapist as well as his other relationships.

**Case B.** Tintner (2010) works with a male client who reports to have chosen her as a therapist because she is overweight and he imagines that sexual and intimacy issues will not complicate the therapy. After voicing this to her he becomes confused when such issues emerge in the relationship.

### **Making Use and Making Sense**

In Case A, the therapist's body (or body part) acquires meaning that is relevant to the client's internal and interpersonal dynamics and the way it is managed influences the course of the therapy. In this case, Gubb responds to the client by exploring the meaning behind his question which uncovers his paranoid dynamics. Had Gubb answered directly they may not have identified his paranoia. Gubb (2013) and Lowell and Meader (2005) emphasise exploring the form and timing of clients' references to the therapist's body in order to understand their particular meaning for the client. Responding to the client directly or not responding at all can foreclose an opportunity to understand the client more fully. Lowell and Meader advocate that, rather than disclosing facts, therapists should share feelings about the client, treatment or therapeutic relationship in order to "preserve the patient's freedom to use the therapist as an object of assumptions and projections." (2005, pp. 244-245).

In Case B, Tintner's client tells her that he chose her because she is overweight and he does not imagine sexual feelings to emerge. Tintner (2010) states that being overweight makes her body a noticeable feature to clients and – due to cultural attitudes towards weight – evocative of strong emotions. Clients may allude to her body size but rarely raise it directly, perhaps because discussing, observing and associating to the body is not common social practice (Tintner, 2010). However, Tintner (2009) has found that direct conversation about her body often precedes a deepening of relationship where clients open up about other difficult topics. Tintner wonders if such candor has the effect of lifting taboos and facilitating freer or more direct expression in general.

In Case B, sexual dynamics enter the relationship after Tintner's client has expressed his feelings towards her body. Perhaps the effect of speaking directly about her body demonstrated to the client that Tintner (including her body) was safe to bring these feelings to. Further, perhaps Tintner's toleration of a potentially painful reference to her body modeled to the client that he did not have to keep such distance from his own unspeakable feelings.

## Co-created Bodies

*There is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand (Ogden, 1994, p. 3)*

**Case C.** Orbach (2003, 2004) develops a sense of a calm, robust, able body with a client who has an awkward troubled body. She infers that the client has evoked in her a stable, resourced body from which – like an auxiliary body – the client can use to break down, integrate and rebuild her body. Orbach’s bodily transformation only occurs in sessions with this particular client.

**Case D.** Burka (1996) notices feeling frumpy and dowdy with a sexually aggressive male client. She dresses up for him and becomes flustered in his presence. This shifts early in the therapy relationship to a sweet, maternal and nurturing feeling. She sees the shift (“from clumsy fatgirl to nurturing mother”) as a dynamic and unconscious collaboration between them to build a comfortable mother/infant experience before approaching the client’s sadistic use of sexuality (1996, p. 265).

**Case E.** Dimen (2000) uses the toilet before a session with a narcissistic male client. He notices the smell and tells her. She is humiliated. Dimen sees this as a countertransference enactment where she comes to embody the “atmosphere of humiliation” that the client had always inhabited. (2000, p. 26).

## Making Use and Making Sense

Cases C, D, and E are examples of co-created bodies. In the intersubjective relationship, subjectivities and unconscious process interact, and the therapist’s body comes to reflect and enact dynamics specific to the therapeutic dyad (Burka, 1996). In Case C, Orbach (2003, 2004) views her transformation to an able, contented body as a somatic countertransference response to the client’s need for containment by a stable body. Orbach (2003) likens her experience to the sense of competence and mastery the therapist can feel when containing the client as they work through psychic conflict. The therapist is used by the client as an auxiliary to break down and metabolise intolerable, un-integrated affects. The dynamic nature of containment involves the therapist’s capacity to offer a reflexive, well-examined mind to the client as well as the client’s

invoking that capacity in the therapist (Orbach, 2003). Orbach thus understands her experience with this client as her stable body containing the client's troubled body.

Orbach (2003, 2004) views bodily symptoms (including somatic symptoms, body-image issues and body-based fixations and behaviours) as adaptive attempts to connect with a disturbed or unstable body. She sees potential for healing if these symptoms are recognised as body – rather than mental – constellations (Orbach, 2004). Once the disturbed body has been recognised, defences can soften and new bodily structures can be formed in relationship with the therapist's body. According to Orbach,

As we can welcome first the hated body or the disintegrated-in-bits body, the body that is a void, the body that can only weep, scratch or scream, then we can help our patients build from what is and what was rather than fictionalizing their experience of hated bodies (2004, p. 148)

To receive and recognise body hatred is difficult for therapists to tolerate and they may be tempted to return to the familiarity of interpretation (Orbach, 2004). However the therapeutic act required is interpersonal rather than interpretive (Orbach, 2004). Connolly (2013) talks in a similar way about the therapeutic needs of disembodied clients; disembodied clients are those individuals who did not have their vitality tolerated or reflected back in infancy and experience a great disconnect from their body as a result. Connolly states that in order to reconnect with their bodies, clients need a living body in the therapist that will relate to and introject their hated body, and provide experiences of "corporeal mirroring" (2013, p. 649). In her words, "the patient needs to be able to feel that the analyst sees, is aware of, and interacts with his or her body" (2013, p. 649). Again, in order to shift the deadness, the therapeutic task is decisively the provision of a body to relate to, rather than interpretation.

Case C has discussed some of the ways that the therapist's body can contain the client's body such that they may be able to connect with or build a more inhabitable body. Orbach (2004) identifies three types of somatic countertransference which indicate to her that her body is being used by the client. The first is for provision, as has been discussed in Case C, where she came to embody a stable, warm, robust body that could tolerate the client's distress and projections. The second is to communicate affect in a concordant manner (Racker, 1957), with the client's personal experience being evoked in the therapist; for instance, feeling like gagging in the company of a client who is

repulsed by his/her body. The third is for communication of dissociated affect, as in the case of trauma, where a physical sense alerts her to something of the client that is out of the client's awareness (Orbach, 2004).

Case D is another example of a co-created body where, through an unconscious interaction between Burka and her client the dynamic shifted from aggressive to maternal. Burka (1996) became aware that her body was the analytic object through her countertransference enactments – her dressing up, awkwardness and fumbling behaviour in the client's presence. She felt her client was relating to her body in the same sadistic ways he relates to other women's bodies, to which she felt and behaved accordingly intimidated. Reflecting on the shift, Burka (1996) wonders if, as this was early in the therapy, they may have unconsciously collaborated in the creation of a maternal transference to allow the relationship to build before approaching the client's sadistic impulses.

Like Case D, Case E involves a countertransference enactment where the therapist's body acts out a dynamic central to the client and the therapeutic relationship. Dimen is humiliated after her client smells and names her toilet odor which she sees as an identification with the client's experience of toxic shame. The body of Dimen's client was repeatedly invaded as a child having had three rectal surgeries before puberty age. His mother recoiled at his amorous advances as a child and his father taunted his puberty-anxiety as girlish, resulting in a deeply-held all-encompassing sense of self-disgust (Dimen, 2000). Dimen infers that the enactment bestowed on her the task to contain the client's affect until they had worked through his feelings of contamination and shame and was robust enough to take the feeling back himself. Like Case C, Case E demonstrates how the therapist's body can contain the client's body however, unlike Orbach's experience of stability, Dimen's was exposing and excruciating.

In the build-up to the enactment in Case E, Dimen recalls feeling a mixture of frustration and helplessness with the client that she had not fully acknowledged: "I had resisted probing my ambivalence until my body took over, as bodies will do" (2000, p. 26). Dimen seems to speak to an inevitability that bodies will reveal our true underlying feelings – which parallels traditional psychoanalytic views about the body as an outlet for psychic conflict (McDougall, 1989). However, Dimen appears to see her body's "betrayal" in terms of cultural patterning playing out in the intersubjective

relationship. Here she believes a familiar heterosexual split between aggression and nurturance emerged where her body – which could not contain the aggression that her male client embodied – overflowed, revealing her female weakness and his (evacuated) feminine weakness too (Dimen, 2000).

Burka (1996) also talks about how culture infiltrates the intersubjective relationship and influences how client's respond to her body. Burka (1996) states that her round "earth mother" shape is less-desirable than the thin, angular ideal of current standards and can evoke devaluation and judgment from clients. She states that the unconscious elements that client and therapist bring to the relationship are influenced by past experiences (as in the transference-countertransference dynamic) as well as the culturally-defined ways that teach us how to evaluate others' bodies. This is exemplified in Case C where Burka's feeling of being the "clumsy fatgirl" with her client appears to reflect both his narcissistic need to be right and the other to feel wrong, but also the culturally created dynamic that an overweight woman feels inadequate and judged in the company of a man.

Cases C and D refer to relationships where Orbach (2004) and Burka (1996) were hyper-aware of their bodies most of the time; with Orbach feeling consistently calm and Burka feeling constantly surveyed and appraised. Conversely, in Case E, Dimen's (2000) body came into the room seemingly by accident. In these cases the therapists identified that their bodies were meaningful to the interaction through the somatic countertransference rather than direct discussion with the clients themselves and it is unclear if such discussion ever took place. While these cases are quite dramatic, Petrucelli (2008) urges therapists to notice the subtle ways the body responds in interaction with one another, such as an eye twitch, foot falling asleep or stumbling when one sits down. Petrucelli (2008) states that these moments bring something dissociated into the room which can be picked up and explored in treatment.

## **Summary**

This chapter has looked at the therapist's body as the analytic object. It looked at the ways that the therapist can become aware that their body is taking on meaning in the intersubjective relationship and used examples to show how the therapist can make sense of their body in this unique position. The following chapter discusses the

literature, topics and questions raised in this review. It also identifies limitations and suggests future directions for research.



## **Chapter 6: Discussion**

The idea that the therapist's body is being used by the client as an analytic object is relatively new to psychoanalysis and it can create discomfort and anxiety in the therapist. Clinical engagement may mean developing new levels of attunement and sharing of self in uncharted ways, while at the same time professional boundaries need to be maintained. This chapter looks at the role of the therapist's body in the transference-countertransference relationship and discusses the challenges for the therapist to use and allow their physical body to be used as a feature of the therapeutic process. It also looks at the limitations of this review and ideas for further investigation.

### **Summary So Far**

In this dissertation I look at body development as a relational process between the infant's and mother's bodies where inconsistencies and developmental arrests create body disturbances that may be communicated and healed in relationship with another body. I argue that in the transference-countertransference relationship the therapist's body can come to symbolise the maternal body, where projective, associative, and interpersonal dynamics play out. Further, I argue that in the intersubjective relationship the therapist's body is a culturally-embedded, subjective body for the client to engage with as well as an instrument for perceiving somatic communication.

### **The Transference-Countertransference Relationship: The Therapist's Body as Mother**

While the idea of the therapist symbolising the primary object is not new to psychoanalysis, how the therapist can explore the use of their body in this way within the traditional frame raises challenging questions. For instance, how are professional and personal boundaries managed when working with the physical body? And does touch need to be revisited as a part of the therapeutic process? The question of touch is beyond the scope of this paper, however Daly (2014) has suggested that a way therapists can make their body available to clients within the traditional therapeutic frame by expanding the idea of the 'good enough' mother (Winnicott, 1965).

### **The ‘Good Enough’ Body**

The ‘good enough’ therapist’s body, modeled on the Winnicottian idea of the ‘good enough mother’ (Winnicott, 1965), is the therapist’s provision of a body that is tolerant of exploration, inquiry and projection from the client (Daly, 2014). It makes space for the client’s bodily interaction and allows for expression of positive and negative affect (Daly, 2014). Theorists state that clients often have fragmented or objectifying ideas about their and others’ bodies, and they need assistance to integrate these feelings into different – more subjective – configurations (Baker-Pitts, 2007; Daly, 2014; Orbach, 2003, 2004). The ‘good enough’ therapist’s body is in a position to assist the client to explore and integrate fixed ideas, associations and projections to more reflexive forms. Daly (2014) suggests this process is akin to the infant’s transition from object relating to object use: When clients engage with the therapist as a screen or a collection of projections they are considered to be object relating, and treating the therapist as an extension of their internal world (Winnicott, 1969). In order to see the therapist’s subjectivity – known as object relating – clients must ‘destroy’ their projections, shifting their perception of the therapist to an ‘other’ in external reality (Winnicott, 1969). Daly (2014) recommends that therapists and clients speak about both bodies in the room as doing so highlights difference and helps clients to recognise their own and the therapist’s subjectivities. As clients discover they may express negative or critical feelings toward the therapist’s body without evoking retaliation or withdrawal they begin to develop the capacity to observe and explore their responses to the therapist’s body in more reflexive, ego-dystonic ways (Daly, 2014).

### **Being a Subject**

Daly (2014) states that therapists need to model secure attachment to their body in order to facilitate a holding environment that feels safe enough to the client to bring their body into. This includes inhabiting a body that is respected and entitled enough to have its needs and appetites met. Therapists need to reflect on the developmental history of their bodies and their body-vulnerabilities in order to consider how these may play out in the clinical process (Daly, 2014). Therapists must also monitor their responses to the cultural pressures to objectify and be dissatisfied with their bodies (Baker-Pitts, 2007; Daly, 2014). Body subjectivity could be confused with being completely at ease with one’s body, however, Baker-Pitts offers some balance with the following: “analyst’s body subjectivity relies on a degree of uncertainty and openness to how her body experience is shaped and changes in relation with cultural pressures, her gender, her

own internal objects, and the relational encounter” (2007, p. 128). Baker-Pitts refers to female-therapist to female-client interactions here, however I believe that her comment could be applied to whatever gender the therapist identifies with.

### **Sharing Subjectivity**

Sharing subjectivity may be confused with self-disclosure, however, Lowell and Meader (2005) suggest that sharing responses relevant to the client’s presentation or the relationship rather than disclosing fact is more beneficial. Further, the latter may shut the exploration down or even be detrimental to the client, depending on the client’s difficulty, capacity, and level of functioning.

### **False-Body Enactments**

In the case that therapists miss or avoid their bodies being used by the client, they risk creating a taboo in the therapeutic discourse reminiscent of previous traumas experienced by clients with unstable bodies (Burka, 1996). Resultantly, clients may shut parts of themselves away and share only what attributes seem acceptable – enacting a false-body presentation – with the therapist (Orbach, 1995). Furthermore, cultural messages that encourage body objectification may be perpetuated (Baker-Pitts, 2007; Daly, 2014). The issue of how a therapist would know if this taboo has been created is problematic as it is unlikely that clients would share this with the therapist (Daly, 2014; Tintner, 2010). Thus the question of how directive the therapist should be in drawing attention to the topic comes to the fore.

### **To Raise or not to Raise**

There are varying opinions about whether to raise the topic of the therapist’s body when it appears to have become the analytic object, however the consensus is to engage with it when it arises (Baker-Pitts, 2007; Daly, 2014; Orbach, 2003; Petrucelli, 2008; Tintner, 2010). Tintner (2009, 2010) feels that client’s will not raise the topic themselves and that they need the help of the therapist to do this. Having lost a lot of weight Tintner’s appearance changed dramatically, which affected the dynamic with some clients. Tintner believes that acknowledging clients’ reactions to her body lifted taboos and validated clients’ observations (2009, 2010). She contrasts this with previous clients who had made references to her body which she was too ashamed or anxious to explore. These clients left therapy because, she believes, she did not respond to their cues. Similarly, Daly (2014) and Burka (1996) state that clients need to be invited into such a

personal dialogue. Personally I feel that exploring associations to the therapist's body is an area where rich engagement and insight can be gained, but that one first needs to reflect on the needs of the client, the stage of the therapeutic relationship and the capacity of the therapist. The reasons why clients raise, do not raise, or do not notice the therapist's body will be personal to them and their interpersonal dynamics. Gubb (2013) offers a timely reminder that there is a balance between acknowledging how clients' responses may reflect dynamics, and bringing in unprovoked and unnecessary self-disclosure which may be more about the therapist's agenda.

### **Attunement**

A central feature of the therapist's role is to tune into and track the content and process of the therapeutic exchange (Yalom, 2002). The content refers to the words spoken between the client and therapist while the process refers to the interpersonal relationship (Yalom, 2002). From the literature reviewed in this dissertation, it appears that addressing the therapist's body as an analytic object can be approached from either position, however reflecting on the process is fundamental. For instance, Tintner (2009, 2010), Gubb (2013), Daly (2014), and Lowell & Meader (2005) write about the content introduced by the client or the therapist. However, comments are understood based on the process – looking at timing, non-verbal behaviour, stage of the therapy, and transference-countertransference dynamics. This is exemplified in Case A where the client focuses on Gubb's hand which, when explored, reveals the client's underlying paranoia. Conversely, Orbach (2003, 2004), Connolly (2013), Petrucelli (2008), and Burka (1996) talk about picking up on the use of their body from the somatic countertransference – a core part of the process. Again, the exploration of these phenomena is based on the interpersonal relationship and the client's dynamics. It is not clear in these cases if or when the countertransference was shared with the clients however, one presumes that the decision to do so is based on the therapist's assessment of the client's needs.

According to Orbach (2003, 2004) and Connolly (2013) who write about individuals with troubled bodies, the clients' needs were based at the level of the body and they needed to be addressed at this level, rather than through interpretation. One way to make sense of these presentations is by looking at the process of empathy. Empathic attunement is understood to be an intersubjective process where meaning and connection come through the recognition of one person's experience by another (Stern,

1985). It follows then that pain or distress at a body level will need recognition by another body, and that this pain will transform when that recognition is offered, as exemplified by Connelly,

At the beginning my incapacity to accept the deadness present in the room led me all too often to an excess of interpretative activity in the attempt to make myself feel more alive with the result that [the client] felt even more hopeless and dead...It was only when he realized that he was capable of provoking bodily reactions in me that things gradually began to move and he began to make use of my emotional attunement (p649)

Connolly's reference to emotional attunement appears to be about her verbal interpretations which symbolised the client's deadness into language rather than recognising his experience in a reciprocal, bodily way.

Body empathy or reciprocity appears to be a process that is more subtle than demonstrative, where therapists make adjustments to the way they sit with and interact with the client. For instance, Connolly (2013) states that clients who feel dead cannot tolerate too much autonomy or aliveness from others and that the therapist's empathic stance involves modulation of these factors. Another example comes from Daly (2014) who talks about trying to breathe in sync with a client so that the client could feel the attuned presence of another. Further still, Orbach (2006) and Wrye (1996b) talk about bringing clients into their bodies where they can be held, which denotes a position taken by the therapist that may not be consciously perceptible to the client. The need for body empathy may be a reason why verbal interpretations are found to be limited with somatically-based presentations. Further, the persistence of body symptoms in psychotherapy – the talking cure – may be related to a lack of awareness around body empathy in psychoanalysis despite longstanding treatment.

### **Therapists that do not Experience Somatic Responses**

Not all therapists relate to experiencing somatic countertransference (Shaw, 2003), which raises the issue of how these therapists could attune to bodily communication. Shaw (2003) states that some therapists have other ways of picking up non-verbal communication, while Daly (2014), and Lowell and Meader (2005) suggest that body attunement and reflexivity can be developed. The use of the body as a perceptive instrument is extensively explored in the body-therapies and knowledge from these schools may assist therapists if they would like to develop body awareness. Likewise,

practices such as yoga and meditation have been found to be useful in connecting therapists to their sensory and somatic-based experience (Shaw, 2003).

Daly (2014) raises the point that anxiety hinders attunement and receptivity, and that the therapist's level of discomfort may contribute to bodily references being missed. She suggests that finding ways to be more comfortable with the use of the body both as an analytic object and as an instrument of perception is indicated (Daly, 2014). Daly also suggests that reflection on body-countertransference feelings needs to be incorporated into supervision and personal therapy to help reduce therapists' fears of talking about the body in the clinical encounter.

### **The Tradition of Blaming Mothers**

Describing the relational development of the body and the mother's role in it could be interpreted as blaming mothers. This is not the purpose of this dissertation nor do I think it is the purpose of the theorists I have included. Mothers are burdened with expectations for their bodies to fit two highly conflicting forms: first, the idealised form where her desires and sexual appetite are in full; and second, the maternal form where her needs and hungers are denied and replaced with the tasks of function and nurturing (Orbach, 1978, 2003). It would be expected that mothers would feel unstable in their bodies as a result. The purpose of discussing mothering in this review is to point out how women inherit unstable bodies, live in a culture that normalises and perpetuates body distress, and, through the process of mothering and socialising, transfers their body instability down generations. Psychoanalysis has been criticised for minimising the subjectivity of mothers in its developmental theories (Daly, 2014) and an aim of this review is to give voice to the subjective bodily experience of mothers as weighing heavily on personal and interpersonal levels.

### **Therapists Responses**

For many therapists, the idea that their body may be the analytic object induces anxiety. It may feel overly personal, invasive or painful to recognise that clients are scrutinising, projecting into or using our bodies as they do, especially if therapists have body insecurity themselves (Daly, 2014; Orbach, 2004; Tintner, 2010). Further, cultural trends that objectify bodies impact therapists as well as clients which may make these interactions particularly difficult for therapists to engage with.

Gubb (2013) states that thinking about the therapist's body as intersubjective and meaningful to the clinical encounter is relatively new to psychoanalytic theory. Orbach (2003) states that the theory being generated is still provisional and that in order to integrate bodies into theory the overvaluation of mental and symbolising functions in psychoanalysis needs to be rebalanced. In my searches, locating and understanding the material was a slow process and I wonder if this reflects the paucity of the literature as well as an element of resistance from therapists to consider their bodies as part of the therapeutic discourse. It is certainly uncomfortable to consider what my body may communicate to clients and whether my body is 'good enough' for clients to use. Orbach (2003) states that clients already use our bodies as they do our psyches and that our task is to help them to make use of them actively, consciously and effectively. She reminds us that the challenges, intimacy, and exposure of the therapeutic relationship create growth in clients and therapists alike and that refining sensitivity to body countertransference helps therapists to make sense of what they are experiencing.

### **Who is Writing About this Topic**

Reflecting on the theorists I have found most useful, all were women, many of whom identify as feminist (Baker-Pitts, 2007; Daly, 2014; Orbach, 2003, 2004), and many work in eating disorders (Daly, 2014; Orbach, 2004; Petrucelli, 2008). Having conducted a hermeneutic literature review, I chose literature based on my subjective responses and I am unsure if these theorists reflect my preferences or if these are the only theorists producing the literature. Firstly, it is no surprise that these are the theorists I resonate with as I identify as feminist and I am interested in women's gendered experiences. However, literature of this sort invariably points out that conflicted body-experience and eating disorders are highly represented among women, with eating disorders often representing adaptable and understandable ways of managing women's social experience (Orbach, 1978). Further, as comparing and contrasting bodies is common to women with-or-without disordered eating, it follows that exploring the body in relationship to the therapist's body would be of interest to women. Therefore, while it is no coincidence that my hermeneutic approach led me to these authors, it also appears that it is no coincidence that these authors are producing literature on this topic.

## **Limitations**

Feminist perspectives have been criticised for generalising women's experience to encompass 'all women', misrepresenting and silencing subgroups (Trepagnier, 1994), and this critique could be applied to my comments in this review. I have not come across (nor have I sought out) literature from authors who explicitly identify as being of colour, lesbian, gay, bisexual, transgender, or intersex. I have not looked at the bodily experience of fathers nor have I compared sons' and daughters' experiences of the mother's body. I have not explored the experience of sick bodies, disabled bodies, or disfigured bodies. Because of the literature chosen, men's experiences – from the therapist's or client's perspectives – do not feature strongly in this review. Last, I have not included literature on erotic transference-countertransference which I imagine may overlap with this topic. For these reasons this review probably reflects mainstream feminist perspectives on the idea of the therapist's body as the analytic object.

There is much scope for future research, for instance, to explore the bodily experiences of gay people, people with sexual addictions, or those who self harm. Another area could be how the intersubjectivity of bodies plays out in therapist-client dyads of differing gender or sexuality; or how body intersubjectivity plays out in groups. In New Zealand exploring the perspectives and experiences of Maori and subgroups within Maori culture would be interesting particularly in view of the transmission of body distress down generations and the history of colonisation on Maori culture. New Zealand has a multi-cultural demographic and looking at the body experiences of other ethnicities, or how culture impacts the perceptions of bodies between different groups are some ideas for further investigation.

## **Summary**

This chapter has used psychoanalytic concepts from Winnicott, the relational school of psychoanalysis, and the intersubjective school to discuss the findings of this review. It looked at the idea of the 'good enough' body, how direct the therapist should be in raising the topic of their body, empathic attunement, and the therapist's relationship to their own body. It also described the types of authors and theorists used in this review, the limitations of my searches, and ideas for future research. The following chapter summarises this dissertation and offers concluding remarks.



## **Chapter 7: Conclusion**

This dissertation was motivated by personal experiences I had of my body in relationship to others bodies. A qualitative literature review was conducted to explore psychoanalytic perspectives on the therapist's body as clinically meaningful using the concept of the analytic object to do this. A hermeneutic approach was used to guide the search process which included using my subjective responses to choose and interpret a variety of literature and texts.

The role of the therapist's body in psychoanalysis was first reviewed. I suggested that as the drive model of classical psychoanalysis implies a one-person psychology, the therapist's personal self did not feature in the therapeutic process. However, with the rise of interpersonal models, post-modernism, feminism and other socio-cultural changes psychoanalytic theory has expanded to focus on the interpersonal relationship, which implies a two-person psychology. As a result, the person of the therapist is increasingly recognised as a feature of the therapeutic encounter, and making space for exploration of the therapist's body.

Theories on body development from the relational and intersubjective schools were then described, which formulate body development to occur in relationship with significant other bodies. These early experiences are seen to create a base structure for which future bodily experience builds on. Care and handling that is inconsistent or lacking in empathy is seen to lead to distress and fragility in the body and vulnerability to ongoing body difficulty. In chapter one I identified my dysmorphic responses and wondered about the idea of body intersubjectivity. In chapter four, body intersubjectivity was discussed in terms of attunement, reciprocity, and communication between the mother's and infant's bodies which happens on non-verbal, unconscious levels. I also asked how the therapist's body is viewed in the transference-countertransference relationship, and it was proposed that, in view of the relational development of the body, the therapist's body represents the maternal body and is evocative of primitive projections and associations.

These ideas were discussed using clinical examples and psychodynamic theories, including Winnicott, the relational school and the intersubjective school. Chapter five expanded on the idea of body intersubjectivity by looking at the therapeutic relationship

and the ways the therapist can make inferences about the client's experience based on their experience in the intersubjective relationship. Examples explored how therapists noticed changes in their body subjectivity in response to particular clients and how they used these dysmorphic responses to consider clients' body experiences and interpersonal dynamics.

My research question asked how the therapist's body as the analytic object may be worked with in practice, and in chapter six the concept of the 'good enough' body was used to describe ways the therapist can welcome and recognise clients' body subjectivity. Examples included developing body reflexivity, exploration of body references, toleration of dysmorphic responses, and attunement to bodily cues. The question of whether bodily healing could come through the therapeutic relationship was also asked and it was suggested that in a containing, intersubjective relationship with the therapist's body, clients can incorporate new bodily experiences, develop subjectivity, and improve bodily distress.

This review looked predominantly at female theorists, many of whom identify as feminist and work in eating disorders. Feminist theory is interested in how the social environment influences human development and in chapter four it was suggested that cultural values are transmitted through the mother and come to influence the infant's subjective body development. The question of how the body-objectifying messages of consumer culture impact the therapeutic relationship was raised and in chapters five and six I discussed how cultural norms and values infiltrate the intersubjective relationship and influence how therapist and client relate. As cultural messages perpetuate body insecurity in therapist and client alike, it was suggested that the manner in which the therapist manages the pressure to judge and objectify bodies can impact how clients come to process their body experiences.

Overall exploring perspectives on the therapist's body as the analytic object has proved to be an interesting and complex topic. There is much scope for further research to be done and there is also much space in the literature to hear from therapists about how they work with their body when it becomes meaningful to the therapeutic encounter.

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## **Appendix A**

### **Keywords**

embodi\*, psychoanaly\*, psychodynamic, psychotherap\*, “client’s body”, “patient’s body”, “analysand’s body”, “\*therapist’s body”, “\*analyst’s body”, intersubjectiv\*, intercorporeal\*, “body attach\*”, “body form”, “body image”, “therapeutic relationship”

## Appendix B

### Search Terms

Table 2.

Search Terms Used in Database Searches.

Search term	
1	embod* OR body OR intercorporeal* OR intersubjectiv* OR "body attachment" OR "body form" OR "body image"
2	"therapeutic relationship" OR "intersubjectiv* relationship"
3	psychoanaly* OR psychotherapy* OR psychodynamic*
4	(embod* N5/adj5 analyst) OR ("body image" N5/adj5 analyst)
5	"therapist's body" OR "analyst's body"
6	"client's body" OR "patient's body" OR "analysand's body"
7	embod*
8	"therapeutic relationship"
9	psychoanaly* OR psychodynamic

## Appendix C

### Database Searches

Table 3.

Results of Database Searches Undertaken May-July 2014.

Search terms <sup>2</sup>	OVID PsycINFO	EBSCO Psychology and Behavioral Sciences Collection	Psychoanalytic Electronic Publishing (PEP)	Relevance
1	30000+	30000+	30000+	Not relevant
2	10000	1000	6000	Not relevant
3	202000	37000	81000	Not relevant
1 AND 2 AND 3	2000	400	Unable to search 3 fields	Not relevant
1 AND 2			6800	Not relevant
4	16	11	Unable to do proximity searches	Not relevant
5	52	5	204	More relevant
5 AND 6	2	3	25	Not relevant
7 AND 8 AND 9	50	2	Unable to search 3 fields	More relevant
7 AND 8	67	12	769	More relevant
7 AND 9	945	124		More relevant

<sup>2</sup> Taken from Table 2

