BODY, MOVEMENT AND DANCE IN PSYCHOTHERAPY, 2016
http://dx.doi.org/10.1080/17432979.2016.1177796

Routledge
Taylor & Francis Group

Demonized body, demonized feelings: languaging the affective body

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ABSTRACT
As body/movement psychotherapists, we have numerous theories, techniques and skills for bringing the body into the therapeutic treatment. Drawing on a phenomenological perspective in which the client's subjective experience holds primacy, this paper explores the transition from the client's sublinguistic world of dynamic somatic/motoric experience to verbal, abstract language. The author proposes that the most therapeutically effective transition requires attention to the client's affectivity from an experience-near point of view. Using a case study to illustrate, the author suggests that understanding and incorporating vitality affects in the experience-near therapeutic interaction offers a viable solution to transitioning from body to language.

ARTICLE HISTORY Received 8 February 2016; Accepted 20 March 2016

KEYWORDS Experience-near; sublinguistic; vitality affect; reverie

Introduction

We all have clients who find it hard to talk about feelings. We have clients whose feelings are trapped in bodily symptoms, frozen postures, stereotypical gestures or painful muscle tension. We have clients who say 'I'm fine', or 'I'm a bit anxious', but can't articulate the sensations behind the words. And we have clients whose trauma, originating in very early, relational worlds, has locked up feelings that are now only accessible as bodily forms of memory. This silent but embodied world of trauma has been noted by many researchers and body psychotherapists (Herman, 1992; Ogden & Fisher, 2014; Rothschild, 2000; Siegel, 2001; Van der Kolk, 2014).

As psychotherapists, we can struggle to bring the body completely into the session room. We are able to find words for emotions in ourselves, our clients or within the dyad. The issue is that our words may be problematically experience-distant to our clients' body-self. Our words speak a different language.

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Greenspan (1999) and others (Lecours & Bouchard, 1997) recognised that the affect takes on multiple forms of representation in addition to words. Presymbolically, affect can be expressed somatically, motorically and imagistically (Landale, 2002; Panksepp, 1998; Tomkins, 1962, 1963, 1991, 1992). While the verbally expressed abstract and metaphoric representations are psychotherapy's sacred ground, early preverbal developmental trauma means that feelings now manifest as distressing somatoform disorders or are patterned into procedural ways of being with others. These are difficult to access verbally.

The experience-near concept

What might an experience-near, sublinguistic representation of emotion look or sound like? Greenspan offers ideas regarding the words that might be used when someone is experiencing a feeling at a somatic, motoric or symbolic level (1999, p. 230). These communications can nonetheless feel 'experience-distant' (Kohut, 1959; p.396) to the client. In other words, they do not fully capture the immediacy of what the body is feeling. My psychoanalytical orientation is based on the postulates of Self Psychology (Kohut, 1971, 1984; Lee, Rountree, & McMahon, 2009), while my body psychotherapy work is grounded in the somatic/motoric trainings of Laban Movement Analysis (LMA) (Bartenieff & Lewis, 1980), Bodymind Centring (Cohen, 2012) and dance movement therapy. In all these theories, I have found that remaining experience-near is critical when working therapeutically.

Nonetheless, clinically, I have struggled to find words to describe what is happening in the session. Sometimes words, well *English words* as we know them, are inadequate. Intuitively, this makes sense. An adult vocabulary does not communicate to an infant or young child. Sounds, onomatopoetic noises, tones, do (Meares, 2005). In order to communicate my understanding, I have said to a client 'so you feeling kinda ZIGGLY inside?' or 'it's BLURBLING over inside right now?' 'Ziggly' and 'blurbling' are of course nonsense words in normal daily usage, yet they can speak directly to a client's inner experience. The power of such an empathic experience for the client is that deeper feelings and memories are possibly unlocked, furthering the therapeutic process (Lee et al., 2009).

The term *experience-near* was popularised by Heinz Kohut (1982, p. 396) in the development of the psychoanalytic methodology of Self Psychology. The concept of experience-near characterises a clinical stance in which data about a client are collected via a vicariously introspective examination and reflected back to the client in order to co-construct a personal and individualised explanatory theory (or narrative). Experience-distant theorizing involves greater generalisations, such as one encounters in meta-psychologies (such as Object Relations, Jungian Analysis, etc.), psychological techniques (such as Cognitive Behavioural Therapy, Acceptance and Commitment Therapy, etc.) and metaphysical constructs (such as Ego, Id, Object, etc.). As therapists we aim to stay as close to our

client's experience as possible because such understanding increases awareness of feelings, brings memories to the surface and allows further amplification and exploration. The case of Eve is offered to illustrate the empathically attuned process of working experience-near with body-communicated affect.

The case of Eve

Eve was referred to me by an interstate group specialising in using meditation for chronic illness. Stymied in their attempts to help her, they referred her on, suggesting she was not trying to help herself. Eve presented as a gentle, thoughtful woman in her 50s, and spoke in a flat, expressionless manner. She said little, but it was clear she was distressed.

Chronically ill for many years, with medically unexplained symptoms, Eve had been prescribed an ever-increasing cocktail of medications that treated depression, anxiety, multiple sclerosis, insomnia, menopause, stress, pain, indigestion and cold sores. The medical profession seemed unable to understand her body, so they pushed medications on her to silence her symptoms. Six months prior to our first session, deeply distressed at being overmedicated Eve tried to withdraw from many of the medications on her own! I met an exhausted, frightened woman who described feeling trapped in what she referred to as 'weird sensations', some of which might be withdrawal-related. Outwardly agreeable, Eve gave a sense of a weakened, and ebbing internal vitality.

Eve had little to say and expressed uncertainty as to my interest in her. She preferred to ask me a question, 'how will you work with me?' I began saying 'my hope is to do my best to understand your feelings and experiences…' At the word 'feelings' Eve interrupted, and warding me off as if I were a vampire, said 'No. Not feelings. Feelings are dangerous'.

Eve wanted to focus only on her physical issues, and how her life had been taken over by unbearable and unbelievable internal physiological sensations, including wringing, pulling, twisting and prickling, comingled disturbingly with numbness. The sensations were incessant and holding them at bay caused extreme exhaustion. Eve had stopped telling doctors about her sensations because the response was usually invalidation or over-medication. She stopped telling family or friends about her discomfort because their faces betrayed judgements that such sensations were *not nice*. This aligned with her deeper suspicion that she was alien and bad. Recently, Eve had totally lost her voice when the meditation group said she was overly dramatic and 'acting out'. In my office Eve crumpled and sighed loudly, wondering why she was such a mess.

Sadly, our clients have also learned to be experience-distant to their own body self, or to develop a bodymind languaging split (Shapiro, 2003). For example, when we need a medical professional, we are required to use a language that speaks to them, not to the experience of our body. Chronic pain clients experience this acutely – 'I have pain here and here; it is sharp, burning,

stabbing...' They are required to provide specific locations of pain and understandable descriptions of expectable pain sensations. But what if the location of the pain is diffuse, or worse yet, in an odd place? What if the sensation is not a typical pain, but nonetheless disturbing and uncomfortable sensation? When Eve described to her doctor or previous therapists that her 'cheek felt dragged down into my neck and choking me', her language was too foreign to them. They could not see any signs of palsy from their objective outside position, so it was deigned that Eve's hysterical mind was causing the problem. For many of our clients, the observable, the expectable, the typical and understandable, are the required language when they speak about their body, no matter how it misrepresents the actual experience. The experience of feeling becomes alien, dangerous or demonized as crazy.

Meanwhile, I watched Eve sit primly on my couch and then segue to squirming and wriggling. She would shift her position and rearrange pillows every few minutes. Her world appeared to offer no comfort. Then to my surprise, Eve toppled onto her side and lay there, unable to sit up any longer.

Although Eve had eschewed exploration of emotional content, I wondered if this simple motoric sequence contained emotional themes she was trying to communicate (Greenspan, 1999). Entering Eve's world at the motoric level, I replayed her movement sequence in my bodymind. I felt the constant readjustments of disjointed body parts, abrupt shifts and jerky muscular contractions. My imagination associated to the unsettled discomfort of an infant whose basic needs, such as nappy change or feeding, had been unnoticed or forgotten, or worse, or neglected. I replayed Eve's tumbling onto her side. I felt a sense of giving up. Finally, as I tried on her side lying, I sensed her words ('I am exhausted') and her body were at odds with one another. In my physical replay of Eve, I did not feel settled. I wondered if Eve needed permission to rest.

As with all attempts to understand a client, I held these ideas lightly (Kohut, 1984; Orange, 2003) and watched what happened next. This approach is also key to working in an experience-near way. Generalizations, whether from metapsychologies or my own interpretations, are distant to the client in that they are mine, not necessarily hers. Heidegger (1962) noted that any interpretation that makes something implicit explicit can only be from the standpoint of the interpreter's perspective (Heidegger, 1962; cited in Orange, 2011, p.195).

In subsequent sessions, I experienced another nonverbal quality – Eve faded away. I felt a gradual dimming of vitality, and when it happened I faced a zombie-like, wide-eyed, but empty stare and a tense, non-breathing rigidity. This occurred regularly during our first year, and at those times the room would become devoid of energy. Attempting to verbally explore this experience with Eve yielded limited response. Eve had significant verbal capacities, just not about sensations and feelings.

With Eve, it seemed that several levels of communication were occurring. While we talked about inconsequential things, like cats or cricket, odd

and abrupt shifts in Eve's physical vitality played out and would grab my somatic-movement-affective attention. Rhythmic variations in her use of time, such as her abrupt level changes, or the disjointed squirming, ignited my curiosity about Eve's experience of the on-goingness of time in her childhood. Additionally, Eve's energetic ebbing and flowing, or fading in and out created an unpredictable rhythmical question. The fading had a wispy ghostliness, which took on form and then evaporated. One session, when I asked her about her experience of this, she stated matter-of-factly that she often became *zombie-fied*.

The discontinuousness of her presence was interesting in that it wasn't exactly like dissociation, and yet it was. Musing on her attachment experiences, I wondered about the physical and emotional availability of her childhood caretakers. Were they there only fleetingly? Did they waft in and out of her young life, leaving her without a reflection and little sense of presence much of the time? Had she been invisible to them? Did she need to be invisible for them? Eve told me she had no memory of events before the age of 20.

These energetic discontinuities triggered my therapeutic instinct to find greater continuity between us. I suggested increasing session frequency. Eve would only agree to twice weekly, saying she felt most comfortable communicating at a distance, such as with emails. I agreed to accept emails and texts between sessions. Eve's between-session emails offered me emotional information. Listening within and between the words, I could hear despair and hopelessness. Ever so occasionally, I received an extended shout of 'HEEEELLLLPPPP' or howls of pain ('OWWWW') in written form. I imagined hearing an unattended infant screaming for a response.

One email said in small font, 'why should I bother?' These four simple words staring at me on the screen evoked a sense of limp, lifeless and internal collapse. I wanted her to know I saw her, felt her, heard her… but I had to do it via email. I typed back immediately pounding out bold capitals 'BECAUSE YOU MATTER'. More than just the words, the vitality of our email exchanges became essential. Later in the therapy I learned that my concrete, forceful reply had struck Eve as a profound response.

Other than the emotional subtexts' of the emails, Eve made it clear we were not to speak about feelings, family history or anything icky, so we often just sat in the room together. I was keen to understand her but really only had her non-verbal offerings as data. Extending Stolorow's (2007) work on emotional trauma, which he defines as 'unbearable emotional pain that cannot find a relational home', Cates (2014, p.37) discusses *insidious emotional trauma* which she describes as 'repetitive demonization of emotionality over the course of development whereby feelings are eviscerated, leaving in their wake disembodied cognition'. Not only are feelings demonized but so is self-awareness about emotional pain. The danger of having feelings extends beyond the concern of how the feeling states will be received to the dread of annihilation if affect emerges at all. Cates' patients describe this annihilation as 'sinking into a void' (2014,

p. 39). Interestingly, Eve often mentioned dreams of falling into deep crevasses in the earth and never hitting the bottom, or slipping between lily pads into murky bottomless ponds.

Capturing the nonverbal interaction

When demonisation prevents feelings from being expressed, only the body is left to speak out. I wondered how a verbal expression of feelings could be made safe for Eve. Co-creating language for Eve's bodily affect could assist a sense of safety because her trauma could find a 'relational home' (Stolorow, 2007; cited in Cates, 2014, p. 37). However, paradoxically, languaging affect could also be an annihilating process (Cates, 2014). Both Eve and I wanted to understand her painful somatic sensations, insatiable exhaustion and floaty dissociative trances but any verbal explorations terrified her.

Like many psychotherapists, I faced the question of transforming nonverbal affective experience into relational linguistic meaning. Bion (1962, p. 37) introduced the word 'reverie' (from the French, meaning dreaming or daydreaming) into the psychoanalytic lexicon. More specifically, he was interested in a form of reverie which seems similar to a somatic self-object function (Lauffenburger, 2014). Because an infant does not have access to mental functions mature enough to integrate the bodily feelings resulting from early sensory and relational experiences, an important function of a mother's psyche is to reshape, detoxify and transform the infant's archaic sensations and reflect them back to the infant (Bion, 1962). Bion felt mothers needed a 'capacity for 'maternal reverie' (1962, p. 309). Schore (2001) viewed a mother's role similarly, only describing the process in terms of attachment, right brain development and affect regulation.

A later theorist, Ogden (1997) saw reverie as a parallel dreaming process occurring intersubjectively between and privately within client and therapist. Ogden describes using his own body sensations and somatic awareness to capture primitive qualities occurring within the relationship. His reveries are viewed not as glimpses into the client's unconscious but as metaphorical expressions of what the unconscious experience might be like, and seems quite similar to 'vicarious introspection' (Kohut, 1959, p. 459).

Nebbiosi and Federici-Nebbiosi (2008) discuss rhythm as a relational element aiding the co-creation of meaning, which seemed more germane to my experience. Rhythm emerges in the way we breathe, walk, talk, work, as well as in the way we relate to our environment and others. To give form to this rhythm, the Nebbiosis' teach a process of miming one's client, recognising that 'knowledge resides within the analyst's body of which he is completely unaware' (2008, p. 224). In dance movement psychotherapy this type of mirroring, which 'involves literally embodying the exact shape, form, movement qualities and feeling tone of a person's actions' (Tortora, 2006, p. 259) is only a part of the overall

therapeutic process in which the DMP's first step is to 'match' (through attunement and nuanced mirroring) with the client's nonverbal cues (Tortora, 2006).

The dynamic on-goingness of vitality affects (Stern, 1985, 2010) provided an experience-near theory for my wordless dynamic, rhythmic observations of Eve. Observing infant–mother dyads and adult therapeutic relationships, Stern noted ever-fluctuating, energetic intensities, temporal-spatial rhythms and fluid qualities that occur unceasingly, and called them 'vitality affects' (Stern, 1985, 2010, p. 41). Stern proposed that these rhythms were the basic enlivenment that permeated our humanness, and hypothesised them as essentially proto-affects. Although I chose not to mime Eve during our sessions, I ran and reran my internal replays of Eve's body level rhythmic phrasing outside of the session. Using my LMA training, I could identify the invariants of experience (force, space, time, flow) (Bartenieff & Lewis, 1980, p. 51 noted by Stern (1985)) in Eve's body communications.

Unable to create an operational definition for vitality affects, Stern offered examples of his observations. He suggested words such as "exploding", "surging", "bounding", "halting", and many other adjectives, adverbs and gerands (Stern, 2010, p. 7). One can feel the dynamic qualities of such words. *Exploding* evokes a sudden, powerful and outwardly directed energy. *Surging* suggests a force that is increasing in strength through time. *Bounding* has a repetitive, light and upward pull after a forceful downward push. *Halting* gives a sense of sudden deceleration with increasing tension. Stern recognised human emotional interactions as combinations of the basic physical invariants of time, force, spatial direction and flow (1985, 2010). Without this embodied proprioceptive information, we lose the sense of our self. Resonance obtained through our mirror neurones (Gallese, Morris, & Migone, 2007), gives us a sense of the other. Time, space, force and flow are the ground of our own sense of self as well as our sense of others.

Applying vitality affects theory

Literally moved by Stern's ideas, as I physically replayed Eve's dynamic sequences, I also searched for dynamic words such as those used by Stern. The rhythmic phrase of *squirming-wriggling-shifting-collapsing* emerged. Attuning to this phrase motorically, developmentally and relationally, I imagined a struggle (squirming), an attempt at action (wriggling-shifting), then followed by surrender or capitulation (collapsing). Her abrupt change in force from a struggling strength to weakly collapsing led me to wonder about Eve's sense of agency. I imagined a child fighting for something, or to engage another, but ultimately giving up in hopelessness. Eve had told me that in her adult work life as a lawyer, she would multi-task feverishly, battle untiringly for her clients, only later to collapse in chronic fatigue or pain. The lifelong persistence of archaic, traumatic sensorimotor patterns have been noted by many authors (Cates, 2014;

Ogden & Fisher, 2014; Rothschild, 2000; Stolorow, 2010), and now they were dynamically alive to me.

As sessions continued, Eve's collapses became more disconcerting. She would disappear into a state of non-being, which is noted by Atwood as a type of 'psychotic or almost catatonic attempt to hold one's remaining vitality at a safe depth in order to protect it from abuse, neglect and pain' (Atwood, 1983, p. 59). I pondered Eve's comments that sometimes she was on remote control, like a robot. A quote from Sheets-Johnstone (1999) came to mind:

> Robots… are remote control puppets to which signals are sent; they are not moved to move, but programmed to move. Zombies are even more remote, mere intellectual figments plumped with sound and fury but signifying nothing pertinent to animate life… the hard problem is to forego thought experiments and listen assiduously to our bodies… the hard problem is to give animate form and the qualitative character of life their due (p.275).

Sheets-Johnstone reminds the therapist to tune into their own vitality in order to assist a client. So with my own somatic vitality streaming in the background, I would listen to Eve. And when, like oxygen being sucked out of the room, I would feel my energy drain while she spoke, I would enquire into her experience. She would say she was being invisible 'like a piece of fluff'. I imagined a weightless entity that made no impact on anyone, only to be blown around by the wind, and easily overlooked. The image echoed Atwood's 'non-beingness' (1983, p. 40) and I wondered if invisibility offered her young self-safety. Eve would say she remembered nothing, except that Fluff was her family's nickname for her. Nonetheless, her dynamic body was telling the story.

A narrative-free, affect-avoiding therapeutic process proceeded with Eve's bothersome somatic symptoms holding the story of her core affective experience. In infancy our core affective experiences encode nonverbally, and when they are not met by the responses of an emotionally attuned caregiver who gives us physical and verbal understanding, they remain embodied (Cates, 2011). In her fluffy nothingness, Eve's affective experiences had no words, but we learned to sense them. Subtle shifts in her voice quality became obvious. Mostly her tone was flat and measured, but occasionally her voice crackled. Eve called it 'squawking', and it occurred when she didn't feel believed, or that she was wrong or bad.

When words are not available due to the danger-inducing insidious trauma, our main tool is the kinaesthesia conversation or a 'kinaesthetic process of mutual engagement…a body to body [form of] reverberation' (Cates, 2014, p. 36) which is similar to 'interaffectivity' (Stern, 1985, p 132–33) where a deeply felt, somatically represented affect is perceived and returned in an ongoing bidirectional exchange. Our kinaesthetic conversation occurred between the silent reverie of my listening/attuning body and Eve's dynamic phrases of vitality affects. Eventually Eve's squirming-wriggling-shifting diminished, allowing me to imagine that I might be offering sufficient soothing and comforting within our intercorporeal exchanges.

Holding the affective body

As Eve began to access her voice, she was able to say she wanted to lie down voluntarily rather than topple over, but doing so brought a new danger. Her weird facial sensations immediately increased, with her right cheek going cold, then wavy, then undulating, as if watery currents were flowing inside her. She became scared and distressed. I softly reminded her that I was with her, and she could sit up at any time. She continued lying down.

Hoping to understand the rhythmic fluidity she described, I entered my own fluid-space of reverie and suggested she describe to me what was happening. Eve listened to her wavy cheek, but almost immediately her eyes popped open. She gasped. I wondered if, with her eyes closed, she felt she had disappeared. I didn't ask, but murmured rhythmically and repetitively, as if singing a lullaby, 'I am right here. I am here right now. I am here with you. We are still here'. Eve tried closing her eyes, but each time they popped open to stare at me. I continued my lullaby, while Eve continued the rhythmic opening and closing of her eyes.

Arriving for the next session with more energy than usual, Eve reported that 'last time had been a difficult but interesting experience'. And then she faded away, though she was able to say she wanted to lie down. Once again the wavy undulating sensations in her cheeks and lips returned. Keeping her eyes closed for longer periods, she reported her sensations. Quietly, she slipped into sleep for 20 min. After her nap, Eve excitedly told me her experience. Her cheeks and mouth had been 'blooming!' Using her hand, Eve showed me the sensation, rhythmically opening and closing her fingers and thumb. The sucking and releasing rhythm was reminiscent of an infant's rooting and sucking reflexes. Blooming became a symbol of her emerging vitality! The zombie was breathing, suckling, life was returning.

A new rhythm emerged in our sessions; Eve would talk a bit and then lie down and sleep. I would drop into myself, breathe fully and enjoy our sense of mutual content. The concept of intercorporeity (Merleau-Ponty, 1964), a bodily form of intersubjectivity defined as 'an intersecting relationship wherein my body and the body of the other are both instances of the same corporeal process that runs through the sentient world' (p. 168) became the essence of the therapy. Eve and I met and communicated in our silent physicality. As analysts, we must remember that 'although we are intrigued with our analysand's *discussion* of subjective experience, we should not forget bodily experience, as it is a continuous research tool for probing ourselves in the same instant as we deal with our client's subjective experience'. (Pacifici, 2008, p. 112; my emphasis). As Eve slept, I would specifically monitor my internal fluidity/fluid system (Cohen, 2012). I focused my somatic attention on my fluid system because fluids according to Cohen they 'underlie presence and transformation and play a major role in the counterbalancing of tension and relaxation, rest and action' (Cohen, 2012,

p. 67). Additionally, our body fluids support, bathe and nourish every cell of our being. I wanted to offer Eve that wholeness.

I pondered what might have threatened Eve so fiercely to cause a retreat into a lifeless shell, leaving only reactive somatic expressivity. Early in our work together, Eve mentioned she might have been sexually abused, but did not want to know. She said previous therapists had tried to explore this with her, and she would flee the therapy. Pacifici makes another important point in working with the body: 'all too often translating the body's language into words can fragment and undermine a significant and rich process' (2008, p. 109). Previous therapeutic attempts to explore trauma had fragmented Eve. The rush to put a narrative interpretation on sublinguistic experiences occurred too quickly, was un-attuned, and essentially experience-distant to be of therapeutic value.

Instead, I offered my solid and available corporeality. Silently, I shared a basic soothing and calming presence that held her squirming discomfort securely. Like a mother playing with her baby's toes, 'this little piggie goes to market, etc'. I delighted in her physicality, so that she didn't have to disappear. And I offered emotional connection, supplying an atmosphere in which she might re-access her own vitality. Through our resonating physicality, I hoped to offer Eve safety where more of her inner world could emerge.

Connecting the verbal and nonverbal

I agree with Stolorow (2007) that one's sense of being comes about with the integration of bodily affect and language. The world in which we live and work demands words, and often does not realise the importance of the sublinguistic. But body movement patterns have few words, particularly if they are encoded prior to the development of symbolic thought and language. For Eve, and others, the premature leap to the words of experience-distant has disrupted the therapeutic processes.

The vitality affect concept (Stern, 1985, 2010) offers a vehicle for experience-near transformation of sensorimotor experience into words. Eve had warned me not to discuss emotions as she knew them i.e. using words like *fear, anger, sadness*, etc. but to focus instead on her physical sensations. By embracing sensory-action-filled words such *fading, fluffing, wringing, pulling, twisting, undulating, waviness* and *blooming*, which are vitality affects, Eve felt understood, and the therapy was able to proceed effectively.

Stern argues that psychoanalysis believes exploring deeper meaning of the psychodynamic narrative is critical to cure, whereas in truth, attending to the micro-physical experiences available and understanding them as vitality affects actually provides the terrain from which abstractions and generalisations can be given form. He says about vitality affects, that they are

> NOT emotions…not motivational states…not pure perceptions…not direct cognitions… not acts, as they have no goal state and no specific means. They fall in

> between all the cracks. They are the felt experience of force - in movement - with a temporal contour, and a sense of aliveness, of going somewhere. They do not belong to any particular content. They are more form than content. They concern the 'how', the manner, and the style, not the 'what' or the 'why'. Regardless of the content, this Gestalt of vitality has its own flow pattern. It constitutes a separate kind of experience. *I argue that dynamic forms of vitality are the most fundamental of all felt experience when dealing with other humans in motion* (2010, p. 8).

In the first few years of therapy, sessions with Eve may have looked to an outside observer as something akin to a mother and child inventing their own special language. And in many ways, it was. Honouring her sensorimotor communications, and languaging them in an experience-near manner, allowed Eve and I to ultimately create more socially normal descriptions of her feelings. And it allowed us to navigate the dangerous emotional minefield created by insidious trauma that made feelings dangerous and demonized.

Two years on, Eve was able to ponder her sense that neither mum nor dad had ever been interested in her. As she did, I sensed incipient anger emerging. Even then, we did not name it as anger, but discussed it as 'a clenching pulsing fist inside her' and how her energy was 'going all jagged'. Even as we worked sensitively with this languaging, in the next session Eve reported that, on leaving the session, she felt like she was 'unravelling'. The following morning she said that she had a sense of 'dropping into the darkness' and 'falling through the cracks to nothingness'. Viscerally, she recalled the feeling of me sitting and singing to her, and slipped this feeling over herself like a 'comfortable onesie'. Holding onto the physical feeling of that 'onesie-ness', she forestalled the unravelling.

It might be said that in the therapy the vitality affects verbally and metaphorically reflected Eve's feelings to her. I believe it was different from that. I contend that my willingness to stay somatically and motorically close to Eve using my own body sensations, allowed our 'nonsense' (vitality affects) words to gain meaning. I believe that letting go of my need to create a narrative allowed Eve to find hers, and staying with the somatic-motoric communications, she found a way to move from her lonely, isolated, invisible and wordless place. I add my concern that Eve's pain may have been far less if previous therapists and medics had allowed her sensorimotor descriptions to have validity and be met with interest and curiosity. Staying experience-near to the body and allowing language to develop from it is key to working with some presentations of childhood developmental trauma (Van Der Kolk, 2007) and chronic illness.

Summary

There is always more intricacy and complexity to any psychotherapy, however the intent of this paper was to offer an insight into working with, and languaging, the sublinguistic communications which form significant parts of many therapies. Additionally, although vicarious introspection and empathic

attunement are familiar concepts in body psychotherapy, this paper intended to provide specific examples of working experience-near (Kohut, 1959) to support the communications of the body.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Sandra Kay Lauffenburger maintains a clinical practice in Self Psychologically-based psychotherapy in Canberra, Australia. She incorporates her long expertise in somatics and movement, which has allowed her to work effectively with presentations such as medically unexplained symptoms (MUS), chronic illnesses, PTSD, complex trauma, personality disorders and borderline presentations. Sandra lectures at graduate and tertiary levels in Movement and Somatic Psychotherapy. Most recently she developed and presented a semester course titled "Using Somatics and Movement in Counselling" for the University of Canberra, Faculty of Health. Sandra is an Associate Editor of the Journal for Body, Movement and Dance in Psychotherapy. She offers face to face and skype supervision for practitioners who want to include the dynamic body in their therapeutic practice.

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