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Joanna Wiederhorn
Shifting Paradigms: The
Embodied Intersubjective
Matrix

ABSTRACT

This theoretical thesis traces two paradigmatic shifts currently transforming psychodynamic theory and practice: the shift from a one-person to a two-person psychology and the shift from conscious cognition to unconscious embodied affect. These two shifts support a phenomenological understanding of the clinical encounter as inherently intersubjective and embodied. The concept of embodied intersubjectivity is explored by weaving together relevant literature from the fields of relational psychoanalysis, interpersonal neurobiology, contemporary developmental psychology, and body psychotherapy. The view is offered that, for some clients more than others, developing a deeper connection with one's embodied sense of self, and having that experience recognized in a somatic third space by another embodied subject, is one factor that may contribute to client change. By resonating in a state of embodied recognition both client and therapist come into contact with a felt sense of true self-experience.

SHIFTING PARADIGMS: THE EMBODIED INTERSUBJECTIVE MATRIX

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

“People say that what we’re all seeking is a meaning for life. I don’t think that’s what we’re really seeking. I think that what we’re seeking is an experience of being alive, so that our life experiences on the purely physical plane will have resonances with our own innermost being and reality, so that we actually feel the rapture of being alive.”

– Joseph Campbell (1991, p. 1)

Two paradigmatic and interrelated shifts in psychotherapy have unfolded over the last few decades. The first shift is from a one-person to a two-person psychology. This shift highlights the intersubjective context of human development and clinical work. The second shift is from a focus on cognition towards a focus on affect; embodied emotion. This theoretical study seeks to explore how the intersection of these two shifts is currently transforming clinical theory and practice. Both of these shifts have to do with a move away from the Cartesian mind, isolated from other minds and split from the body, and toward a conceptualization of an intersubjective bodymind. The clinical encounter can now be contextualized as taking place within an embodied intersubjective matrix: the space within which two bodyminds interact through non-verbal, implicit, bodily-based, affective communication. The process that facilitates change in psychotherapy is increasingly being understood as intrinsically intersubjective and embodied.

How This Study Came to Be

This past fall I came across the work of the psychoanalyst Emmanuel Ghent (1989, 1990) and was deeply stirred by his writings. In his seminar at the Postdoctoral Program in

Psychotherapy and Psychoanalysis at New York University, Ghent assigned analytic candidates the task of writing down as much as they knew about the theoretical beliefs that guided their practice, repeating the exercise at the end of the course. Ghent (1989) titled his own attempt at such a daunting task: *Credo – The Dialectics of One-Person and Two-Person Psychologies*. In explaining his use of the term “credo” Ghent suggests that belief plays a central role in the field of psychotherapy where “hard facts are hard to come by” and where “every analyst theorizes, indeed thinks and practices on the basis of a belief system or credo” (p. 169). Other psychoanalysts including Benjamin (2005), Bromberg (2012), and Lichtenberg (2014) among others, took Ghent’s credo, his expression of his personal belief system, as an invitation to write their own. Reading these papers led me to think about what theoretical beliefs guide my clinical practice as I embark on a professional path as a clinical social worker. I found myself returning again and again to the same questions: What do *I believe* is transformative about psychotherapy? What do *I believe* brings about change in the client - *and* the therapist?

As I mulled over the aforementioned questions I thought about my own experience as a client in psychodynamic psychotherapy. Perhaps this is because, at this point in my career, I have spent more time “on the couch” as opposed to “in the chair.” However, I believe that even seasoned therapists’ belief systems are not only formed through education and practice but are also highly influenced by their personal experiences as clients. Over the course of my personal experience as a client in psychotherapy, I have noticed a distinct difference between cognitively understanding a specific insight and feeling it to be true in my body. I have had “aha” moments in which, through the process of meaning-making, I have gained insight and/or developed greater acceptance of previously unconscious thoughts or feelings. I have found, however, that although meaning-making, or intellectual insight, helps to develop deeper self-awareness, it does not

always lead to significant changes in how I feel or how I function. In other words, insight alone is not enough. When meaning-making is paired with a bodily-based felt sense, a *knowing in my bones* - and when both these experiences are shared with my therapist in a co-created relationship - it is then that I perceive an organic change in how I feel and how I function. My desire to better understand this experience in my own therapy led me down the ensuing path of research and study.

Mitchell and Black (1995) conclude their book, *Freud And Beyond: A History of Modern Psychoanalytic Thought* with the following sentence: “Clinical psychoanalysis is most fundamentally about people and their difficulties in living, about a relationship that is committed to deeper self-understanding, a richer sense of personal meaning, and a greater degree of freedom” (p. 253). I believe that when deeper self-understanding, a richer sense of personal meaning, and a greater degree of freedom are developed, both through symbolic language and embodied experience, and both within the self and in relationship with another, what we gain is the ability to more deeply feel, as Campbell articulates in the opening quote of this chapter, “the rapture of being alive.” In other words, we engage in a therapeutic relationship dedicated to a deeper more meaningful experience of self, on both a symbolic and embodied level, with the hope of coming into contact with a more enlivened state of being.

The Shifting Paradigm of Clinical Context

In his plenary address at the American Psychological Association’s 2009 annual convention, Allen Schore described the field of psychology in the latter half of the 20th century as shifting from a behavioral paradigm to a cognitive paradigm, and most recently towards an emotional paradigm. According to Kuhn (1962), the nature of a paradigm shift is change that occurs across interdisciplinary fields of study. A. N. Schore (2009b) suggests that we are now in

the midst of a paradigm shift sparked by increased communication and interdisciplinary study across the fields of neurobiology, psychology, psychiatry, and biology. A. N. Schore (2012) describes a changing focus in theory and research “from left brain conscious cognition to right brain unconscious affect” (p. 3). It is a shift from the explicit, verbal, rational domain to the implicit, integrative, nonverbal, bodily-based emotional domain (A. N. Schore, 2009b).

Paralleling this shift from cognition to emotion, the field of relational psychoanalysis, influencing the broader field of psychodynamic psychotherapy, has undergone a shift from a one-person to a two-person psychology. No longer is the therapeutic process conceptualized as taking place within an individual or between a subject and an object, but rather between two subjectivities (Benjamin, 1990, p. 184). A. N. Schore (2012), in his discussion of the corresponding paradigm shift currently taking place in relational psychotherapy, cites Bromberg (2012):

Interpersonal and Relational writers largely have endorsed the idea that we are in fact confronted with a paradigm change and have conceptualized it as a transformation from a one-person to a two-person psychology. I feel that this formulation is accurate, and that three central clinical shifts are intrinsic to the conceptual shift: A shift from the primacy of content to the primacy of context, a shift from the primacy of cognition to the primacy of affect, and a shift away from (but not yet an abandonment of) the concept of “technique.” (p. 126)

Along with the paradigm shifts discussed above, influenced by research in the neurosciences, an interest in the body has re-emerged in psychodynamic discourse (see Aron, L. & Anderson, F.S., 1998; Anderson, F. S. 2008; Corrigan, J., Payne, H., & Wilkinson, H., 2006; Marks-Tarlow, 2012; Fogel, A., 2009 and others). What body psychotherapists have long

known, mainly that it is not only two minds interacting in the intersubjective matrix of clinical practice but also two bodies, is now being incorporated into mainstream psychodynamic theory and practice. A. N. Schore emphatically states: “psychotherapy involves changes not in the cognitions of the patient’s human mind/brain machine but in the affective embodied experiences of his or her brain/mind/body” (2012, p. 12). Somatic, embodied awareness is now becoming widely recognized as a valuable and under-explored tool in clinical practice.

Embodied Intersubjectivity

In this theoretical study I will explore the phenomenon of embodied intersubjectivity, which is abstruse in nature and difficult to grasp, by weaving together relevant literature from the fields of intersubjective relational theory, interpersonal neurobiology, contemporary developmental psychology, and body psychotherapy. Over the last two decades, research from developmental psychology and the neurosciences has redefined our understanding of the interconnectedness of body, mind, brain, and relationships. Much of this research is consonant with the intersubjective perspective of relational psychoanalysis.

The subject of this thesis is not the materialistic or physical body, but rather the intersubjective, experiential body. I will explore what Fogel (2009) refers to as *embodied self-awareness* and what Gendlin (1996) refers to as the *felt sense* - the capacity to feel or sense emotional meaning in the body (Wilberg, 2003). Further, I will examine how the felt sense is created and moves within and between two bodies in the intersubjective third space, and how this process contributes to healing in the therapeutic encounter. I will argue that *part* of what is transformative about psychotherapy is developing or increasing a felt sense of oneself, an embodied self-awareness, through the process of mutual recognition with another embodied being.

Relational psychoanalysis contends that in psychotherapy we learn to have a deeper relationship with ourselves through the process of being in relationship with another. I will take this perspective one step further and argue that part of what is transformative in psychotherapy is experiencing a deeper *embodied* relationship with ourselves through the process of being in relationship with another *embodied* being. I would like to emphasize that by no means am I suggesting that embodied experience is more significant than symbolic meaning-making: as opposed to being in competition with one another, these two therapeutic factors are complementary (BCSPG, 1998b, p. 904). Rather, I would like to suggest that, for some clients more than others, a deeper experience of embodied self-awareness, developed through the process of engaging in an embodied relationship with another, is one of many factors that may contribute to the transformative nature of psychotherapy.

A greater understanding of the nature of embodied intersubjectivity on the part of the therapist has the capacity to contribute to clinical practice in a number of significant ways. This theoretical study is primarily concerned with the following three. First, by tuning into her embodied felt sense of the present moment, a wealth of information lurking below the surface of verbal, analytic, explicit communication becomes available to the therapist. Equipped with this information she can better analyze and make sense of the client's experience. Second, working on an embodied intersubjective level creates a space within which the client has the opportunity to deepen his own felt bodily sense of self, an experience that can be healing in its own right. Third, the therapist's awareness of the embodied intersubjective space, moving both within and between client and therapist, allows the therapist to communicate with the client on a bodily-based level, thus introducing the possibility of shared affective regulation and the exchange of mutual embodied recognition.

Relevance to Clinical Social Work

An integrative, person-in-environment, biopsychosocial approach is the hallmark of clinical social work. At its core, clinical social work is a holistic practice in that it considers the whole person from an ecological perspective. Implicit in the biopsychosocial approach is the interconnectedness of body-mind-brain, the relational environment, and the socio/cultural environment within which the body-mind-brain develops and exists. Thus, the field of clinical social work is positioned to be at the forefront of the integration and application of research from a variety of fields that highlight the relevance of an embodied intersubjective approach in clinical practice.

According to the National Association of Social Work's (2005) Standards for Clinical Social Work in Social Work Practice, clinical social workers now constitute the largest population of mental health providers in the nation. Any clinical interaction between two or more people can be enhanced by a deeper awareness of how we relate on a bodily-based intersubjective level. Thus, the subject matter of this theoretical study is applicable on a wide scale across a variety of professional social work settings and a variety of therapeutic techniques.

Common factors research, based on meta-analytic studies, focuses on identifying the effective "common ingredients" shared by diverse psychotherapeutic orientations (Norcross & Grencavage, 1989). While supporting the efficacy of psychotherapy, common factors research has revealed that no one therapeutic technique or modality is significantly more effective than another. Researchers have concluded that it is the common factors that are responsible for producing client change (Norcross & Grencavage, 1989; Drisko, 2004, p. 84). Relationship factors have been identified as a significant common factor component contributing to client change, second only to client extratherapeutic factors (Drisko, 2004; Hubble, Duncan, & Miller,

2009; Tannen & Daniels, 2010). Relationship factors comprise therapist effects, including empathy, affective attunement, and mutual affirmation to name a few, as well as the therapeutic alliance – the co-created interpersonal space between client and clinician (Hubble, Duncan, & Miller, 2009). The subject matter of this theoretical study, the embodied intersubjective context of clinical practice, can be conceived of as existing beneath the umbrella of relationship factors within the common factors framework. The therapist’s ability to tune into the embodied intersubjective field of communication is one small aspect of therapist effect. Understanding the clinical encounter as an embodied intersubjective process is a way of further contextualizing the therapeutic alliance across a diverse range of psychotherapy modalities.

Structural Overview of the Thesis

As stated above, this theoretical study explores the intersection of two paradigmatic shifts in clinical theory and practice: a shift toward an intersubjective context and a shift toward bodily-based affect. In accordance with the theoretical thesis format, I use relational psychoanalytic theory and interpersonal neurobiology as the two main theoretical lenses through which I will explore the phenomenon of embodied intersubjectivity.

In the following chapter I provide a brief intersubjective phenomenological frame to give the reader a sense of the philosophical theories underpinning the ideas presented in this paper. I then provide an introduction to the relevant fields from which embodied intersubjectivity is currently developing. As I have not devoted an entire chapter to body psychotherapy, I offer somewhat more detailed background related to this field. Chapter II concludes with definitions of relevant concepts and terms.

In chapter III, I turn to relational psychoanalysis: a historical overview of the development of relational theory will be followed by an in-depth exploration of the

intersubjective context of clinical work. In chapter IV, I explore how research and theory from the field of interpersonal neurobiology supports an embodied intersubjective understanding of the clinical context. In both chapters III and IV, I refer to contemporary developmental psychology and infant research, as both relational psychoanalysis and interpersonal neurobiology incorporate research from these fields into their theories. Throughout this paper, I weave literature and terminology from the field of body psychotherapy with that of relational psychoanalysis and interpersonal neurobiology to illuminate the phenomenon of embodied intersubjectivity. In the discussion chapter, I integrate findings from the preceding chapters and argue that gaining a deeper experiential awareness of one's embodied sense of self, through the process of being in relationship with another embodied being, is *one* of the transformative aspects of psychotherapy.

CHAPTER II

Framework and Conceptualization

“Those who are aware of themselves as centered ‘inside’ an insulated container...are captured by an illusion generated by the mechanisms of ego-protection, as well as by spatial models inherited from a classical science which is now outmoded.”

- Deborah Hay (2000, p. 13)

An Intersubjective Phenomenological Frame

Descartes famously argued in the seventeenth century that a sense of self develops out of cognition: *I think, therefore I am*. In one fell swoop, Descartes introduced a fundamental split: the isolated mind existed both divided from the body and separated from other human beings and the external world (Frie & Reis, 2001). Freud, influenced by both the age of Enlightenment and the Scientific Revolution, accepted and built upon Cartesian rationality. Classical psychoanalysis understood the mind/body problem through a dualistic frame, conceiving the body and mind as separate entities (Stolorow & Atwood, 1992, p. 41).

The theories presented in this paper are fundamentally phenomenological and intersubjective in nature. Most simply defined, intersubjectivity has to do with, “the nature of interaction between two subjectivities” (Frie & Reis, 2001, p. 297). The philosophical concept of intersubjectivity developed out of continental philosophers’ attempts to overcome the isolated and dualistic Cartesian understanding of consciousness: “philosophers since Descartes have sought to link human subjectivity, or self-consciousness, to our interactions with other human beings and the world around us” (Frie & Reis, 2001, p. 300). Although numerous philosophers

have contributed unique and divergent points of view on intersubjectivity and phenomenology, for the purposes of this paper I will briefly highlight the relevant contributions of G. W. F. Hegel and Maurice Merleau-Ponty.

According to Frie & Reis (2001), Hegel's "intersubjective model of self-consciousness...is frequently seen as the precursor of psychoanalytic theories of intersubjectivity" (p. 301). In the *Phenomenology of Spirit* (1807/1977), Hegel proposed that individual self-consciousness is reliant on recognition by another self-conscious being. It is only through the process of being recognized by another that we become self-conscious, come to know ourselves (Benjamin, 1988; Frie & Reis, 2001; Stern, 2009). In every relationship there are two self-conscious beings each striving to achieve recognition, and thus engaged in a struggle *for* recognition. Hegel famously referred to this mutual struggle for recognition as the master-slave dialectic. Benjamin (2004), influenced by Hegel, defines intersubjectivity "in terms of a relationship of mutual recognition – a relation in which each person experiences the other as a 'like subject,' another mind who can be 'felt with,' yet has a distinct, separate center of feeling and perception" (p. 5). In the next chapter I will further discuss how Benjamin built upon Hegel's model of self-consciousness in her intersubjective theory of development.

Merleau-Ponty (1945/2012), in *Phenomenology of Perception*, argued that we experience the external world and acquire knowledge through bodily-based sense perception. This concept, that "we can only understand our lived world with the apparatus with which we are provided to sense it, namely our bodies" is known as the lived-body paradigm (Shaw, 2003, p. 39). For Merleau-Ponty, perception is prereflective in that we are perceiving the world around us through our bodies from the moment we are born. In other words, our first experience of ourselves in the world, and in relation with others, is an embodied experience.

From a phenomenological perspective, our bodies are formed in relationship with others: “the experience of our body results from the dyadic process of sensing the other, and the other sensing us” (Ben-Shahar, 2014, p. 95). Embodied being, which is the only type of being humans can know, is dialectical and interactive in its very nature. Frie and Reis (2001) explain: “All of our experiences and the meanings that animate our lives follow from our bodily involvement with the world. To exist as a body is to be inherently interactional” (p. 306). From this perspective, we do not exist because we *think*, but rather because we are *embodied* (Totton, 2003). The fields of body psychotherapy, relational psychoanalysis, and interpersonal neurobiology all reject the Cartesian dualistic split between body and mind and embrace the phenomenological perspective of an embodied, interrelational state of being: “Where once the mind was seen as isolated from others and divided from the body, these theorists see subjectivity as developing and existing within an intersubjective and bodily context” (Frie & Reis, 2001, p. 307).

The intersubjective relational paradigm, now at the forefront of psychoanalytic theory and practice, and characterized by an inclusive theoretical stance, has encouraged an open dialogue to develop between relational psychoanalysts, body psychotherapists, and neuroscientists (Ben-Shahar, 2014). The intersection of these fields has sparked a renewed interest in nonverbal affective communication and has brought the body back into mainstream discourse. The client and therapist’s bodily phenomena are no longer understood as distinct from their minds (Shaw, 2003, p. 33). Physical sensations, once devalued in clinical practice, are now viewed as a valuable source of information (Hopenwasser, p. 216). Instead of *I think therefore I am*, Ben-Shahar (2014) suggests, “I am embodied in a relational context, therefore I am” (p. 91) and Fogel (2009), “*I feel, therefore I am*” (p. 27).

Body Psychotherapy

Although the body was at the center of Freud's metapsychology when he proclaimed that the ego was, "first and foremost a body ego" (Freud, 1923, p. 26), it was subsequently marginalized within the field of psychoanalysis, which became known as 'the talking cure' (Young, 2006). Freud's interest in developing psychoanalysis as a natural science led to a disavowal of the body in clinical practice (Rappaport, 2015; Ben-Shahar, 2014). Thus, the body was largely ignored in the therapeutic encounter, with the exception of the work of Wilhelm Reich, considered the forefather of body psychotherapy. Reich's work, however, was highly controversial and he was eventually expelled from the psychoanalytic community. Shaw (2004) contends that the body was thrown out of psychoanalytic discourse along with Reich (p. 271). While the field of body psychology has kept the place of the body alive and well in psychotherapeutic practice, it has historically remained on the periphery, viewed as a controversial outsider by other psychotherapy orientations.

The relationship between mind and body has always been at the core of body psychotherapy (Ben-Shahar, 2014, p. 91). Research from the neurosciences is now confirming many of the theories that have long guided the practice of body psychotherapists. In *Body Psychotherapy: An Introduction*, Nick Totton (2003), a British body psychotherapist and one of the founders of Embodied-Relational Therapy, defines body psychotherapy as follows:

Body psychotherapy, then, is a therapy for the whole person which approaches whatever facet of a given individual – body symptoms, sensations, feelings, images, thoughts, subtle energy, spirituality – is most accessible in this moment as a way of making contact. It then tries to work inwards from that point to the more defended, ignored or excluded aspects of that person's being. It is body psychotherapy only in that it does not exclude

the body, but treats embodiment as an intrinsic and important feature of human existence.
(p. 26)

In his book *Touching The Relational Edge: Body Psychotherapy* Ben-Shahar (2014), building upon Totton's (2003) categorization of body psychotherapy modalities, divides the diverse array of body psychotherapy modalities into six categories: Reichian body psychotherapy, personal development and human potential treatments, body psychotherapy for trauma work, process oriented body psychotherapy, expressive body psychotherapy, and relational body psychotherapy (p. 39). Within each of these categories are a variety of submodalities that offer unique and sometimes contradictory theoretical positions and practice techniques including touch, breath-work, movement, and more. Nevertheless, all of these various sub-fields of body psychotherapy view the self as an embodied entity and share the common goal of increasing sensory awareness in the client. At the same time, "Body psychotherapy recognizes that there is no living human body without mind – no soma without psyche; and therefore in approaching a human body we are also approaching a human mind" (Totton, 2003, p. 24). By working with the body directly, body psychotherapists seek to assist clients in releasing bodily-based restrictions, uncovering nonverbal emotional memory, and thereby "dissolve[ing] a corresponding pattern of psychological restraint" (Totton, p. 19).

Body psychotherapists generally work from a holistic approach meaning that the bodymind (client) is conceptualized as a whole that can never be fully understood by breaking it down into its component parts. Traditionally, the western medical model, which psychoanalysis grew out of, has approached the body as a biological entity. Although many neuroscientists and psychoanalysts are now in agreement with body psychotherapists in accepting the bodymind as existing on a biopsychosocial continuum, body psychotherapists view the bodymind as larger

than the sum of its parts whereas neuroscientists, and many psychoanalysts, generally relate to the bodymind in a more reductionist fashion (Ben-Shahar, 2014, p. 96, 97). Within the field of interpersonal neurobiology this is beginning to shift.

A vast array of somatic techniques, particularly in the field of traumatology, have exploded over the last few decades and are increasingly incorporated into mainstream psychotherapy. This theoretical study will not expound upon specific somatic techniques or skills aimed at engendering greater embodied awareness in the client and therapist. Rather, this study will focus on understanding the context of clinical work as an embodied intersubjective matrix as well as how this understanding affects clinical practice. In other words, this thesis seeks to contribute to the theoretical underpinnings that are common to all psychosomatic therapy modalities.

Relational Psychoanalysis

The relational paradigm shift in psychoanalysis, which took shape during the 1980s, influenced by the postmodern era, reconceptualized the psychotherapeutic encounter as a relationship between two subjective bodyminds. The relational model was originally conceptualized as a theoretical umbrella, “capable of holding the dialectical tension between the interpersonal and intrapsychic” (Aron & Lechich, 2012, p. 213). The terms relational and intersubjective are often used interchangeably, which speaks to how central the concept of intersubjectivity is to contemporary relational psychoanalysis. The late 20th century saw the influence of postmodernism across a wide range of disciplines, including psychoanalysis. The postmodernist critique of absolute, objective truths and the theoretical constructs of positivism led intersubjective psychoanalytic theorists to rethink the therapist’s position as an objective, neutral observer. As opposed to Freud’s initial conception of a scientific observer (therapist)

making objective interpretations about a subject's (client's) isolated intrapsychic mind, in the intersubjective perspective, the therapist and client are viewed as two subjectivities interacting in a field of mutual regulation and recognition.

The intersubjective position focuses on how the therapist and client's individual intrapsychic experiences intermingle, interact, and jointly influence one another in the context of the treatment relationship. Relational theory is not only interested in the client's internal experience but also the clinician's and actively seeks to understand how the two relate to one another in the treatment relationship. Contemporary intersubjective relational psychoanalysts, influenced by developmental/attachment theory, infant research, and feminist theory, have reimagined the clinical encounter. Throughout this paper I use the terms relational psychoanalysis, interpersonal relational psychoanalysis, and intersubjective relational psychoanalysis interchangeably to refer to the broad field of relational/interpersonal/intersubjective psychoanalysis. The field of relational psychoanalysis will be explored in-depth in chapter III.

Relational Body Psychotherapy

The burgeoning field of relational body psychotherapy is beginning to bring together the theories of relational psychoanalysis, the findings of interpersonal and developmental neuroscience, and the theory and technique of body psychotherapy (Ben-Shahar, 2014; Nolan, 2014). Ben-Shahar (2014) describes this merging of theories as a "relational-embodied paradigm" (p. 16). According to Nolan the "relational body-mind perspective" is drawn from humanistic psychotherapy, relational body psychotherapy, relational psychoanalysis, infant development research and neuroscience. Nick Totton (2003, 2012) and Asaf Ben-Shahar (2010, 2011a, 2011b, 2012, 2014) are two of the central contributors to this developing field. According to Ben-Shahar (2014), relational body psychotherapy "represents a determined effort

to maintain the bodily focus of body psychotherapy, including somatic intervention, without reducing the complex tapestry of the therapeutic relationship: an attempt to hold the paradoxical polarities rather than choose one over the other” (p. 58).

Ben Shahr (2014) acknowledges that the field of relational body psychotherapy has been deeply influenced by the ideas of contemporary relational psychoanalysis, particularly the concept of an intersubjective analytic third space. Although Ben-Shahr notes that relational psychoanalytic theorists are beginning to attend to embodied communication, he argues that relational psychoanalysts would learn a great deal from further familiarizing themselves with the theory and technique of body psychotherapists (p. 94, 104). I agree with Ben-Shahr on this point and believe the concept of embodied intersubjectivity reaches far outside the confines of relational body psychotherapy and is relevant to a wide range of clinical practice. Theoretical principles from the field of relational body psychotherapy can be incorporated into more traditional models of talk therapy. One does not need to work directly with the body to incorporate a relational embodied perspective into one’s work.

Interpersonal Neurobiology

Over the last two decades and due in large part to the developing technology of brain imaging, research in the neurosciences has begun to translate “classical psychoanalytic concepts into brain structures and circuitry” (Marks-Tarlow, 2014, p. 224). Interpersonal neurobiologists are conducting research and are theorizing on the problem of the mind/body, which has long concerned psychoanalysts and body psychotherapists alike: “what began as initial forays of the decade of the brain transformed into a torrent of 21st-century science’s more complex (re) explorations of the fundamental problems of brain/mind/body that are relevant to both researchers and clinicians” (A. N. Schore, 2012, p. 3). Ultimately, the findings of interpersonal

neurobiologists, developmental neuroscientists, and neuropsychologists are confirming the centrality of the treatment relationship and the relevance of the body in clinical practice. Thus, in chapter IV, I will use interpersonal neurobiology, primarily focusing on the contributions of Daniel Siegel and Allan Schore, as a lens through which to understand the phenomenon of embodied intersubjectivity.

Although research from the field of traumatology will not be covered in this paper due to limited space and time, it is worth noting that traumatology research has also been instrumental in leading a new movement toward somatically-informed psychotherapy. It is now widely accepted that post-traumatic stress is both a mental and physical reaction to trauma. Traumatic memories are understood to be stored in the nervous system and thus, in the body. Various somatically-oriented treatment techniques and body-based interventions such as Peter Levine's somatic experiencing and Pat Ogden's sensorimotor psychotherapy are increasingly becoming more widely accepted as treatment methods for trauma.

I would like to propose that it is not only traumatized clients who need to reconnect with their embodied experience of self in order to heal from what we consider to be mental affliction. Wylie (2004) states:

It's been an implicit premise of psychological science and clinical practice both, as it is of our entire culture that our singular human identity resides in our disembodied minds. The West's infatuation with Cartesian dualism has made our bodies somehow strange to us, a self-alienation reinforced by clinical psychology (p. 5).

Thanks to interdisciplinary research across a variety of fields within the social sciences, particularly the neurosciences, we now know that emotions are inherently embodied experiences. The embodied felt sense can no longer be disregarded in the psychotherapeutic encounter.

Definition of Relevant Terms and Concepts

The problematic nature of attempting to describe bodily sensations, nonsymbolic experience, through words is clearly evident throughout this paper. Ultimately, somatic experience is intangible subjective phenomena that cannot be translated into verbal experience (Shaw, 2004, p. 284). Bromberg (1991) explains, “No matter how evocative the language, words are but symbols for the experiential ‘thing’ as a felt truth” (p. 401).

In discussing Lacan’s position on the tension between experience and symbolization, Knoblauch (2005) tells us that there is always going to be “a gap between experience and its representation that is impossible to communicate and fully know” (p. 814) due to “the limitations of symbolization because of the displacement effect of language and the futility that language meets as description of lived experience” (p. 808). And yet, to develop a theoretical understanding of the relevance of embodied experience in clinical practice we must attempt to describe it with words, knowing that we have set ourselves an unattainable and somewhat absurd task. It is thus easy to understand why a common language with which to describe embodied intersubjectivity has yet to develop. In the following section and throughout this paper I will demonstrate how the fields of body psychotherapy, relational psychoanalysis, and interpersonal neurobiology are using different terminology to express similar ideas related to the phenomenon of embodied intersubjectivity.

Embodiment.

The intersubjective exchange and co-creation of an embodied sense of self is the focus of this paper. Embodiment does not refer to the physical body itself but rather to the subjective experience, the felt sense, of *being* a body. Totton (2003) defines embodiment as “the state of being united bodymind” and further explains that the term embodiment is “often used to name

the state of experiencing this unity” (p. 62). When we have a felt sense of our bodymind, we are experiencing an embodied state of being. Similar to Totton’s definition, Ben-Shahar (2014) makes a distinction between two ways in which he uses the term embodiment: “The first...signifies a phenomenon whereby our entire existence is a priori embodied...The second way of using the term is as a skill of strengthening and cultivating the relationship between the bodily and the psychological aspects of our being” (p. 93). For the purposes of this paper I will use the term embodiment to describe both a subjective state of being and a skill that can be honed (Ben-Shahar, 2014, p. 94).

Bodymind, mindbody, and brain-mind-body.

Throughout the literature drawn upon in this paper, the bodymind continuum is referred to variously as bodymind, mindbody, and brain-mind-body. For the purposes of this paper, I will use these terms interchangeably. Nonetheless, it is interesting to note that each field generally tends to highlight the part of the whole that it primarily focuses on. The body psychotherapists tend to refer to the bodymind (Totton, 2003; Ben-Shahar, 2014), the relational psychoanalysts tend to refer to the mindbody (Anderson, 2008; Aron & Anderson, 1998), and the interpersonal neurobiologists to the brain-mind-body (Marks-Tarlow, 2014; A. N. Schore, 2012).

The felt sense.

The term, *felt-sense*, was coined by Eugene Gendlin, an American philosopher and psychotherapist. In his research, Gendlin found that clients who naturally connected verbal insights with bodily-based feelings reported the greatest benefits from psychotherapy.

His conclusion was that such clients were naturally able to use bodily sensing to (a) *feel for* words with which to express otherwise murky or unclear aspects of their experience,

and (b) *check out* whether their own or other people's verbal articulation of a problem was in resonance with their direct somatic experience of it. (Wilberg, 2003, p. 5)

Based on his research findings Gendlin developed a technique called Focusing designed to help both clients and therapists develop inward bodily attention. In his now classic text, *Focusing* (1996), Gendlin attempts to define the felt sense in the following ways:

The felt sense is the holistic, implicit bodily sense of a complex situation (p. 58).

A felt sense is a bodily sensation, but it is not merely a physical sensation like a tickle or a pain. Rather, it is a physical sense *of* something, of meaning, of implicit intricacy. It is a sense of a whole situation or problem or concern, or perhaps a point one wants to convey. It is not *just* a bodily sense, but rather a bodily sense *of*... (p. 63).

A characteristic of this felt sense is that it is experienced as an intricate whole. One can sense that it includes many intricacies and strands. It is not uniform like a piece of iron or butter. Rather it is a whole complexity, a multiplicity implicit in a single sense (p. 20).

It is clear from the above quotes that the felt sense is a way of describing an intangible subjective phenomena that cannot fully be put into words. The felt sense does not refer to well-known emotions such as fear, anger, sadness, or surprise, to name a few. The felt sense refers to a sensation in the body of something that cannot be defined or quantified and is more complex than a single emotion (Gendlin, 1996, p. 19). The technique of Focusing helps the client to get in touch with his/her implicit felt sense as well as to develop what is at first vague and ambiguous into something that can be consciously known (Ben-Shahar, 2014, p. 53). The clinician's ability to attune with her own bodily-based felt sense of her moment-to-moment experience opens the

possibility for an embodied communication between client and clinician as well as the opportunity for the client to deepen his/her own felt bodily sense of self.

Peter Wilberg (2003), a radical British philosopher and psychologist, built upon Gendlin's work with an approach he refers to as soma-psychology. What Gendlin refers to as the felt sense, Wilberg calls soma-sensitivity. According to Wilberg, whereas Focusing is primarily concerned with the factors that contribute to developing a client's felt sense of self, soma-sensitivity training is geared toward assisting therapists to increase their effectiveness by developing "bodily self-awareness and sensitivity to the body of the client" (p. 5). Although I will not use Wilberg's terminology in this paper, I would like to highlight the distinction he makes between the physical body and the "inwardly *felt body*" of both client and therapist (p. 4). Wilberg (2004) explains that psychotherapy is "effective only to the degree to which [it] not only alter [s] the client's mental state or mood but deepens their felt *bodily* sense of self and of inner connectedness to other" (p. 4).

Embodied self-awareness.

Alan Fogel, (2009) an American psychologist and researcher on social and emotional development, makes a distinction between conceptual self-awareness, "thinking about the self," and embodied self-awareness, "feeling the self" (p. 10). Fogel defines conceptual self-awareness as "engagement in a thought process of categorizing, planning, reasoning, judging, and evaluating" (p. 1) and places this type of self-awareness in the left-hemisphere of the brain. Embodied self-awareness is defined as, "the ability to pay attention to ourselves, to feel our sensations, emotions, and movements online, in the present moment, without the mediating influence of judgmental thoughts" (p. 11) and is placed in the right-hemisphere of the brain.

Fogel argues that we *define* ourselves conceptually but we *inhabit* ourselves “via the concrete feeling and acting of embodied self-awareness” (p. 30).

Embodied self-awareness involves both interoception and body schema. Interoception is the ability to tune into sensations inside of our bodies including pain, visceral sensations, hunger, digestion, arousal, and the rise and fall of our breathe, to name a few. Body schema refers to an awareness “of the movement and coordination between different parts of the body and between our body and the environment” (Fogel, 2009, p. 10, 11). It is the ability of one part of the body to recognize another part of the body as part of the same whole. Embodied self-awareness is what enables us to be emotionally present, experiencing our emotions as feeling states in the body. According to Fogel, when we are in tune with our embodied self-awareness we are able to actually feel our sadness or excitement as sensations in the body (p. 11). Embodied self-awareness enables us to exist in what Fogel refers to as the *subjective emotional present*.

Somatic resonance, affective resonance, and attunement.

Somatic resonance or affective resonance is a useful term to describe what is actually taking place when a shared embodied awareness is co-created between two bodies in the intersubjective space. Somatic resonance can be conceived of as a nonverbal, nonconscious conversation, or sharing of energy, taking place between two bodies and has to do with the “capacity to sense another person through our bodies” (Ben-Shahar, 2012, p. 13, 14). When the therapist is able to resonate with the client’s felt sense, both client and therapist will recognize this resonance as “a shift in the felt quality of the dyadic field” (Wilberg, 2003, p. 11).

Siegel (2012) suggests that the circuitry of our nervous systems allow us to create resonance by attuning with another. Siegel defines attunement as an open and receptive focus on the flow of energy between two or more people or within one person, and resonance as the

process by which “our observing self takes on some of the features of that which we are observing” (p. 23). According to Siegel, when two people are attuned to one another, an interpersonal resonance is co-created “in which each person *feels felt* by the other” (p. 23). This concept will be further discussed in the section on mirror neurons in Chapter IV.

True and false self.

D. W. Winnicott’s oft-referred to concept of true self (Ghent, 1990; Bromberg, 1991; Fogel, 2009; Benjamin, 2005; Ben-Shahar, 2014; and others) is rooted in embodied self-awareness. The development of true and false self originates in Winnicott’s theory regarding the capacity to be alone in the presence of another. By the phrase “capacity to be alone,” Winnicott does not mean actually being alone but rather the ability to enjoy solitude, which comes from the early life experience of feeling alone in the presence of a primary caregiver. In Winnicott’s (1965) words: “Thus the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone else is present” (p. 30). It is this early life experience of being alone in the presence of the primary caregiver that encourages the development of the true self.

Winnicott (1965) uses the term ego-relatedness to describe a relationship between two people, child and caregiver (therapist and client), that allows for both togetherness and aloneness at the same time. In ego-relatedness one or both people are focused on the experience of being alone, “yet the presence of each is important to the other” (p. 31). Through being alone in the presence of an attentive but non-demanding caregiver the infant begins to detect its own “personal life.” Winnicott (1965) explains:

When alone in the sense that I am using the term, and only when alone, the infant is able to do the equivalent of what in an adult would be called relaxing. The infant is able to become unintegrated, to flounder, to be in a state in which there is no orientation, to be

able to exist for a time without being either a reactor to an external impingement or an active person with a direction of interest or movement....In the course of time there arrives a sensation or an impulse. In this setting the sensation or impulse will feel real and be truly a personal experience. (p. 34)

Winnicott is articulating an experience of self that originates from a place of interoception, a sensing from within. This personal impulse, expressed by the infant through a spontaneous gesture is, in essence, the potential of true self. That potential, which Winnicott seems to believe human beings are born with, is developed into a true or false self through being in relationship with the primary caregiver. The self develops “out of the subtle dialectic of maternal responsiveness” (Mitchell, 1992, p. 5). According to Winnicott, the development of a true or false self hinges on the way in which the primary caregiver responds to the infant’s spontaneous gesture. Winnicott (1965) explains the conditions for a “moment of illusion” that leads to the development of true self:

The good-enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly. A True Self begins to have a life, through the strength given to the infant’s weak ego by the mother’s implementation of the infant’s omnipotent expressions. (p. 145)

The misattuned caregiver, instead of sensing the infant’s authentic impulse, imposes his/her own impulse upon the infant. The infant, in an attempt to make sense of the caregiver’s imposed impulse, experienced as an “external impingement” complies with it: “the baby learns to want what the mother gives, to become the mother’s idea of who the baby is” (Mitchell, 1992, p. 10). This compliance is the earliest development of the false self. In other words, the false self is a self that is constructed in reaction to external stimuli. Infants and children would rather

compromise their authentic sense of self than risk being unaccepted, or worse unloved, by the primary caregiver.

True and false self-states exist on a continuum and everyone has some degree of both. In a healthy individual, the false self is essentially a social self that protects the true self from the external world (Grolnick, 1990). The need for security, the desire to exist in a social context with others, leads to self-consciousness regarding how one's spontaneous self-expression impacts others. It is this desire to maintain secure relationships that leads to some level of development of a false self in all people (Mitchell, 1992). When the false self develops to the point of pathology, the individual is left feeling "unreal or a sense of futility" (Winnicott, 1965, p. 148). Authentic spontaneity and a felt sense of realness are the main features of true self whereas feeling unreal and inauthentic are the main features of false self. False self can present in a number of different ways. On a bodily-based level, clients who appear to be wearing muscular armor (Ben-Shahar, 2014) or clients whose movements are restricted may be struggling with an overdeveloped false self.

For the purposes of this paper, the important take away is that the potential to experience true self comes from an awareness of one's physiological processes at any given moment in time. Winnicott (1965) tells us, "The True Self comes from the aliveness of the body tissues and the working of body-functions, including the heart's action and breathing" (p. 148). Thus, true self is deeply related to embodied self-awareness.

Mitchell (1992) argues that since Freud's structural and topographical models, psychoanalytic theoreticians have accepted a spatial metaphor for conceptualizing the self and thus attempted to locate the center of the self. Mitchell proposes that it is perhaps more useful to conceptualize the self "as a temporal rather than a spatial phenomenon" (p. 9). From this point

of view, there is no static, innate, core self existing in space. Instead there are true or authentic experiences existing over time. According to Mitchell, “the crucial difference lies not in the specific *content* of what I feel or do, but in the relationship between what I feel and do and the spontaneous configuration and flow of my experience at that point in *time*” (p. 9). The same content, action, behavior, or thought can feel like an authentic expression of one’s experience of self in a particular time and place, and like an inauthentic expression of one’s experience of self in another time and place. Thus, there is no true self, however, there is true or authentic self experience. I return to the concept of true and false self as it relates to embodied intersubjectivity and embodied recognition in the discussion chapter of this paper.

Limitations and Potential Bias

Engaging with a topic as ineffable as embodied intersubjectivity presents clear limitations. As previously acknowledged, words cannot do justice to a topic that exists in the domain of embodied, interpersonal experience. Additionally, the topic of embodied intersubjectivity is vast. I have drawn upon a wide range of theoretical research from interrelated fields and yet I have just begun to skim the surface of the literature that is relevant to a deeper understanding of the topic at hand. The enormity of this topic combined with the limited scope of a master’s thesis means that this study is incomplete and the basis for further inquiry at best (Zucker, 2014).

Intersubjective theory recognizes that we cannot escape our own subjectivity. I can only engage with the ideas and theories presented in this paper through my personal subjective lens. Although I strive to stay alert to the ways in which my personal subjective bias may exert influence over this paper, I know that there is much that remains unconscious. While my education and clinical experience are relevant, it is my personal experience with psychotherapy

and embodiment practices that has most informed both my choice of topic as well as my approach. Before coming to the field of clinical social work, I studied modern dance and yoga. I have experienced numerous forms of bodywork including therapeutic massage, Rolfing, and Zero Balancing to name a few. I have also worked with a number of psychodynamically informed psychotherapists over the last 12 years. As noted in the introduction to this paper, I have experienced psychological benefits from combining what I have learned in the aforementioned modalities. It is important to note that my privileged social position as a white, upper-middle-class, heterosexual cisgender woman has afforded me the opportunity to engage with such a wide array of embodiment practices and long-term psychotherapy. Further, my sociocultural identity has influenced how I have been treated as a consumer of these services and consequently how they have affected me. All of this has informed my beliefs about the relevance of embodied self-awareness to mental health and thus influenced the construction and execution of this theoretical study.

In the following chapter I turn to relational psychoanalysis. I begin with a historical overview, placing the relational paradigm shift in context. I then consider some of the core concepts of relational theory including the relational perspective on intersubjectivity, transference/countertransference, and thirdness.

CHAPTER III

RELATIONAL THEORY

“The basic relational configurations have, by definition, three dimensions – the self, the other, and the space between the two. There is no “object” in a psychologically meaningful sense without some particular sense of oneself in relation to it. There is no “self,” in a psychologically meaningful sense, in isolation, outside a matrix of relations with others. Neither the self nor the object are meaningful dynamic concepts without presupposing some sense of psychic space in which they interact, in which they do things with or to each other.”

- Steven Mitchell (1988, p. 33)

Relational theory is not defined by a singular school of thought or cohesive set of theoretical principles. The relational model has been portrayed as a “big tent” (Aron & Lechich, 2012, p. 211), a “conceptual space” (Mitchell, 1988, p. xvii), and a “shared subculture” (Mitchell & Aron, 1999, p. xii). As opposed to a unified theoretical model, it is better conceptualized as a framework defined by shared principles: a space in which diverse sets of relational perspectives coexist in dialectical tension with one another. Mitchell & Aron (1999) describe the relational matrix as placing “an emphasis on maintaining the tension between the extremes, on ambiguity, dialogue, dialectic, and paradox” (p. xviii), while Aron and Lechich (2012) define the relational model as characterized by, “pluralism and multiplicity, emphasizing ‘both/and’ rather than ‘either/or’” (p. 211). Such openness and multiplicity makes it nearly impossible to encompass all of relational theory in a single chapter. Thus, I will begin with a brief historical overview of the roots of relational theory, providing some background for the evolution of key relational concepts. The theory of a relational mind, the concept of intersubjectivity, the reconceptualization of the transference/countertransference dynamic, and the concept of the

analytic third will be explored. Particular attention will be paid to Jessica Benjamin's construction of intersubjectivity, mutual recognition, and thirdness.

Steven A. Mitchell (1988), considered one of the most prolific and central contributors to relational theory, observed that, post Freud's death, the field of psychoanalysis suffered from a lack of communication between various theoretical schools of thought, creating a fractured discipline. Mitchell argues that such a divide existed because the field of psychoanalysis remained stuck under the shadow of Freud's structural and drive metatheory: a comprehensive explanation of human nature. The creation of a closed, complete theory became the norm in the field of psychoanalysis, creating multiple schools of thought cut off from one another (Mitchell, 1988, p. 6).

Instead of striving to create one individual metatheory, Mitchell and other early relational theorists, Greenberg, Ghent, Bromberg, among others, endeavored to create an atmosphere in which multiple relational theories might coexist in dialectical tension with one another. Mitchell and Aron (1999) suggest that one of the central beliefs of relational theory, "is the 'deconstruction' of misleading dichotomies and exaggerated polarization" (p. xviii) previously prevalent in the psychoanalytic community.

Historical Background

In their seminal text in which they introduce the concept of a relational matrix, Greenberg and Mitchell (1983) delineate two incompatible and fundamentally alternative models of mind: a classical drive theory model and a relational model. Mitchell (1988) remarks:

The distinction between a monadic theory of mind and an interactive, relational theory of mind...is crucial in sorting out differences among psychoanalytic concepts....Although all psychoanalytic theories contain both monadic and dyadic features, each theory

necessarily breaks on one side or the other of this dichotomy in assigning the source of the structuralization of experience, the shaping of meaning, and this choice is fundamental. (p. 5)

Freud originally conceptualized psychoanalysis as a natural science complete with objective truths regarding human nature. For Freud, the mind was prewired; the infant came into this world with internal, pre-structured drives. Freud's theory of mind viewed human beings as biological organisms driven by a need to discharge physical tension that developed due to bestial urges. Freud believed these bestial urges took shape in the mind as sexual and aggressive wishes pushing to be released. As the child is socialized, the mind begins to develop "complex and elegant compromises between the expression of impulses and the defenses which control and channel them" (Mitchell, 1988, p. 2). The ego is constantly negotiating between the expression of desire and the fear of punishment. In Freud's conceptual framework, psychopathology was the result of repressed sexual and aggressive fantasies; drive energy that had not been sufficiently discharged. Relationships with others were viewed simply as "vehicles for the expression of drive and defenses" (Mitchell, 1988, p. 39).

All of psychodynamic theory and practice is based on Freud's groundbreaking discovery of the unconscious mind, a contribution that has forever altered how we understand ourselves. In the words of Ben-Shahar (2014):

According to Freud, humans were primarily acting unconsciously, unaware of the drives, anxieties, and desires that motivated them...self-awareness was not a given but had to be worked at and gained: we were required to pursue self-knowledge, with diligence and integrity, in order to fully assume the human potential inherent in us all. (p. 12)

By discovering the unconscious and providing us with a technique to delve into its depths, Freud gave us the ability to know ourselves more deeply. However, Freud's structural model stayed within the boundaries of the Cartesian isolated mind: "a self-enclosed wordless subject or mental apparatus containing and working over mental contents and ontologically separated from its surround" (Stolorow, 2013, p. 384).

British object relations theory.

The British object relations movement, forged in the 1940s and 1950s in Great Britain, signified a departure away from Freud's emphasis on biological drives and a mind in isolation and towards an emphasis on actual relationships with others. The object relations movement consisted of numerous schools of thought: "a cluster of largely unrelated theoretical innovations" (Mitchell & Aron, 1999, p. xi). What the various object relations theorists held in common was a recognition of, and emphasis on, how being in relationship with others helped to form the intrapsychic environment of the individual.

The term object in psychoanalysis is "defined as the largely human target or influencer of an instinctual impulse, or drive" (Ghent, 1992, p. xiii). Melanie Klein was the first to use the term *object relating*. Klein focused on how infant and caretaker's interactions influenced the way the child related to the world around it. Klein postulated that the infant was wired for human interaction but only in so much as the object (mother) satisfied the infant's drives. Whereas for Freud the object was accidental, the nursing breast just happened to be attached to the mother, for Klein the object of desire was implicit in the experience of desire. Klein imagined that the libidinal urge to love is accompanied by an image of a loving object. Klein's concept of object relating maintained allegiance with Freud in that objects were conceived of simply as a means to an ends; an object is valuable to a subject only in so far as it can satisfy a

libidinal or aggressive drive. In this model, objects are drive derivatives (Mitchell & Aron, 1999). Although Klein is responsible for initiating a shift within classical theory toward object relations, Mitchell and Aron (1999) cite W.R.D. Fairbairn and Harry Stack Sullivan's contributions as the "central theoretical axis" (p. xvii) of the relational turn.

Through his work with abused and neglected children, Fairbairn became interested in understanding why human beings are prone to repeatedly engage in hurtful relationships if our primary drive, as Freud postulated, is pleasure seeking. In answer to this question, Fairbairn formulated his theory of object relations and in the process made a radical departure away from Freud's theory of instinctual drives. For Fairbairn, being in relationship with others was the central organizing motivation of human behavior. If a child is provided with pleasurable experiences early in life, that child will seek pleasure because pleasure is connected to the caregiver. If, on the other hand, a child primarily experiences pain while interacting with the primary caregiver, that child will seek out pain as a means to being in relationship with others. Fairbairn viewed the intrapsychic world as developing out of relationships with early caregivers as opposed to Freud's conception of an intrapsychic world ruled by biological urges (Ghent, 1992, p. xiv). Fairbairn stressed, "the longing, the hunger for contact and connection, that propels human relationships" (Mitchell, 1988, p. 28). He viewed human beings as wired for human interaction and famously re-conceptualized the libido as object seeking as opposed to pleasure seeking. Ghent (1992) describes Fairbairn's reconceptualization of libido as "Clinging to terms that belong to drive theory while totally transforming their meaning" (p. xiv).

American interpersonal theory.

Around the same time that various theories of object relations were taking shape in Great Britain, the interpersonal school of psychoanalysis was forming in the United States. Harry

Stack Sullivan, Erich Fromm, Clara Thompson and other interpersonal theorists founded the William Alanson White Institute, the home of interpersonal psychoanalysis, in the 1940s. Greenberg and Mitchell both trained at the William Alanson White Institute and thus were greatly influenced by interpersonal theory and practice (Aron & Lechich, 2012).

Whereas the British object relationalists emphasized the influence of early relationships on an individual's intrapsychic environment, the interpersonalists emphasized the importance of real relationships in the external world. For Sullivan, the "mind always emerges and develops contextually, in interpersonal fields" (Mitchell & Aron, 1999, p. xv). Sullivan felt the mind could not be conceived of as separate from the interactive field it was relating in. In terms of clinical practice, the interpersonalists shifted the focus to present, here-and-now relations in the client's life. Sullivan and his colleagues were interested in understanding the origins of their clients' interactive patterns of relating with others as opposed to past fantasies and impulses (Mitchell & Black, 1995, p. 64). At the time it was established, the interpersonal school was considered a radical break from classical psychoanalytic schools of thought. In retrospect, many relational and contemporary interpersonal theorists believe that, in an effort to separate from classical theory, the interpersonalists swung too far in the direction of external, interpersonal relationships and in the process "tended to deemphasize the internal world and internal psychic structures" (Mitchell & Aron, 1999, p. ix).

Although the British object relationalists and the American interpersonalists focused on different aspects of being in relationship with others and used different terminology they both ultimately broke with Freud's structural/drive theory. Both the British object relations school and the American interpersonal school emphasized the formative importance of being in relationship with others. However, whereas the British object relations school emphasized the

presence of the “other” on the individual’s intrapsychic world, the American interpersonal school emphasized the influence of actual interpersonal relationships (Mitchell, 1988, p. 9).

Ferenczi.

It would be remiss to discuss the historical roots of relational theory without making mention of Sandor Ferenczi who is often cited (Aron & Lechich, 2012; Ben-Shahar, 2010; Berzoff, 2011) as the forefather of a relational point of view although his contributions to the field were ignored for many years. Ferenczi and Freud’s infamous split stemmed from Ferenczi’s interest in the interaction between analyst and analysand. For Ferenczi, the relationship between the analyst and analysand was just as valuable an analytic tool as was understanding the intrapsychic world of the analysand, a belief held by many contemporary relational practitioners. A detailed exploration of Ferenczi’s work is outside the scope of this paper, however, it is important to note that Ferenczi’s writing, particularly his concept of mutual analysis, has influenced many relational thinkers.

Origins of the Relational Movement in Psychoanalysis: A Social Theory of Mind

Relational theory began to take shape in the 1980’s with an emphasis on the relationship between the intrapsychic and the interpersonal. The relational matrix sought to bridge a gap between the British object relations school and the American interpersonal school while also acknowledging the contributions and influence of various psychologies of the self, particularly Kohut’s self psychology and existential theories (Mitchell, 1988; Mitchell & Aron, 1999). In addition to the above-mentioned primary influences, Mitchell and Aron (1999) also acknowledge intersubjectivity theory, American psychoanalytic feminist theory, social constructivism, modern ego psychology, contemporary psychoanalytic hermeneutics, the legacy of Sandor Ferenczi, and more, as playing a part in the relational turn of psychoanalysis (p. xi-xii).

The term, relational model, first appeared in Mitchell and Greenberg's (1983), *Object Relations in Psychoanalytic Theory*. Mitchell and Greenberg (1983) trace the evolution of a paradigm shift, beginning with the British object relations school of thought, in psychoanalytic theory: a shift away from an individual theory of mind and towards a social theory of mind. Mitchell (1988) defines the relational model as, "an alternative perspective which considers relations with others, not drives, as the basic stuff of mental life" (p. 2) thus signifying a post-Freudian era of psychoanalytic theory. Human beings were no longer understood as driven by a biological need to discharge sexual and aggressive urges but rather as driven by a biological need for attachment; an intrinsic desire to be in relation with others. "Human beings did not evolve and then enter into social and cultural interactions; the human mind is, in its very origins and nature, a social product" (Mitchell, 1988, p. 18). What all relational theories hold in common is an emphasis on how being in relationship, both real and imagined, molds psychic life.

The genius of Mitchell and other early relational theorists was in recognizing how each of these separate theoretical schools of thought, British object relations theory, the American interpersonal school, and assorted self psychologies, complemented one another by focusing on a particular component of what came to be regarded as the relational matrix. The relational matrix was conceived of as a framework for assimilating relational concepts from varied and distinct psychoanalytic schools of thought without assigning priority to any one theoretical system (Aron & Lechich, 2012, p. 213). Each separate dimension of the relational matrix had already been expounded upon by different schools of thought: whereas the British object relations school focused on the intrapsychic world, the interpersonal school made interpersonal relations superordinate, and the self-psychologists focused primarily on self-organization. Mitchell (1998) argues: "To assign priority to sense of self, object ties, or patterns of interaction is like

trying to decide whether it is the skin, the bones, or the musculature that preserves the body form” (p. 35). Instead of placing priority on any one mode of being a multidimensional relational approach “takes into account self-organization, attachments to others (‘objects’), interpersonal transactions, and the active role of the analysand in the continual re-creation of his subjective world” (Mitchell, 1988, p. 8).

Core Concepts of Relational Theory

There are two broad central tenets that define relational theory. The first tenet, explored above, clearly articulates a distinction between a monadic, isolated mind, as in Freud’s drive theory, and an interpersonal mind that develops within a relational matrix. The second tenet is an openness to maintain the dialectical tensions and multiplicities that inevitably exist in a theory and practice that attempts to explain human behavior. Aron and Lechich (2012) point out that, historically, psychoanalytic theory has struggled with “binary oppositions such as conscious/unconscious, intrapsychic/interpersonal, inner world/outer behavior, conflict/deficit, oedipal/pre-oedipal” (p. 211) and I would add, mind/body. With the construction of a third space in which a both/and perspective prevails, the relational model attempts to move beyond such dichotomies (Aron & Lechich, 2012, p. 211).

Intersubjectivity and mutual recognition.

Stolorow and his colleagues, working within the self psychology tradition, are credited with exposing the myth of the isolated Cartesian mind and introducing the concept of intersubjectivity into the American psychoanalytic dialogue (Aron, 1996; Benjamin, 1990; Aron & Lechich, 2012). Stolorow and Atwood (1992) define intersubjectivity as, “*any* psychological field formed by interacting worlds of experience” (p. 3). In this view, intersubjectivity refers to the contextual field in which two subjectivities interact, while mutually and reciprocally influencing one

another. Whereas Stolorow's form of intersubjectivity is broadly conceptualized as a systems view, Jessica Benjamin has advanced a developmental view of intersubjectivity (Mills, 2005, p. 159). According to Benjamin (1990), intersubjectivity "refers to that zone of experience or theory in which the other is not merely the object of the ego's need/drive or cognition/perception, but has a separate and equivalent center of self" (p. 186). Stolorow and his colleagues view intersubjectivity as the intersection of two subjectivities and inherent to all relationships, whereas Benjamin views intersubjectivity as the *capacity* for mutual recognition and as a developmental achievement (Mitchell & Aron, 1990, p. 183).

In the paper, *Recognition and Destruction: An Outline of Intersubjectivity* Benjamin (1990) links feminist theory with contemporary developmental psychoanalysis and seeks to understand how the meeting of two subjectivities is different from the meeting of a subject and an object (p. 185). Benjamin critiques the traditional psychoanalytic theories of development that portrayed the mother as a mere object, her sole purpose being the fulfillment of the child's needs (Aron, 1991, p. 245). Benjamin argues that the term "object" robs the mother of her own subjectivity and suggests that a relational theory of psychoanalysis should aim to repair traditional psychoanalysis' problematic tendency to reduce the other to simply an object. In Benjamin's intersubjective developmental theory, the child's recognition of the mother's subjectivity is conceived of as a developmental achievement (p. 186). She declares, "where objects were, subjects must be" (1990, p. 184).

Drawing upon Hegel's master-slave dialectic, Benjamin (1990) asserts: "The need for recognition entails this fundamental paradox: in the very moment of realizing our own independent will, we are dependent upon another to recognize it" (p. 190). We become self-

conscious of our own subjectivity through the process of being recognized by another subject. In being recognized by another subject we, in turn, recognize the other's subjectivity:

Intersubjective theory postulates that the other must be recognized as another subject in order for the self to fully experience his or her subjectivity in the other's presence. This means, first, that we have a need for recognition and second, a capacity to recognize others in return – mutual recognition. (Benjamin, 1990, p. 186)

The subject (child) looks to another subject (caregiver) to confirm his/her independent will. The recognizing subject (caregiver) “tells us we have created meaning, had an impact, revealed an intention” (p. 186). At the very moment we receive confirmation of our own independent will, we paradoxically recognize that there are other subjects out there with “separate center[s] of feeling and perception” (Benjamin, 2004, p. 5).

Referencing Winnicott's theory of “object usage,” the process by which the child recognizes the object as a separate person through first attempting to destroy the object before surrendering to it, Benjamin “demonstrate[s] the need for both recognition and negation in the establishment of human subjectivity” (Mitchell & Aron, 1999, p. 183). From an intersubjective position, Benjamin (1990) resolves the paradox of recognition by arguing that the need to assert the self and be recognized by the other can coexist in dialectical tension (p. 191).

For Benjamin, experiencing our own subjectivity and having the capacity to recognize others as subjects are mutually dependent experiences. It is through a process of mutual recognition that we are both recognized and recognize others. Benjamin re-conceptualizes the rapprochement phase of development as not only an achievement of separation-individuation but also an experience of connection, mutual recognition, and attachment. Benjamin's (2004) conception of intersubjectivity underscores, “both developmentally and clinically, how we

actually come to the felt experience of the other as a separate yet connected being with whom we are acting reciprocally” (p. 6).

Infant research and developmental attachment theory profoundly influenced Benjamin’s and other relational psychoanalytic theorists’ construction of intersubjectivity. Researchers such as Beebe, Stern, Lichtenberg, Fosshage, and Lachmann have shown that the infant’s mind does not develop in isolation but rather in a shared relational matrix with the primary caregiver (Lachmann, 2001). The field of infant research has provided empirical evidence that supports Winnicott’s famous statement, “There is no such thing as an infant.” Winnicott, considered by many an early relational theorist (Berzoff, 2011; Mitchell, 1988), understood the identity of the mother-infant unit as preceding the individual identity of the infant (Ben-Shahar, 2010, p. 42). Ogden (1994) suggests that Winnicott intentionally left his statement incomplete: “[Winnicott] assumes that it will be understood that the idea that there is no such thing as an infant is playfully hyperbolic and represents one element of a larger paradoxical statement” (p. 463). There is, of course, a physically and psychologically distinct mother and distinct infant. Ogden (1994) continues, “The mother-infant unity coexists in dynamic tension with the mother and infant in their separateness” (p. 463).

Infant research has demonstrated that the infant is constantly “coconstructing its world in interaction with its environment” (Lachmann, 2001, p. 168). It is not only the caregiver’s subjectivity influencing the infants, but also the infant’s subjectivity influencing the caregiver: “Both engage in a relational dance in which each regulates the other’s emotions in verbal and nonverbal ways” (Berzoff, 2011, p. 234). The intersubjective perspective on the mother-infant dyad has profoundly altered the way contemporary relational theorists understand and relate to the therapist-client dyad.

Just as the intersubjectivity of the mother-infant dyad coexists in dynamic tension with the mother and the infant as separate and distinct individuals so too does the intersubjectivity of the therapist-client dyad coexist in dialectical relation with the therapist and clients' separate individual identities (Ogden, 1994, p. 463). No longer is the therapeutic process conceptualized as taking place within an individual or between a subject and an object, but rather as between two subjectivities (Benjamin, 1990, p. 184). Aron (1991) applied Benjamin's intersubjective developmental perspective to the therapeutic dyad:

Just as psychoanalytic theory has focused on the mother exclusively as the object of the infant's needs while ignoring the subjectivity of the mother, so, too, psychoanalysis has considered analysts only as objects while neglecting the subjectivity of analysts as they are experienced by the patient. (p. 247)

Aron (1999) argues that the client's sense of the therapist's very real subjectivity should not be denied. Through recognizing the therapist's subjective presence, the client comes into contact with her own subjectivity.

Transference and countertransference.

In Freud's original model of psychoanalysis, the therapist was viewed as an objective scientific observer working with technical neutrality to understand his subject of inquiry, the client (Aron, 1991, p. 247). The ideal analyst was akin to a blank screen onto which the client projected his/her thoughts, feelings, and fantasies. This construction of transference/countertransference "gave the analyst the illusion of order" (Ben-Shahar, 2010, p. 41).

The intersubjective perspective has transformed our understanding of transference and countertransference. Transference is no longer viewed as the client's misconceptions about the

therapeutic relationship based on past experience. Rather, transference is understood as an intermingling of past and present. Merton Gill's (1994) reformulation of transference greatly influenced how contemporary relational theorists came to understand the transference/countertransference dynamic (Aron & Lechich, 2012, p. 214). Gill (1994) observes:

Instead of being defined as the distortion of the analysand's experience of an objective analyst as a result of the analysand's accustomed patterns of interpersonal relationships, transference becomes the analysand's plausible experience of the relationship. It is based on the contributions of both participants to the here-and-now interaction as well as on their respective past experiences. Analogously, the countertransference is the analyst's experience of the relationship based on the contributions of both participants to the here-and-now interaction as well as on their respective past experiences. (p. 156)

Transference and countertransference are not rooted solely in the past nor are they representative exclusively of the present but rather exist between the two.

Instead of being viewed as a barrier to or interference with treatment, the therapist's unconscious thoughts, feelings and fantasies have been reconceptualized as a clinical tool: a place from which to uncover information that may be relevant to the analysis (Aron, 1991, p. 248; Ben-Shahar, 2010, p. 41). From a relational perspective, the dichotomy between transference and countertransference is a false one. Transference and countertransference are viewed as interdependent; the therapist's subjectivity and the client's subjectivity mutually influencing one another in a co-constructed interaction.

The analytic third.

As the field of clinical inquiry has expanded its boundaries to include not only the subjectivity of the client but also the subjectivity of the therapist, as well as the interaction

between the two, many theorists have explored the concept of a three-person psychology, a third space, or a third subjectivity: “a realm that transcends the subjectivities of the two participants” (Gerson, 2004, p. 75). Thomas Ogden (2004) introduced the concept of the analytic third to the field of psychoanalysis. Ogden (2004) describes the analytic third as, “the experience of being simultaneously within and outside of the intersubjectivity of the analyst-analysand” (p. 463) and a little later as, “a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting” (p. 464).

Similar to the discussion around intersubjectivity, there is no singular agreed-upon definition of thirdness in the psychoanalytic literature. A number of psychoanalytic theorists across a variety of psychoanalytic orientations have explored the concept of the third thereby developing a wide array of theoretical perspectives as to what constitutes thirdness.

Consequently, the third has taken on a variety of contradictory and ambiguous meanings (Gerson, 2004; Aron, 2006; Aron & Lechich, 2012; Benjamin, 2004). Gerson (2004) observes:

For some, this something called a *third* that transcends individualities is thought of as a product of an interaction between persons; others speak of it as a context that originates apart from us even as it binds us together; and there are some for whom the third is a developmental achievement that creates a location permitting reflective observation of lived experience, be it singular or communal. (p. 64)

A detailed analysis of the varied conceptions of thirdness that exist in psychoanalysis is beyond the bounds of this paper. I will focus on Benjamin’s (1994; 2004) definition of a *shared third* followed by Rappoport’s (2012) extension of a *somatic third*.

Complementarity and enactment.

As with all dyadic relationships, the intersubjective clinician/client relationship often becomes stuck in complementary interactions, which can evolve into impasses and enactments. Aron (2006) recommends thinking about “The structure of complementarity...as a straight line” (p. 354) and provides the metaphor of a seesaw to explain the linear configuration of a complementary dyadic relationship. If the dyad wants to remain on the seesaw they have only so many options for relating to one another. They can go up and down, they can move along the length of the seesaw closer and further apart, or they can switch places, reversing positions. Without a third point of view, both members of the dyad remain unaware that they are on a seesaw in the first place and thus unaware that they can get off it, i.e. relate to one another in a nonlinear fashion. In articulating the constraints of complementarity, Aron (2006) states:

For a couple, a therapist and patient dyad for example, this means that the structure of complementarity keeps them locked into a relational positioning in regard to each other so that one member is diametrically opposite to the other in some significant respect. (p. 354)

In a complementary relationship roles can be reversed but the structural organization of the relationship remains intact. Examples of complementary roles are subject/object, giver/taker, doer/done to, powerful/powerless (Benjamin, 1990). Complementarity is thus problematic because it keeps the client/clinician trapped in one pattern of relating, a pattern that may be an enactment. In contemporary relational theory enactments are understood as, “the unique way in which the analyst is affectively pulled into and discovers him or herself as a participant in the patient’s relational matrix in ways that the analyst had not predicted and might not recognize until later” (Aron & Lechich, 2012, p. p. 219). In relational practice, enactments are an

inevitable component of the therapeutic work. Unpacking enactments, bringing the unconscious interactive elements of the therapist-client relationship into conscious focus, is considered to be at the core of clinical work (Berzoff, 2011, p. 223).

Jessica Benjamin's third.

In her seminal article, *Beyond Doer and Done To: An Intersubjective View of Thirdness*, Benjamin (2004) explains how the third enables the dyad to move beyond limiting complementary interactions. As opposed to Hegel's master slave dialectic in which the struggle for recognition must end in either destruction or unification, Benjamin (1990) proposes that instead of resolving the contradiction of mutual recognition we hold it in paradoxical tension through the intersubjective position of thirdness (p. 190).

Surrendering to the third.

Benjamin's conception of thirdness is an expansion on Ghent's notion of surrender. In *Masochism, Submission, Surrender – Masochism as a Perversion of Surrender*, Ghent (1990) makes a distinction between submission and surrender. He proposes that masochism is the perversion of a desire to surrender to one's true self. In Ghent's (1990) seminal paper he argues that, in some instances, the masochistic desire to submit to the power or control of a sadistic other is a perversion of a deeper desire to surrender to a true self. Ghent suggests that "however deeply buried or frozen" (p. 109), human beings have a wish to give up their false selves and that this wish is part of "an even more general longing to be known, recognized" (p. 111). Ghent defines this longing for surrender as, "the wish to be found, recognized, penetrated to the core, so as to become real, or as Winnicott put it in another context 'to come into being'" (p. 122). Ghent points out that whereas in the West the word surrender has connoted defeat, in the East surrender is more closely related to transcendence and liberation (p. 111).

In articulating the difference between submission and surrender, Ghent (1990) lays out some of the central features of surrender, of which I will highlight three. First, Ghent notes that one does not surrender “to another” but rather, “in the presence of another.” Second, Ghent describes surrendering as “an experience of being ‘in the moment,’ totally in the present, where past and future, the two tenses that require ‘mind’ in the sense of secondary processes, have receded from consciousness.” Third, Ghent highlights that surrender’s “ultimate direction is the discovery of one’s identity, one’s sense of self, one’s sense of wholeness, even one’s sense of unity with other living beings” (p. 111).

Benjamin interpreted Ghent’s concept of surrendering in the presence of another as a “letting go into *being with* them” (p. 8). If we are not surrendering to another person, then what are we surrendering to? For Benjamin, we are surrendering to the third. She (2004) explains:

Elaborating this idea, we might say that the third is that to which we surrender, and thirdness is the intersubjective mental space that facilitates or results from surrender. In my thinking, the term surrender refers to a certain letting go of the self, and thus also implies the ability to take in the other’s point of view or reality. Thus, surrender refers us to recognition – being able to sustain connectedness to the other’s mind while accepting his separateness and difference. Surrender implies freedom from any intent to control or coerce. (p. 8)

For Benjamin, the third is conceived of as a principle rather than a rule of technique. Benjamin (2004) notes, “My aim is to distinguish it from superego maxims or ideals that the analyst holds onto with her ego, often clutching them as a drowning person clutches a straw” (p. 7). It is in this way that Benjamin views her conception of thirdness as an expansion of Ghent’s (1990)

concept of surrender. In the intersubjective matrix, we are not holding onto a third but rather surrendering to it (p. 8).

The one-in-third and the third-in-the-one.

Benjamin (2004) describes “different aspects of thirdness” making a distinction between the *one-in-third* and the *third-in-the-one*; separate yet interconnected attributes of the *shared third* (Aron, 2006, p. 356). Further complicating the matter, Benjamin, and other theorists who have developed Benjamin’s ideas, have referred to the one-in-the-third and the third-in-the-one by a number of other names. The one-in-the-third has been described as the *nascent, energetic, rhythmic*, and *primordial* third whereas the third-in-the-one has been described as the *moral third* and the *intentional third* (Aron, 2006; Benjamin, 2004).

Benjamin (2004) defines the third-in-the-one as, “This ability to maintain internal awareness, to sustain the tension of difference between my needs and yours while still being attuned to you” (p. 13). Benjamin used the mother-infant dyad to expound on the third-in-the-one. Within the mother-infant relationship, the mother’s subjective awareness of herself as separate and distinct from the infant is the third-in-the-one. The third-in-the-one, the intentional third, “facilitates the differentiation of the self and other within their very connectedness” (Aron, 2006, p. 358).

The one-in-the-third describes the experience of being one with another person (Aron, 2006, p. 356). In Benjamin’s (2004) words, “literally the part of the third that is constituted by oneness” (p. 17). The infant is, at first, unaware of him/herself as separate from the mother. The mother, although able to maintain awareness of herself as a separate and distinct being also, at times, gets lost in the experience of being one with her infant: the mother is “split between two subjective positions, one aligned with the child and one distinct and marked” (Aron, 2006, 358). The mother and infant establish a pattern of interacting with one another that exists solely

between them and is created by them. Aron (2006) depicts the one-in-the-third as the rhythm established between the mother-infant dyad through “eye gaze, reciprocal speech, gestures, movements, and mutual mirroring” (p. 356).

Benjamin (2004) uses the example of jazz musicians improvising with one another to give life to the concept of the one-in-the-third. Jazz musicians, who have improvised with one another for many years, can communicate without exchanging words, gestures, or even glances but simply through their felt-sense of one another. When lost in an improvisational riff, the musicians have no clear leader or follower. Rather, they seamlessly move in and out of following and leading, without conscious awareness of this process. Benjamin (2004) describes this occurrence as a “nonverbal experience of sharing a pattern, a dance, with another person” (p. 16).

Growing up, I took an improvisational dance class from the age of 8 till 18. Almost all of the girls in the class started together in elementary school and finished together at the end of high school. Early on, our teacher taught us an exercise, called *Mirror*, in which we would line up facing each other. The girl standing across from you was your partner. The exercise started with one partner, identified as the leader, making slow improvisational movements. The other partner, identified as the follower, would mirror the movement in present time. After five or so minutes, we would change roles, the mirror becoming the leader and the leader the mirror. We would then begin the exercise a third time, without establishing who would lead and who would mirror. Through close observation of one another, we would establish a shared space in which we moved together, at times lost in a rhythmic pattern of relating, both simultaneously leading and mirroring. Over the years as we grew older, we continued with this exercise. By the time we got to high school we had become so attuned with one another that we would quickly fall into

a pattern of moving together in which there was no clear leader or follower. This space, in which two people dance together, seamlessly passing the role of leader and follower back and forth without any pre-established understanding, is the space of the rhythmic or energetic third. It is the union created when two (or more) people are affectively resonating with one another (Benjamin, 2004, p. 17). It is the space within which resonance emerges. Thus the principle of the one-in-the-third or the rhythmic third is closely related to the experience of somatic or affective resonance.

Bringing together the one-in-the-third and the-third-in-the-one Benjamin (2004) conceptualizes a shared third. Benjamin (2004) explains the shared third as:

Establishing a co-created rhythm that is not reducible to a model of action-reaction, with one active and the other passive or one leading and the other following. Action-reaction characterizes our experience of complementary twoness, the one-way direction; by contrast, a *shared third* is experienced as a cooperative endeavor. (p. 18)

The shared third is thus understood as an intersubjective space in which two people are able to get lost in a co-created rhythm of relating while at the same time maintain their subjective awareness of themselves as existing outside of the co-created rhythm.

The somatic third.

In her article entitled, “*Creating the Umbilical Cord: Relational Knowing and the Somatic Third*”, Evelyn Rappoport (2012) introduces the term, *somatic third*, as an expansion of Benjamin’s rhythmic third. The somatic third is defined as, “the space of physical resonance and interactive sensory regulation” (p. 384). Rappoport suggests that it is helpful to conceptualize the somatic third as “expanding the boundaries of the relational work, with an approach informed by the data recently available from the neurosciences” (p. 384).

The somatic third is the space within which nonverbal communication takes place as well as a form of nonverbal bodily-based communication. It is the space within which therapists and clients empathically resonate with one another on an embodied level. Through clinical case material Rappoport (2012) explains how the somatic third is created between and within two bodies as well as how awareness of the somatic third, on the part of the clinician, contributes to healing in the therapeutic dyad.

Benjamin (2004) describes the rhythmic third as a space of affective resonance - empathic emotional connection - between and within two minds. Rappoport argues that by working directly with the body, therapist and client can resonate with one another in the space of the somatic third thereby expanding their ability to affectively resonate with one another in the space of the rhythmic third.

In accessing the somatic third, Rappoport (2012) describes, “Working with the body more directly and actively, with awareness and intention” which results in a “linking of affect and soma” (p. 384). Rappoport draws upon techniques from somatic experiencing to access the somatic third. Rappoport argues that consciously bringing the body into the treatment relationship changes the shared space, *the energetic third*, between therapist and client. In discussing the effects of a co-created somatic third between herself and the client whose case material she presents in her article, Rappoport (2012) observes:

As the felt sense experience flows between us, mutual recognition is felt and recognized, with each of us viscerally influencing the other. Together we begin to function as mutually enlivening subjects who meet in the space of the analytic third, ‘outside the two, but connected to both.’ (p. 385)

Citing Eldridge & Cole (2008), Rappaport (2012) suggests that when the therapist shifts the focus of the work away from meaning making and toward an awareness of bodily sensations, meaning will often “emerge organically from the intersubjective space” (p. 384). It is worth acknowledging that Rappaport does not value an embodied felt sense over meaning making, which is considered the central tenant of psychoanalytic work. Instead, she suggests that embodied self-awareness on a visceral, sensory level is the foundation *for* meaning making and leads us towards it.

Rappaport clearly demonstrates how working with the rhythmic third and further, the somatic third, enlivens the therapeutic encounter. It is my contention that relational body psychotherapists (Ben-Shahar, 2012; Diamond, 2001; Hricko, 2011; Shaw, 2003; Stone, 2006) are articulating a similar experience of attunement when they refer to, *somatic resonance* and *embodied resonance*. Hricko (2011), citing Shaw (2003) defined somatic resonance as, “empathic resonance that occurs body to body and includes the energetic inter-subjective space between client and therapist” (p. 25). Ben-Shahar (2012), citing Schafer (1992) and Turp (2000) states, “somatic resonance allows us to connect to the shared field in an attuned manner, responding to a *showing* not yet a *telling*” (p. 14). Reading Hricko and Ben-Shahar’s definitions of somatic resonance, it is easy to see the connection to Rappaport’s concept of the somatic third.

In the discussion chapter I return to the theoretical concepts reviewed in this chapter, further connecting the intersubjective context of clinical work to the embodied dimension. In the next chapter I explore how research findings and theoretical concepts from the field of interpersonal neurobiology support relational psychoanalysis’ intersubjective conceptualization of both human development and clinical practice. Further, I demonstrate that the mind is no longer understood as existing in the head-based brain but throughout the body.

Chapter IV

Interpersonal Neurobiology

“when we interact, we are impacting each other’s internal biological state and influencing the long-term construction of each other’s brains. This, in essence, is how love becomes flesh.”

- Louis Cozolino (2014, p. xv)

During the last two decades the neurosciences have produced a wide breadth of research that is consonant with and can enhance the perspective of relational psychoanalysis. The findings of interpersonal neurobiology support two basic principles explored in this paper: that we are social beings, created through the process of being in relationship with one another, and that embodied self-awareness is a vital component of an integrated sense of self (Carroll & Orbach, 2006). In this chapter I explore key concepts from the field of interpersonal neurobiology that inform an embodied intersubjective perspective on clinical process and context. I begin with a brief overview of the field, followed by an in-depth description of Daniel Siegel’s embodied and embedded mind. I then turn my attention to the preverbal embodied relational experience of early life and the emotion-processing, bodily-based right-hemisphere of the brain. I touch upon the relevance of mirror neurons and conclude with a discussion of the Boston Change Process Study Group’s concept of implicit relational knowing.

Since the decade of the brain (1995-2005), the integrative interdisciplinary field of interpersonal neurobiology has emerged. Interpersonal neurobiology draws from a wide range of disciplines within the biological and social sciences including anthropology, biology, cognitive science, genetics, linguistics, mathematics, physics, psychiatry, psychology, sociology,

systems theory and, of course, neuroscience (Siegel, 2012). Similar to the relational matrix this interdisciplinary field can best be conceptualized as a broad tent encapsulating a variety of subfields. Some of the subfields that have emerged include contemporary developmental neuroscience, modern or relational neuropsychology, regulation theory, and developmental affective neuroscience (J. Schore, 2012, p. 90). Technological advances in brain imaging (i.e. magnetic resonance imaging (MRI) and Positron Emission Tomography (PET)) have made it possible to study the inner workings of the brain and thus led to a surge of research in these fields (A. N. Schore, 2012; Marks-Tarlow, 2012). Developmental neuroscientists are studying how early affective relational patterns literally shape the right hemisphere of the developing brain. Interpersonal neurobiologists such as Siegel (2012), A. N. Schore (2012), and Marks-Tarlow (2012) are developing theoretical models based on this research as well as considering how this research relates to psychodynamic theory.

Interpersonal Neurobiology is concerned with human experience, the nature of mind and mental well-being, and the interconnectedness of the brain-mind-body with relationships (Siegel, 2012; Marks-Tarlow, 2012). According to Cozolino (2014), “At the core of interpersonal neurobiology is a focus on the neural systems that organize attachment, emotion, attunement, and social communication” (p. xvii). As previously discussed in the introduction to this paper, A. N. Schore (2009a, 2009b, 2012) has enthusiastically argued that we are in the midst of a paradigm shift evidenced by a changing focus in both theory and research across the social sciences. A. N. Schore (2012) remarks, “Neuroscience is transitioning from studies of left brain language-based cognitive processes and voluntary motor functions to studies of the embodied functions of the right-lateralized emotion-processing limbic system and stress-regulating HPA [hypothalamic-pituitary-adrenal] axis” (p. 5).

The Embodied and Relational Mind

Interpersonal neurobiologists are re-exploring the Cartesian mind/body divide that has long plagued philosophers and psychologists alike (A. N. Schore, 2012; Siegel, 2012). The question of what the mind actually *is* and where it resides proves to be quite elusive. Siegel (2012) has developed a model of the mind that is understood as “both embodied in an internal physiological context and embedded in an external relational context” (p. XXV). Instead of existing solely within the “head-brain,” the mind is conceived of as existing throughout the entire body as well as between people.

Siegel (2012) views the mind as an emergent process; the mind arises out of an interaction of elements within a complex system. The complex system the mind emerges from is a flow of energy and information circulated throughout the body and exchanged in interpersonal relationships (Siegel, 2012, p. 1-6). The mind is thus understood as an evolving process that exists within and between two or more brain-mind-bodies. Siegel (2012) provides the following working definition of the mind: “A core aspect of the mind can be defined as an embodied and relational process that regulates the flow of energy and information” (p. XXVI).

Siegel (2012) uses the term brain to describe “the extended nervous system distributed throughout the whole body” (p. 4). Traditionally, the term brain has referred to the cluster of cells contained within the skull, the command center of the central nervous system. However, research from the neurosciences continues to demonstrate that the skull-based cluster of cells we generally refer to as the brain is “inextricably interconnected with the whole of the body through the peripheral nervous system and all the signals from the body’s physiological processes” (p. 3). That is, the “head-brain” relies on input from the extended nervous system, located throughout the entire body, in order to function.

Within Siegel's model, the brain is conceived of as an embodied neural mechanism contained within both the body proper and the cluster of cells in the "head-brain" (p. 3-2). The brain is thus the structure within which the energy that is mind flows. Siegel (2001) explains:

The reality appears to be that the processes of the mind emanate from the structure and function of the brain. The brain itself is an integral part of the central nervous system, which is fundamentally interwoven within the whole body. Thus, though we may speak of the mind as emanating from the neurophysiological processes of the brain, this statement is an abbreviated way of referring to the flow of energy and information within the brain as a fundamental part of the functioning of the body as a whole. The patterns in the flow of energy and information, the essence of the mind, are a product of both bodily (neurophysiological) processes and interpersonal interactions. (p. 70)

Siegel is using the term brain to refer to both the central nervous system and the peripheral nervous system, both the brain in the head and the brain in the body. Instead of referring to a brain-body-mind, Siegel uses the shorthand brain-mind. Although I believe Siegel is attempting to simplify things, I think that this use of the term brain is confusing simply because "brain" has historically referred to the organ of soft nervous tissue contained within the skull. For this reason I think it makes more sense to use the term brain-body-mind as opposed to brain-mind when referring to the complex system that makes up a human being.

Influenced by systems-theory, Siegel (2012) argues that a core feature of the mind is its ability to self-regulate the complex system that it both exists within and emerges from. The mind not only arises from a flow of energy and information in an embodied and relational system, but it also regulates that same flow of energy and information. Energy is the thing that the mind both emerges out of and regulates. Siegel (2012) defines energy as "a potential to

create, to induce movement, change, or action” and information as “a swirl of energy with meaning, a pattern of energy that symbolizes something other than itself” (p. 1-8). Within the brain-body-mind, neural firing patterns carry electrochemical energy. How energy is carried between people is not as well understood by science. Siegel suggests that the flow of energy and information, both within and between people, may ultimately be what gives rise to subjective experience, consciousness, and mental activities such as emotion, thinking, and memory (p. 1-9).

The mind, brain-body, and relationships are an interconnected system. According to Siegel (2012):

We do not need to separate the two – each is a fundamental part of what the mind is and where the mind resides. The system we are focusing on is not brain[body] *or* relationships – it is a system that entails the flow of energy and information within the brain[body] and between one another. (p. 1-8, 1-9)

Conceptualizing the mind as an embodied and relational process helps us to recognize the embodied self-awareness of the client, the embodied self-awareness of the therapist, and the relationship between the two as imperative to clinical work. If we think of the brain as a neural-network that exists throughout the entire body, the relevance of bodily awareness to mental well-being and clinical work becomes obvious.

The client/therapist dyad is not only co-creating an intersubjective third space but they are also co-creating a joint mind that exists between them. The client and therapist’s separate *embodied* minds create and regulate the intersubjective mind. At the same time, the intersubjective mind influences and regulates the client and therapist’s separate embodied minds. This is how mutual regulation occurs in a dyadic relationship. Just as an individual brain-mind-body has the capacity to regulate the complex system it emerges out of, so too the intersubjective

brain-mind-body has the capacity to mutually regulate the complex system that is the client/therapist relationship. Ben-Shahar (2014) observes:

When a therapist and client sit together in the clinic, mind is neither merely an object, nor simply a separated subject; instead, *mind is an intersubjective process*, inclusive of the therapist and client, the processes that take place within them and between them – it is a wider mind. (p. 101)

By describing the intersubjective mind as a wider mind, a term Ben-Shahar borrows from the anthropologist Gregory Bateson, Ben-Shahar is introducing the holistic perspective of body psychotherapy, mainly that the intersubjective mind is greater than the sum of its parts.

Siegel (2012) contends that the principle of integration is what defines health. From an interpersonal neurobiology perspective, human beings are seen as naturally inclined toward integration. Impaired mental health is seen as a lack of integration between brain-body-mind and relationships and is understood as caused by a combination of genetic, experiential, and chance factors. Psychotherapy is viewed as a process or movement toward greater integration (Siegel, 2012, p. 4-6).

If we accept that, as clinicians, part of our job is to assist our clients in moving toward greater integration (health), and also accept that the brain is more accurately understood as located throughout the wider nervous system of the body, it is essential that we incorporate embodied self-awareness into mental health practices. Further, Siegel's model of an embodied mind helps us to understand why the body must be centrally involved in the transference/countertransference discussion.

The Preverbal Relational Matrix of Early Life and Regulation Theory

Drawing upon the findings of modern attachment theory and developmental research, interpersonal neurobiology posits that over the first two years of life the right hemisphere of the brain develops in a preverbal relational matrix with the primary caregiver. Modern attachment theory, building on Bowlby's (1969) original attachment model, and supported by research in interpersonal and developmental neuroscience, tells us that our earliest experience of being alive is a preverbal, bodily-based, right brain experience. According to A. N. Schore & Schore (2012), "for the rest of the life span, attachment processes lie at the center of all human emotional and social functions" (p. 27).

The integrative research of Allen Schore (2003, 2012) has been instrumental in revealing connections between infant attachment and affect regulation, and the development of the mind-brain-body. A. N. Schore has proposed that modern attachment theory is essentially a theory of regulation. In an article entitled *Modern Attachment Theory: The Central Role of Affect Regulation in Development and Treatment*, A. N. Schore and Schore (2008) presented regulation theory as a modern update of attachment theory:

...as a result of interdisciplinary developmental and neurobiological research over the last 15 years Bowlby's core ideas have been expanded into a more complex and clinically relevant model. We will argue that at this point in time, any theory of development and its corresponding theory of therapy must include these psychobiological findings regarding precisely how early emotional transactions with the primary object impact the development of psychic structure, that is, how affective attachment communications facilitate the maturation of brain systems involved in affect and self regulation. (p. 10)

According to A. N. Schore (2012), regulation theory highlights three major themes: that experiences in the first two years of life significantly influence the developing structure of the brain, that bodily-based emotion is essential to a fuller understanding of the human condition, and that, right brain implicit unconscious processes are dominant over the course of the lifespan (p. 1, 2).

Before the left-brain has formed, before we are able to think symbolically, we come to know ourselves through the context of a bodily-based relationship with a primary caregiver: “The individual is seen to ‘emerge out’ of a relationship with a significant ‘other’” (Marks-Tarlow, 2014, p. 220). The newborn infant is not conscious of itself as separate from the primary caregiver. According to Fogel (2009), “Self-awareness in early infancy has no concept of ‘me’ and ‘you’ as separate beings” (p. 20, 21).

The primary caregiver interprets the infant’s bodily-based sensations as specific feelings or needs thus making sense of the infant’s internal world before the infant is able to do so for itself. The crying infant does not know what it is crying for. It is the attuned caregiver who interprets the infant’s cry as that of a specific feeling or need, i.e. hunger, sleepiness, etc. The infant thus develops the ability to make sense of his/her own bodily-based sensations as specific feelings. It is the attuned caregiver’s understanding and responsiveness, communicated in part through the handling and holding of the infant’s body that develops into self-care and emotional regulation (J. Schore, 2012, p. 107). Right brain to right brain non-verbal communication between infant and caregiver shapes the infant’s sense of self and internal working models of relationships (Marks-Tarlow, 2012, p. 22). Modern infant attachment research is reminiscent of Winnicott’s famous statement, “There is no such thing as a baby,” and supports relational psychoanalysis’

understanding of the infant as primarily object seeking, as opposed to drive driven (J. Schore, 2012, p. 107).

The Emotion-Processing, Bodily-Based Right-Hemisphere of the Brain

The command center of the brain consists of the right and left hemispheres, divided by the corpus callosum, the part of the brain responsible for neural integration of the two hemispheres. The relationship of the right and left hemispheres is not dissimilar to Freud's conceptualization of the conscious and unconscious mind. A. N. Schore (2003) has described the right hemisphere as the "biological substrate of the human unconscious."

The right hemisphere is the home of a "motivationally informed emotion-processing unconscious" that develops out of the infant's earliest relational environment (J. Schore, 2012, p. 107). The left hemisphere begins to ascend at around 18 months, becoming prominent at 3 years. Thus, the right hemisphere of the brain is dominant during the first two years of life (J. Schore, 2012; Marks-Tarlow, 2012; Fogel, 2009). The infant begins to develop embodied self-awareness in the first three years of life through interpersonal interactions with its primary caregiver. As the left hemisphere, conceptual self-awareness, has yet to develop during the first two-years of life, the infant's sense of self is "nonconceptual and nonlinguistic" (Fogel, 2009, p. 20).

Right and Left Brain: Different Perspectives on the World

While the two hemispheres of the brain were once understood as specialized in performing different tasks, brain laterality researchers now conceptualize the right and left hemispheres as having "different perspectives on the world" (Marks-Tarlow, 2012, p. 15). Whereas the left hemisphere is considered the home of conscious, rational, linear thinking, the right hemisphere is the realm of *nonconscious*, holistic, subjective emotional nonlinear experience (Marks-Tarlow,

2014, p. 220; A. N. Schore, 2012, p. 7). Within the literature of interpersonal neurobiology, as well as other related fields, the term nonconscious is used to distinguish between Freud's dynamic unconscious and other aspects of experiential knowledge that remain outside of explicit, left-hemisphere conscious processing but that are not necessarily repressed or defended against (A. N. Schore, 2012). However, unconscious and nonconscious are still often used interchangeably.

According to Schore (2012), "We can no longer think of 'the brain' as two halves of a single entity. Rather, these two systems process different types of information in very different ways" (p. 7). The right brain processes nonverbal, implicit, procedural memory. J. Schore (2012) describes the implicit memory system of the right brain, present from birth:

[it] operates rapidly and unconsciously and is heavily connected to the autonomic nervous system. It is organized to give an emotional valence to events, to detect safety and threat, and is subjectively experienced as emotional memory. This earliest type of memory is right lateralized, unconscious, implicit, bodily-based, and emotional. (p. 95)

The right hemisphere processes the felt sense of experience, recording affective information in implicit, nonconscious memory. Marks-Tarlow (2012) suggests conceiving of the left hemisphere as utilizing a top down approach and the right hemisphere utilizing a bottom up approach. The right hemisphere of the brain is the part of the command system of the central nervous system that receives neural information from the body, the peripheral nervous system. In other words, the right hemisphere processes kinesthetic physiological information from the body on a nonconscious level (A. N. Schore & J. Schore, 2012).

Marks-Tarlow (2012) uses the metaphor of mistaking the forest for the trees to explain the difference between the right and left hemispheres. Whereas the right hemisphere maintains a

holistic expansive attention, understanding the forest as something greater than a collection of individual trees, the left hemisphere focuses in on the features of each individual tree (p. 15, 16). The left hemisphere specializes in making sense of experience by honing in on details, recording factual information in explicit, conscious memory through the use of symbolic, verbal thought processes (Marks-Tarlow, 2012; A. N. Schore, 2012). Psychotherapy, the “talking-cure,” along with the wider western culture within which it was first created, has long valued the deliberate cognitive capacities of the left-brain over the intuitive, implicit processes of the right brain (Fogel, 2009).

Mirror Neurons

Mirror neurons can be understood as the neurological basis of empathy and affective resonance. In the 1990s it was discovered that the same neurons are fired when an action is taken and when an action is observed (Ben-Shahar, 2014; Siegel, 2012). The same is true regarding emotions. Strait (2014) explains, “observing an emotion and experiencing an emotion activates the identical neural structure” (p. 316). The fact that we neurobiologically mimic actions and emotions that we observe in others is scientific evidence of the fact that our nervous systems are affected by other people’s actions and behaviors. Gallese, Eagle, & Migone (2007) use the term “embodied simulation” to refer to the process by which mirror neurons are activated within one person when observing another person engage in an action, or experience an emotion.

The discovery of mirror neurons offers a neuroscientific understanding of affective resonance, a form of empathy (Cozolino & Santos, 2014, p. 164). Our ability to affectively, empathically resonate with another person is grounded in the stimulation of mirror neurons in the premotor regions of our frontal lobes (Cozolino & Santos, 2014; Hopenwasser, 2008). This means that, “knowing ourselves deeply supports our knowing others’ internal worlds as well”

(Siegel, 2012, p. 23-2). The discovery of mirror neurons supports the concept of a co-created embodied intersubjective space within which our nervous systems resonate with one another.

The Boston Change Process Study Group and Implicit Relational Knowing

The Boston Change Process Study Group (BCPSG), created in 1995, is a group of psychoanalysts, developmental researchers, and psychoanalytic theorists. BCPSG (1998a) view themselves as contributing to an “interdisciplinary synthesis of scientific research and clinical theory and observation” (p. 284). Although they do not specifically identify themselves as interpersonal neurobiologists, I view their work, guided by developmental research, dynamic systems theory, and psychodynamic theory and practice, as closely related to the ideas explored in this chapter and thus chose to include a section on their work here.

In a pivotal paper entitled, *Implicit Relational Knowing: Its Role in Development and Psychoanalytic Treatment*, BCPSG (1998a) presented their ideas on the “something more” than interpretation that is needed to bring about change in psychotherapy. BCPSG uses the term “something more” to describe the interactional intersubjective process that catalyzes change in psychotherapy, as opposed to the symbolic interpretative process of making the unconscious conscious. BCPSG (1998a) explains how they started down this path:

Early in our discussions, our attention was drawn to the observation that most patients remember ‘special moments’ of authentic person-to-person connection with their therapists, moments that altered their relationship with him or her and thereby their sense of themselves. (p. 284)

In an effort to develop language with which to describe this “something more,” the BCPSG (1998a) introduced the terms “implicit relational knowing,” “the real relationship,” and “moments of meeting” (p. 285).

BCPSG makes a distinction between two types of procedural knowledge: the procedural knowledge that has to do with knowing how to *do* something and the procedural knowledge that has to do with knowing information *about* something (Lyons-Ruth, p. 577). BCPSG breaks-down the procedural knowledge that has to do with knowing how to *do* something into two categories. The first category has to do with knowing how to do something such as riding a bike or driving a car which, “concerns knowing about interactions between our body and the inanimate world.” The second category has to do with knowing how to be in relationship with others, such as knowing how to express affect (BCPGS, 1998b, p. 905). For this second type of procedural knowing, the kind that has to do with “knowing about interpersonal and intersubjective relations,” BCPSG proposed the term *implicit relational knowing* (p. 905).

The BCPSG emphasize that implicit relational knowing is as much affective as it is cognitive and can remain *nonconscious*, “...operate[ing] largely outside the realm of verbal consciousness *and* the dynamic unconscious” (1998a, p. 285). The term nonconscious helps us to differentiate between Freud’s dynamic unconscious and a realm of experience that is not explicitly conscious, yet is not defended against or repressed (A. N. Schore, 2012).

The BCPSG (1998a) goes on to note “implicit relational knowing begins to be represented in some yet to be known form long before the availability of language and continues to operate implicitly throughout life” (p. 285). Based on the observation that infants indicate surprise or upset when a relational pattern of interaction is disturbed, infant researchers have concluded that infants anticipate relational patterns of interaction from their primary caregivers. This suggests that infants are employing implicit relational knowing in the first year of life. BCPSG (1998b) cites research studies by several members of the group (Stern, 1985, 1995; Sander, 1962, 1988; Tronick & Cohn, 1989; Lyons-Ruth & Jacobvitz, 1999) that demonstrate an

ongoing process of relational negotiation between the infant and the primary caregiver.

According to BCPSG (1998b) it is the “unique configuration of adaptive strategies that emerges from this sequence in each individual [that] constitutes the initial organization of his/her domain of *implicit relational knowing*” (p. 905). Similar to A. N. Schore’s (2012) theory that early attachment patterns and unconscious processes of the right hemisphere of the brain lie at the core of the self throughout the lifespan, the BCSPG (1998b) purport that various types of implicit relational knowings operate over the course of life, “including many of the ways of being with the therapist that we call transference” (p. 905, 906).

BCPSG defines the “real relationship” as “the intersubjective field constituted by the intersection of the patient’s and the therapist’s implicit relational knowing” (p. 285). The term “real relationship” is used to differentiate “authentic personal engagement and reasonably accurate sensings of each person’s current ‘ways of being with’” from the transference-countertransference domain, as well as from the domain of verbal interpretations (p. 285). “Moments of meeting” are the transactional events that occur in the “real relationship” between therapist and client, usually involving heightened affect, that lead to new types of implicit relational knowing. A “moment of meeting” requires an authentic response from the therapist, an affective revealing of some personal aspect of the self. In the following quote in which BCPSG explain how their model is different from “traditional views,” one can see similarities between BCPSG’s (re)construction of psychodynamic psychotherapy with both Schore’s model of regulation theory and relational psychoanalysts’ focus on the here and now therapeutic relationship:

In contrast to more traditional views, we feel that the real relationship is *also subject to* therapeutic change by processes that alter the intersubjective field directly. In traditional

theory, interpretation is viewed as the semantic event that rearranges the patient's understanding. We propose that a 'moment of meeting' is the *transactional* event that rearranges the patient's implicit relational knowing by rearranging the intersubjective field between patient and therapist. (BCPSG, 1998a, p. 285, 286)

Such "moments of meeting" do not require reflection or verbalization to evoke therapeutic change, although both can take place after the fact. The BCSPG suggest that it is the "moment of meeting" itself that brings about change in psychotherapy, not the interpretation of the experience. The work of BCSPG is an example of how research from the neurosciences is being intertwined with aspects of psychoanalytic theory to create new theoretical models.

Conclusion

The perspective of interpersonal neurobiology supports the position of the BCPSG, the broader field of relational psychoanalysis, as well as the metatheory of common factors research regarding the therapeutic relationship as a dominant factor in the change process of psychotherapy. A. N. Schore (2012) remarks upon how the current paradigm shift has both *been* influenced by psychoanalytic theory and *is* influencing psychoanalytic theory:

we are now seeing a resurgence of interest in subjective implicit, unconscious functions, and thereby in psychoanalysis, the science of unconscious processes. Modern psychoanalysis is being reenergized by advances in developmental psychoanalysis, which are describing the early intersubjective origins of the unconscious mind, and in neuropsychoanalysis, which are exploring how intersubjective communications impact internal psychic structure. (p. 13)

I would argue that research in the neurosciences is also reenergizing the theory and practice of body psychotherapy through research on the embodied nature of mind and affect, as well as by bringing a focus on embodied awareness into mainstream dialogue. Interpersonal

neurobiologists' contention that the body-brain-mind must be conceived as and worked with as an integrated whole is consonant with the holistic perspective of body psychotherapists.

A. N. Schore (2012) contends that scientists studying the brain and therapists studying the mind are in agreement regarding the “centrality of bodily-based affective phenomena” however, he highlights that a common language addressing “the subjective emotional realm” has yet to be established (p. 19). In the following chapter I will braid together terminology from interpersonal neurobiology, relational psychoanalysis and body psychotherapy to further elucidate the phenomenon of embodied intersubjectivity as well as underscore Schore's point about the lack of a common language to describe this realm of experience. I will argue that part of what is transformative about psychotherapy is experiencing a deeper connection with one's embodied sense of self and having that experience recognized, in a somatic third space, by another embodied being. I will conclude by further elaborating on how this phenomenon is relevant to clinical social work practice.

Chapter V

Discussion

“And we cannot claim the sense of vitality that we crave unless we learn how to feel that which we cannot know.”

- Mark Epstein (2005, p. 136)

Shifting Paradigms

In this paper I have examined two parallel and intersecting paradigmatic shifts in psychotherapy. The first shift, influenced by relational psychoanalysis, is a movement from a subject/object frame to an intersubjective frame. The second shift, influenced by research in the neurosciences, is a shift in emphasis from explicit, conceptual, symbolic, left brain processes to implicit, bodily-based, affective, right brain processes. Whereas content was once primary, the focus is now on context. These two paradigm shifts are deeply interwoven and are continually altering the clinical encounter.

When I started this project, I was naïve to the complexity of the topic. I knew that exploring the phenomenon of embodied intersubjectivity meant weaving together multiple theories on both embodiment and intersubjectivity, but I had no idea how profoundly interlaced those theories would prove to be. I planned to explain the phenomenon of embodied intersubjectivity with a reductionist method, examining intersubjectivity through the lens of relational psychoanalysis and embodiment through the lens of interpersonal neurobiology. However, I soon realized that embodiment and intersubjectivity are so deeply interwoven, it is nearly impossible to separate one from the other. We come to embody ourselves through being

in relationship with others in an intersubjective context. We relate with one another in an intersubjective context through our bodies. That is to say, intersubjectivity is embodied and embodiment is intersubjective.

In the previous two chapters I demonstrated that the self is no longer understood as a separate, fixed entity but rather a process that is co-created in relationship with others. In both intersubjective relational theory and interpersonal neurobiology, the self has been de-centered, “The field of self expanded beyond the boundaries of skin to include connections with others” (Ben-Shahar, 2014, p. 101). In chapter III, I traced the paradigm shift in psychoanalysis toward a relational theory of mind and described how relational theorists have reimagined the clinical encounter as a meeting of two subjectivities. In chapter IV, I used interpersonal neurobiology to demonstrate the interconnectedness of the body, mind, brain, and relationships, and highlighted the relevance of implicit, affective, bodily-based right-brain-to-right-brain communication in life and clinical work. The interpersonal neurobiological point of view purports that we come to know ourselves, both developmentally and clinically, through being in relationship with others. A reformulation of this point of view is that we come to *feel* ourselves through *feeling* in relationship with others. When we tune into our bodily felt-sense while at the same time tuning into the felt sense in the room, thereby picking up the felt-sense of the other, we come in contact with the embodied intersubjective matrix.

I introduced this paper on a personal note, sharing my own experience as a client in psychotherapy. In an article linking psychoanalysis with polarity therapy Newman (2008) remarks:

I was intrigued by the question of how [clients] could ‘know’ themselves in a more authentic and connected manner - less from mental ‘knowing’ and more from organic,

embodied ‘knowing.’ I felt certain that in order to connect more with the truth or ‘rightness’ of an experience - even the effect of an interpretation or insight - one had to be centered ‘in’ one’s body. (p. 171)

Newman’s musings reflect what I shared of my experience as a client in psychotherapy, namely, that when intellectual insight is paired with a bodily-based felt sense of truth, the effects of psychotherapy are most transformative. In this paper I have attempted to unravel the connection between the bodily-based felt sense that Newman alludes to and the intersubjective nature of the therapeutic relationship. To connect with the truth or “rightness” of an experience, one need not only be centered “in” one’s own body, but also in relationship with another embodied being. The remainder of this chapter is dedicated to discussing and synthesizing these two threads.

The Relevance of Embodied Self-awareness to Mental Health and Wellbeing

As touched upon in chapter II, embodied self-awareness is related to Winnicott’s notion of true self: an individual’s authentic, spontaneous, and creative nature. The initial experience of true self is the infant’s bodily-based felt sense of some physiological impulse. Overtime, the child internalizes the primary caregiver’s ability to interpret that physiological impulse as a specific emotion, need, or desire. According to Winnicott’s (1965) theory, the basis of psychological and physiological wellbeing is the individuals’ connection to their embodied sense of self, from which they *feel* their bodily based impulses in the present moment, and out of which grows an authentic, true self. Recall Mitchell’s (1992) temporal perspective that there is no core true self, only true or authentic experiences. From this point of view, the ability to yield to one’s felt sense at any particular moment creates the possibility of authentic experiencing.

In chapter III, I summarized Ghent’s ideas on the difference between submission and surrender. Ghent (1990) describes surrender as a yearning to give up the structure of the false

self, as an experiential awareness of “one’s sense of wholeness” that is grounded “totally in the present” (p. 111). Ben-Shahar (2014) notes that from a phenomenological perspective the world and thus the context of clinical work is “sensory and somatic in its essence” (p. 109). We can only relate to one another in so far as we have a body to relate with. Ben-Shahar continues, “Surrender... does not take place in a void, but occurs in our bodily, psychological, and relational organization. The human context for such surrender is necessarily bodily” (p. 109). Although Ghent does not explicitly refer to embodied experience, his description of surrender shares similarities with Gendlin’s felt sense and Fogel’s embodied self-awareness. Perhaps part of the yearning to surrender is the desire to *feel* oneself more fully in the subjective emotional present. The kind of surrender I am thinking of is an experience of losing oneself in a felt sense experience of knowing.

When the authentic true self is not encouraged, the false self develops as a defense. In certain expressions of the false self the intellectual process becomes overdeveloped. When this is the case, “there develops a dissociation between intellectual activity and psychosomatic experience” (Winnicott, 1965, p. 144). Elaborating on Winnicott’s theory, Fogel (2009) comments:

*the **True Self** is our embodied self-awareness, our ability to stay comfortably in the chaos of the subjective emotional present, and to use that to inform, verify, and update our conceptual self-awareness....The **False Self** is our conceptual self-awareness in the condition that it becomes divorced from the regulating reassurance of embodied self-awareness. (p. 103)*

When the true self feels threatened we automatically protect ourselves by hiding our feelings and impulses from others and ultimately denying them from ourselves. A pattern of avoiding the

subjective emotional present develops and embodied self-awareness is suppressed. Fogel (2009) defines suppression as “the loss of our ability to feel ourselves” (p. 4) and suggests that denial, repression, and intellectualization are all defensive versions of suppression. Over time, neuromotor pathways develop “that amplify and reinforce our ability in the future to suppress our body states from reaching self-awareness” (Fogel, 2009, p. 102).

A. N. Schore (2012) and Marks-Tarlow (2014) seem to be articulating a similar phenomenon when they refer to an overreliance on the capacities of the left hemisphere of the brain, disconnected from the input of the right hemisphere. Referencing McGilchrist’s (2009) book, *The Master and His Emissary: The Divided Brain and the Making of the Western World*, Marks-Tarlow (2012) explains that the left brain often falsely believes it is in control because it is the seat of conscious explicit knowledge: “it erroneously conceives of itself in charge of the whole, while losing sight of the less visible, body-based, integrative functions of the right” (p. 17). From this point of view, a false self-experience manifests when the conceptual information processing of the left brain is divided from the physiological information processing of the right brain. From a neurobiological standpoint, it seems that the potential for true self-experience is located in both a connection between the left and right hemispheres of the brain, as well as a connection between the central nervous system of the right brain and the peripheral nervous system located throughout the body.

In both chapters III and IV, I outlined how modern developmental research directly supports Winnicott’s notion that an experience of true self is inextricably bound up with both embodied self-awareness and relationships: how we inhabit our bodies, feel ourselves from the inside (interoception), is co-created in relationship with our primary caregivers. According to A. N. Schore & Schore (2012):

Modern attachment/regulation theory explains how these ‘external’ developmental and therapeutic attachment experiences are transformed into ‘internal’ regulatory capacities....The intersubjective process of developing a true self that can enter into meaningful relationships shows us how the internal world is structured on a psychophysiological base... (p. 45).

It is important to highlight how modern developmental theory differs from Winnicott. For Winnicott, the impetus is on the “mother” to attune with her infant. Modern developmental theory understands attunement or misattunement as resulting from the unique interaction between the infant’s biological predisposition (temperament) and its relational environment (Schore & Schore, 2012, p. 32). In the clinical encounter, impasses cannot be explained away as a client’s resistance or a therapist’s lack of attunement. Rather, misattunement in the clinical encounter is understood as existing in the intersubjective field between client and therapist.

In addition to explaining why embodied self-awareness is a necessary attribute of mental wellbeing, I have also emphasized that embodied self-awareness is co-created in relationship with other embodied beings. In chapter IV, I described how the infant learns to make sense of its feelings and sensations by being in relationship with the primary caregiver. This same process occurs in the therapeutic relationship. Just as clients learn how to develop their conceptual self-awareness through being in relationship with a therapist who offers analytic questions and interpretations, so too do clients learn how to develop their embodied self-awareness by being in relationship with a therapist that encourages deeper awareness of an embodied felt sense of self.

Embodied Mutual Recognition

In the introduction of this paper I stated that part of what is curative about psychotherapy is being recognized in a state of embodied self-awareness by another embodied being. In chapter

III, I reviewed Jessica Benjamin's (1990, 2004) developmental theory of intersubjectivity as well as her understanding of thirdness. Benjamin explores the paradox of recognition: we depend upon the recognition of other subjects in order to become self-conscious of our own independent will. When applied to the clinical context, the client becomes consciously aware of aspects of her own subjectivity through a process of mutual recognition with the therapist. In the very moment the client feels her independent subjectivity recognized by the therapist, she is in turn recognizing the therapist as a separate subject. The therapist and client's separate individual subjectivities exist in dialectical tension with the connected intersubjective therapist-client dyad.

Just as the client becomes conscious of her own subjectivity through a process of mutual recognition with the therapist, so the client comes into contact with her *embodied* subjectivity through mutual *embodied* recognition with the therapist. To develop embodied self-awareness one needs to be recognized by not only another subject but by another *embodied* subject. Of course from a phenomenological point of view, subjectivity is inherently embodied: we are all embodied subjects. What I am attempting to get at here is something slightly different.

My proposal is that clients crave to have their embodied self-awareness recognized by an embodied other. I am imagining a client that struggles with embodied self-awareness. Let's call him Mr. D. Perhaps Mr. D first came to therapy completely disconnected from his bodily-based felt sense of himself. Mr. D was the type of patient who, when asked about how he was feeling would answer by explaining what he was thinking. Mr. D's conceptual self-awareness was disconnected from his underdeveloped embodied self-awareness. Mr. D articulated feeling inauthentic both inside himself and in relationship with other people, as well as a yearning for something intangible that he could not quite grasp. One might say that Mr. D's life was made up of mostly false self-experiences.

Through the process of psychotherapy, as Mr. D began to slowly develop a bodily-based felt sense: he was able to perceive sensations in his body that he had previously been unaware of. He developed a stronger connection between his conceptual sense of self and his embodied, affective sense of self. In session, when Mr. D has a fleeting experience of being deeply connected to his bodily-based felt sense, he longs for his achievement to be recognized by his therapist. Just as Mr. D. looks to his therapist to confirm his conceptual self-awareness by recognizing his analytic interpretations of himself, Mr. D. also looks to his therapist to confirm and recognize his subjective, embodied sense of self.

It is as if Mr. D looks to his therapist and through body language and facial expression says, “*Look at me. I’m knowing in my bones!*” Through the therapist’s recognition, Mr. D’s bodily-based felt sense of his authentic true self-experience is confirmed. In chapter II, I discussed Gendlin’s (1996) description of the felt sense as “a physical sense *of* something, of meaning, of implicit intricacy” (p. 63). The felt sense is a holistic experience that is more complex than affective experience. It includes emotional experience but is not the same as simply being aware of feelings and emotions on an embodied level. Thus, resonating in mutual recognition of a felt sense experience can include affective resonance but it is not the same as affective resonance.

The therapist recognizes Mr. D’s embodied self-awareness by resonating with Mr. D in a bodily-based nonverbal somatic third space. The therapist can verbally recognize Mr. D’s embodied self-awareness, but verbal recognition is not necessary. According to Ben-Shahar (2014):

We may assist clients in building bridges between somatic expression and symbolic cognitive and linguistic language, and thereafter process the experience together through

verbal interaction. We may, however, also consent to speak without translators; to directly converse with our clients through our own body, without attempting to symbolize the expression. (p. 94)

Regardless of whether or not the embodied attunement is processed verbally, in order to resonate with Mr. D in the somatic third space, the therapist must be connected to her internal bodily-based felt sense of self and willing to *feel into* the co-created space with Mr. D. If the therapist is stuck in conceptual interpretation, cut off from her bodily-based felt sense, she will not be able to resonate with Mr. D on this level, and thus will not be able to recognize him.

The very moment that Mr. D senses his felt sense of self is being recognized by his therapist, he also mutually recognizes his therapist's separate embodied felt sense of self. In other words, in order for Mr. D to resonate in a state of embodied mutual recognition with his therapist, thereby coming in contact with his own embodied subjectivity, Mr. D's therapist must allow herself to be recognized by him on this level. This requires a great deal of vulnerability on the part of the therapist, her subjective embodied, felt sense of self openly displayed to the client. Such a moment of embodied mutual recognition is, in the language of the BCSPG (1998b), a "moment of meeting." It is a surrender to Benjamin's (2004) shared third encompassing both the rhythmic third, the part of the third that constitutes oneness, and the intentional third, the part of the third that facilitates differentiation. It alters the intersubjective field that is the "real relationship" and can lead to both new forms of implicit relational knowing and new depths of embodied self-awareness.

To summarize, in order for a client and therapist to resonate in a nonverbal state of embodied mutually recognition, both must be attuned to their bodily-based felt sense of self. When a client tunes into an embodied felt sense of some truth, they desire to be recognized in

their embodied state. In order to engage in a process of mutual recognition with the client, the therapist must allow her felt sense of self to be seen.

Surrendering to the Third Through Embodied Self-awareness

Benjamin views her ideas on thirdness as an extension of Ghent's concept of surrender. In Benjamin's (2004) model, we find our way out of complementarity by surrendering to the third. When two people are stuck in opposing positions, finding a third perspective allows the relationship to shift. Discovering the third enables us to open to the other's reality, even if it exists in dialectical tension with our own. Benjamin defines thirdness as an "intersubjective mental space." For Benjamin, surrendering to the third is the process of freeing oneself from the confines of one level of conceptual awareness and opening to another level of conceptual awareness.

I would like to suggest that surrendering to our felt sense is another way of accessing the third. When we are stuck in complementary relationships or thinking, we can find a third space by surrendering our conceptual self-awareness to our embodied self-awareness. By sinking into our bodily-based felt sense we release ourselves from the confines of our conceptual thinking self, the part of us that most likely has become stuck in complementarity, doer-done to relations. Recall that the left hemisphere of the brain, the seat of conceptual self-awareness, excels at honing in on detail whereas the right hemisphere of the brain, the home of embodied self-awareness, maintains a broad, holistic perspective. In the language of interpersonal neurobiology, we can surrender left brain explicit processing to right brain implicit processing, thereby attempting to find a way to *feel-into* thirdness. In this way, thirdness is the intersubjective *embodied* space that facilitates surrender. Marks-Tarlow (2012) comments, "Within the clinical setting, left-brain approaches easily evoke the feeling of 'being done to'" (p.

18). In other words, we often get locked into complementarity when we get stuck in left-brain, analytic, rational, symbolic thinking and relating. When conceptual relating gets stuck, client, therapist, or both can surrender to their embodied self-awareness as a way of finding a third perspective.

I'm imagining a situation in which a therapist, Ms. L, is working with a client whom she experiences as dominating and aggressive. From the beginning, Ms. L is aware of a strong countertransferential reaction to this particular client. During sessions, Ms. L feels as though her client speaks *at* her, barely allowing Ms. L room to speak. Overtime Ms. L realizes that she feels threatened, as though her own subjectivity is being pushed out of the room. She feels herself struggling against her client's aggression as opposed to moving towards it, and yet she can't seem to change course. Ms. L is conscious of the fact that she feels stuck in a doer/done to dynamic but struggles to find a way out. It is as if Ms. L has only two options; either continue to let the client dominate her or take back control by dominating the client. Ms. L begins to feel frustrated with the client, herself, and the work.

One way out of such complementarity might be for Ms. L to drop into her felt sense, attempting to find the holistic perspective of the right brain. Ms. L consciously attempts to shift from a conceptual awareness of the intersubjective dynamic to an embodied felt sense of the intersubjective dynamic. By making this shift, Ms. L is able to unlock herself from the complementarity she has been stuck in. She feels into the somatic third space searching for other ways of being with her client that exist outside of the dominate-or-be-dominated dynamic. By surrendering to her felt sense of self, Ms. L no longer feels the need to defend herself because she has found a more holistic, expansive perspective. She is able to simply *be with* her client.

Ms. L's shift into embodied self-awareness changes the intersubjective space, is felt by the client, and thus enables the therapeutic relationship to find new ground.

Implications for Clinical Social Work

Viewing clinical practice as ingrained within an embodied intersubjective matrix has broad implications for clinical social work. Throughout this paper I have argued that a paradigm shift is currently taking place in the field of psychotherapy: a movement toward a reconceptualization of the clinical relationship as both embodied and intersubjective in nature. If this is so, it is imperative that clinical social workers are aware of this shifting context.

The relational-embodied paradigm shift discussed in this paper is deeply compatible with social work's biopsychosocial perspective. Social work has, historically, emphasized both relationship and process as essential attributes of treatment (Brandell & Ringel, 2004). The interconnectedness of body, mind, brain, and relationships is already embedded in the holistic, biopsychosocial approach of clinical social work. Further, the embodied intersubjective context is simply an expansion of the person-in-environment perspective, a defining characteristic of social work practice. An embodied intersubjective lens can be easily integrated into a person-in-environment approach. This is applicable to both the clinical context and the client's larger sociocultural environment.

Fogel (2009) notes, "In the global marketplace of ideas and products, a higher value is placed on being rational than emotional" (p. 4). As a culture, we have become disconnected from our bodies. Thinking and doing are valued over feeling and *being* (Fogel, 2009). This holds true in the vast majority of psychotherapy modalities where left brain cognition is encouraged over right brain intuition. It is thus understandable that many clients, as well as therapists, identify almost exclusively with their head-based cognition and are somewhat

disconnected from their embodied felt sense of self (Wilberg, 2003). The field of clinical social work, with its biopsychosocial, person-in-environment perspective is positioned to bring awareness of this cultural phenomenon into clinical practice.

In this thesis I did not explore the interconnection between embodied intersubjective relating and the social identities of the client/therapist dyad. I thus specifically chose to not include the respective social identities of the client/therapist dyads in the brief fictionalized case vignettes in this chapter. The literature drawn upon in this paper lacks consideration of how the meeting of two unique social identities impacts embodied intersubjective relating. Further research is needed that looks at embodied intersubjective relating in, for example, cross-racial, cross-gender, and cross-cultural client/therapist dyads. Clinical social workers have the expertise to contribute such research to this area of study.

Similar to the relational paradigm in psychoanalysis, the field of social work has historically remained open to incorporating theory and research from a wide range of related fields. Over the last two decades the field of social work has begun to incorporate theory and research from relational psychoanalysis and interpersonal neurobiology (Schoore & Schoore, 2012, p. 28). This is clearly evident at the Smith School for Social Work where the elective *Neurobiology and Clinical Social Work* has been offered since 2008, *The Role of Emotion in Therapeutic Action* since 2010, *Clinical Applications of Intersubjective Theory* since 2014, and *Psychodynamic Relational Perspectives: Implications for Theory and Therapeutic Process* offered for the first time this year. The inclusion of these elective courses is encouraging. However, it seems as though the body is still curiously left out. I concur with Shaw's (2003) assertion that it is finally time to bring the body in from the cold. The field of clinical social work has tended to shy away from body psychotherapy due to the controversial issue of touch.

Theory and technique from the field of body psychotherapy can assist non-body psychotherapists in bringing embodied awareness into the clinical context while remaining far outside the realm of physical intimacy. Therapists can, in Newman's (2008) words, "help patients move toward an organic sense of wholeness, without the use of physical touch, but by 'touching' into physical experience" (p. 177).

Social workers need to learn how to attend to both the implicit quality of the client's embodied presentation, as well as their own felt sense while sitting in the room with the client. How does the client appear to inhabit his/her body? Does the client possess a sense of embodied self-awareness? Is the client able to make use of and articulate bodily based sensations and feelings? Is the client's conceptual self-awareness and embodied self-awareness working together or disconnected? What is the therapist's felt sense of the intersubjective emotional space between herself and the client? Questions such as these encourage awareness of the embodied intersubjective aspects of clinical work.

Conclusion

In this paper I attempt to weave together a wide range of literature from interrelated fields all endeavoring to understand the nonverbal, implicit, bodily based unconscious intersubjective processes of clinical practice. It is my hope that this theoretical exploration, in which I discuss the more subtle undercurrents of the therapeutic relationship, inspires further curiosity and openness on the part of clinical social workers regarding their own embodied unconscious intersubjective processes.

Stern (2012) asks how we can teach students of psychotherapy the defining attributes and clinical intentions of relational work. He proposes the following answer:

What is taught is a focus on process, not on content. The question is less what things mean in the internal, unconscious world than it is an adaptation of Edgar Levenson's (1989) now-famous phrase, 'What's going on around here?' The Therapist-in-training is advised to try to *feel* what is happening, especially the ways in which the relatedness feels 'stuck.' (p. 620).

A. N. Schore & Schore (2012), in slightly different language, express the same overarching sentiment as Stern:

unconscious nonverbal affective factors more than...conscious verbal cognitive factors...[account for] the essential change process of psychotherapy. Thus, at the most essential level, the intersubjective work of psychotherapy is not defined by what the therapist does for the patient, or says to the patient (left brain focus). Rather, the key mechanism is how to be with the patient. (p. 44)

In short, social work training programs need to more directly address the embodied dimension of *being with* the client. Although specific somatic tools and techniques can and should be taught, the theory behind these techniques must also be attended to. Conceptualizing the clinical encounter as taking place in an embodied intersubjective matrix is the first step toward a theoretical understanding of how the current paradigm shifts are reformulating the clinical context in which we practice.

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