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Training Analysts to Work With Unconscious Embodied Expressions: Theoretical Underpinnings and Practical Guidelines

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In this paper it is suggested that by incorporating embodied practices from bodywork and the performing arts analytic training could be enriched and promote the development of countertransference awareness for body sensations and movement. The historical background and theoretical underpinnings of an analytical training program focusing on embodied subjectivity, intersubjectivity, and objectivity, aimed at integrating experiences of self, other, and interaction, is outlined. The paper describes and discusses the training program developed at the Norwegian Character Analytic Institute over a 10-year period, featuring nonverbal, embodied ways of presenting and working with cases at seminars and in connection with supervision.

INTRODUCTION

In this paper I present and discuss an analytical training program focusing on embodied experience. Analytic training, as well as psychotherapy training generally, has tended to privilege the exchange of words. It is my belief that applying embodied practices as they are found in the dramatic arts, dance, music, and various schools of bodywork could do much to enhance the training experience of clinicians, fostering, in my opinion, greater countertransference awareness of body sensations and movement.

The program was developed at the Norwegian Character Analytic Institute over the past decade. The historical background in the work of Wilhelm Reich and the subsequent development of embodied character analysis in Scandinavia and especially in Norway is briefly reviewed.

The training program I present focuses on three interrelated aspects of embodied experience. The first concerns the experience of our own body and the bodily foundations of the self. The second involves the embodied basis of intersubjectivity, simulation, and imitation of the emotional body states of others. The third aspect concerns reflections over similarities and differences between one's own state and that of others.

In the section setting out the theoretical foundation of the training program I discuss the research evidence for focusing on these three aspects of the analytic interaction. I also briefly review recent developments in neuroscience and developmental psychology in so far as they

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impact on embodied dimensions of experience in analytical practice and training. The work of Antonio Damasio suggests the essential role of the body proper (not only the brain) in the unfolding of consciousness. These ideas are briefly reviewed together with his argument for a body-based conception of self.

I then examine the development of evidence for a neurobiology of intersubjectivity based on the discovery of "mirror neurons" and the innate capacity of newborns to imitate. These findings suggest that empathy involves an ability to participate in another's emotional body states. I argue that the capacity to function reflexively or to mentalize is strongly associated with the ability to compare one's own body states with those of others.

The second section of this paper is devoted to a description of nonverbal, embodied ways of presenting and working with cases in the training program at the Character Analytic Institute in Oslo. The candidate whose case is to be presented is first asked to mime the patient and not to give verbal information. This aspect of the curriculum is aimed at expanding awareness of embodied transference and countertransference. The last part of the paper is a presentation of a supervision model in which the supervisee stages her interaction with a patient. She is asked first to role-play both herself and her patient and then adopt a third position from which to reflect over her experience of playing herself and her patient. This curriculum and supervision model represents a novel demonstration for how attention to the embodied dimensions of affective expression and regulation can benefit analytic practice and training.

ATTENDING TO THE EMBODIED DIMENSION IN TRAINING

Given the current state of knowledge concerning embodied dimensions of emotional experience, communication, and interaction, it would be reasonable to expect that certain features of the performing arts (drama, dance, music) could enhance analytic training. What the performing arts share with psychoanalysis and psychotherapy is a commitment to emotional communication. Practitioners of the performing arts realized long ago that expertise in emotional communication depends on training the body to express emotion. Personally, I have profited from learning and practicing the Pesso Boyden System Psychomotor (www.pbsp.com). The Pesso Boyden System Psychomotor is a psycho-dramatic, interactive form of group therapy developed by dancers Albert Pesso and Diane Boyden Pesso from their work training dancers in emotional expression.

When I suggest that features of the performing arts might enhance analytic training, what I have in mind is not only literal embodied practices but also more generally the use of metaphors and images from these fields. For example Steven Knoblauch (2000), psychoanalyst and jazz musician, applied his musical experience to the analysis of the therapeutic dialogue in terms of rhythm, tone, accompaniment and improvisation. Ringstrom (2001) elaborated on the cultivation of improvisation in psychoanalysis.

Reich in his—aborted—work on developing an embodied psychoanalysis also stressed the relevance of music for an understanding of the prelinguistic nature of emotional experience and expression (Sletvold, 2011). Language reflected the emotional state of the body, he said, but it was not able to get at the deep feeling of emotional states.

> The reason is that the beginnings of living functioning lie much *deeper* than and *beyond* language. *Over and above this, the living organism has its own modes of expressing movement which simply*

> *cannot be comprehended with words.* Every musically inclined person is familiar with the emotional state evoked by great music. However, if one attempts to translate these emotional experiences into words, one's musical perception rebels. (Reich, 1945/1972, p. 359)

It is my contention that body practices developed in traditions of artistic work and traditions of bodywork can enhance contact with "deep feeling . . . beyond the limitations of language" (Reich, 1945/1972, p. 359). Many body-oriented therapies have developed practices and exercises of great use for inculcating awareness of embodied experience. For a presentation and discussion of practices and techniques of bodywork I refer to *Bodies in Treatment* (Anderson, 2008). Such practices I regard as valuable preparatory work for the kind of embodied analytic training that are presented and discussed in this paper.

THE FORMATION OF THE NORWEGIAN CHARACTER ANALYTIC INSTITUTE

I review the historic background for the approach to analytic training presented here in another paper (Sletvold, 2011). Here I briefly introduce some antecedents for the training to be discussed.

Wilhelm Reich (b. 1897) was among the active young analysts in Vienna in the early 1920s. He soon headed the seminar on psychoanalytic technique, which he had initiated. The seminar was much concerned with the latent negative transference. Reich came to identify this transference as a secret resistance; not expressed in the contents of words, it manifests itself in the *form* of the communications, in "the way the patient speaks, looks at and greets the analyst, lies on the couch, the inflection of the voice, the degree of conventional politeness which is maintained" (Reich, 1945/1972, p. 49). "Alongside the 'what' of the old Freudian technique, I placed the 'how'. I already knew that the 'how', i.e., the form of the behaviour and the communications, was far more important than what the patient told the analyst" (Reich, 1942/1978, p. 152).

In the early 1930s Reich became gradually more controversial in the psychoanalytical community, probably as much a consequence of his political activism as of his psychoanalytic views. The split between Wilhelm Reich and the International Psychoanalytic Association (IPA) happened around the time of the 13th IPA Congress in 1934. At that congress the Norwegian delegation comprising Harald Schjelderup, Ola Raknes, and Nic Hoel (later Waal) argued for Reich's right to stay within IPA, and offered him membership in the Norwegian Association. Professor Schjelderup invited Reich to Norway to teach character analysis and conduct his planned psychophysiological experiments at the University of Oslo. Reich stayed in Norway from 1934 to 1939. His seminars on character analysis were attended by most of the Norwegian analysts of the time.

Schjelderup had a high opinion of character analysis but was critical of Reich's theoretical and experimental work. Adopting an independent position both in relation to Reich and the IPA, he developed a rather unique relational perspective in the thirties, criticizing both Freud and Reich for overestimating the role of sexual drive and underestimating the effects of real trauma (Schjelderup, 1941/1988, 1955, 1956). Schjelderup continued as chair of the Norwegian Psychoanalytic Association after the war, but it was no longer recognized by the IPA, which suspected it of a Reichian bias. Ola Raknes (1970) remained a loyal supporter of Reich and his work in the United States.

Toward the end of his Norwegian sojourn and especially after relocating to the United States, Reich lost much of his interest in psychoanalysis and character analysis. His impatient mind went

on to explore what he believed was the biophysical core of the neurosis. In Norway he founded what he called character analytic vegetotherapy; later in the United States he changed its name to "orgontherapy" following his discovery of what he believed was "cosmic orgone energy." Most of Reich's followers both in Norway and the United States more or less enthusiastically tried to keep pace with the development of his ideas. Most IPA analysts, on the other hand, had ceased to take him seriously, and some even thought he was mentally unhinged.

Yet the idea of embodied character analysis was not totally lost. Indeed in Norway it remained a respected point of view. Initially this was thanks especially to Schjelderup and the Danish psychiatrist and analyst Tage Phillipson. They both in their own way took an autonomous position on embodied character analysis. Both forfeited their friendship with Reich along with membership of the IPA. Schjelderup, Philipson, Raknes, and Nic Waal were popular training analysts in Norway in the postwar era. Some of their pupils founded in 1972 the Forum for Character Analytic Vegetotherapy.

In Norway *Character Analytic Vegetotherapy* was a general term for various combinations of psychodynamic psychotherapy and Reichian body work. Internationally, the best-known form of such neo-reichian therapies is probably *Bio-energetic analysis*, developed by Alexander Lowen (1975). By the early 1990s the concept of character analytic vegetotherapy had already changed nearly beyond recognition. Central to this change was the work of Rolf Grønseth (1991, 1998). In what he termed *existential* character analytic vegetotherapy, he dismissed every form of bodywork. Grønseth argued that the therapist had to focus on finding words for his or her impression of the patient's bodily presentation, thereby helping the patient to become aware of his or her bodily state and identity.

Renewed study of Reich's own writings on character analysis in the mid-1990s breathed new life into the Reichian legacy. The Norwegian Character Analytic Institute was formed in 1999, integrating relational psychoanalysis (Mitchell, 1988), character analysis, and elements of bodywork. This synthesis was inspired and facilitated by the independent efforts of Einar Dannevig and George Downing, respectively.

Dannevig had been a leading figure in the analytical and psychotherapy field in Norway for half a century. He maintained contact with the interpersonal psychoanalysis school in New York where he befriended Gerard Chrzanowski. In the mid-1990s Dannevig led two advanced seminars on character analysis, and remained an enthusiastic supporter of the idea of an integrative character analytic institute until his death in 2005.

George Downing, an American-trained psychologist teaching child and adult psychiatry in Paris, studied bodywork in California and psychoanalysis and philosophy in Paris in the 1960s. In his 1996 book, the title of which can be translated as *Body and Word in Psychotherapy*, he showed a number of ways in which bodywork can be integrated with a psychoanalytic psychotherapy focusing on transference/countertransference experience. Regrettably, the book never appeared in English. (For a summary in English of some of his thinking about infant development see Downing, 2004). Downing also argued that body-techniques should be relieved of the special theory invested in them by the Reichian tradition. His alternative framework draws extensively upon infant and child development research, on one hand, and some of Ferenczi's seminal ideas, on the other.

The early 1990s saw the first of several yearly seminars chaired by Downing at the Forum for Character-Analytic Vegetotherapy. These gatherings explored above all the embodied dimensions of the transference/countertransference. Downing's work helped integrate relational

and embodied perspectives and inspired the embodied ways of therapy training that are presented and discussed in this paper. He was also instrumental in the introduction of new models of developmental psychology and emotion theory, especially the work of Stern, Beebe, Tronick, and Damasio. The training program at the Character Analytic Institute remains highly indebted to his theoretical and practical influence.

THEORETICAL UNDERPINNINGS TO THE PROGRAM

Before describing in greater detail the development and structure of the training program I briefly review some of the basic theoretical assumptions on which the program rests. A main point here is to explain how the program not only practically but also theoretically is able to rely extensively on embodied simulation and imitation.

A basic theoretical assumption upon which the training program is designed is that feelings reflect changes in body state, changes triggered by the outer world, but also constituted out of memory and thought. It follows from this assumption that the basic object relation is not between self and object, that is, the traditional psychoanalytic conception, but between body and "object" (other bodies). Sense of self emerges as a result of this relationship, which ideally is an experience not of subject/object but subject/subject relations. In the beginning are the body and the outer world. Consciousness, self, and character develop from and rest on this relationship. That is why psychic structure is relational (Sletvold, 2005).

In extension, representations of one's own and others' bodies are necessary for conscious and unconscious awarenesses to emerge. In this section, I conceptualize subjectivity as a body-based self. I explore intersubjectivity as requiring the representation of other bodies and their experiences, which becomes possible through a form of inner imitation. A third position results from a reflective or "mentalizing" combination of representations of one's own and others' bodies.

Arguments for these three embodied positions are found in neuroscience and developmental research. They have also been theorized in psychoanalysis. Based on Mitchell's (1988) relational-conflict, developmental-arrest, and drive models, Stark (1999) described the corresponding positions as *authenticity, empathy,* and *objectivity*. Outstanding analysts, said Stark, have tended to prefer one or the other of these positions. Analysts should be trained to migrate from one to the other depending on the needs and responding to changes in the analytic interaction, she argued. I share her view, with the proviso that to fully access the information made available in the different positions bodily experience needs to be explored both explicitly and implicitly. The training practices I present and discuss are especially suited for enhancing the analyst's ability to focus on embodied experience from respectively the authentic, emphatic, and objective positions.

The Embodied Self

The conception of embodied self sees the body as a constant referent of the self while other dimensions of self experience are exchangeable. Comprehensive evidence in support of this contention is found above all in the work of the neurologist Antonio Damasio. In *Descartes' Error* (1994) he suggested that what we call self is grounded in nonconscious neural patterns mapping the state of the body. In *The Feeling of What Happens* (1999) he elaborated this view further.

> The deep roots for the self, including the elaborate self which encompasses identity and personhood, are to be found in the ensemble of brain devices which continuously and *non-consciously* maintain the body state within the narrow range and relative stability required for survival. These devices continually represent, *non-consciously*, the state of the living body, along its many dimensions. I call the state of activity within the ensemble of such devices the *proto-self*, the unconscious forerunner for the levels of self which appear in our minds as the conscious protagonists of consciousness: core self and autobiographical self. (p. 22)

Actually, Freud (1923) proposed in *The Ego and the Id* a quite similar conception of the ego as based on internal perception.

> A person's own body, and above all its surface, is a place from which both external and internal perceptions may spring. It is *seen* like any other object, but to the *touch* it yields two kinds of sensations, one of which may be equivalent to an internal perception. Psychophysiology has fully discussed the manner in which a person's own body attains its special position among other objects in the world of perception. Pain, too, seems to play a part in the process, and the way in which we gain new knowledge of our organs during painful illness is perhaps a model of the way by which in general we arrive at the idea of our body. —The ego is first and foremost a bodily ego. (pp. 25–26)

Damasio's conception of self and proto-self comes very close to Freud's conception of ego and id. The main difference is that Damasio, like Reich and relational analysts, sees "the drives" of the id or proto-self as basically rational, shaped by evolution to maximize the chance of survival with well being. So, in Freud's opinion, the roots of the ego or self are to be found in body sensations and feelings, though he had to admit that "Very little is known about these sensations and feelings; those belonging to the pleasure-unpleasure series may still be regarded as the best examples of them. They are more primordial, more elementary, than perceptions arising externally (1923, p. 23, my italics). The contents of Freud's words here, are striking, particularly for the accuracy with which they anticipate contemporary views. Most remarkably, Damasio (2010) recently introduced the idea of primordial feelings for "the feeling state that I regard as simultaneous foundation of mind and self" (p. 256). *Primordial* feelings describe "the current state of the body along varied dimensions, for example, along the scale that ranges from pleasure to pain" (p. 21).

Embodied Simulation and Imitation

The conception of the body-based self predicts that we will feel the same as another to the extent we can induce in our own body the state prevailing in the other. In this way, "replication" or representation of other bodies becomes an essential element for the emergence of intersubjectivity. It makes it possible for us to feel both kinship and difference, as we feel our own body state and some of the states of other bodies. Hobson (1998), in his argument for the intersubjective foundation of thought, suggested "that early forms of interpersonal responsiveness, identification and imitation are what disengage an infant from a one-track relation with the environment" (p. 296).

There are many other aspects to intersubjectivity and interaction apart from imitation, including timing, rhythms, intensity, disruption and repair (Stern, 1985; Trevarthen, 1979; Tronick, 2007). It is, however, my hypothesis that an innate ability to imitate is what makes intersubjectivity, empathy, and identification possible in the way it exists for humans. Freud (1921) also stressed this point when he wrote, "A path leads from identification by way of

imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life" (p. 110, fn. 2).

Some scholars are wary of claims about the fundamental role of imitation. This is possibly because imitation is often restricted conceptually to outer, explicitly behavioral copying. Stern's explanation of affect attunement illustrates and highlights the point.

> The actual actions of the other do not become the referent of the attunement (as they would for imitation); rather, the feeling behind the actions becomes the referent. It is a way of imitating, from the inside, what an experience feels like, not how it was expressed in action. (Stern, 2004, p. 241)

Galese, one of the original researchers of the mirror neuron system, termed this implicit or internal imitation *embodied simulation*,

> a mandatory, non-conscious, and pre-reflexive mechanism that is not the result of a deliberate and conscious effort. . . . When we see the facial expression of someone else, and this perception leads us to experience that expression as a particular affective state, we do not accomplish this type of understanding through an argument by analogy. The other's emotion is constituted, experienced, and therefore directly understood by means of an embodied simulation producing a shared body state. It is the activation of a neural mechanism shared by the observer and the observed that enables experiential understanding. (Gallese, Eagle, & Migone, 2007, pp. 143–144)

My understanding of imitation refers to explicit imitation, miming *and* implicit imitation, embodied simulation. Recent research suggests a close relationship between inner and outer, implicit and explicit imitation. The same brain areas seem to be activated when we observe someone doing something as when we do the same thing ourselves. "In humans, there is a kind of direct resonance between the observation and execution of actions, and the possible relation to monkey mirror neurons has been discussed" (Meltzoff & Decety, 2003, p. 493).

The terms *implicit imitation* and *embodied simulation* point to a process that is largely internal and unconscious. This is also the most economic process and saves a lot of time and energy. It is not coincidental that we talk about gut feeling rather than arm or leg feelings. Reich put the point well when he wrote, "The patient's expressive movements *involuntarily* [emphasis added] bring about *an imitation* in our own organism. By imitating these movements, we 'sense' and understand the expression in ourselves and, consequently, in the patient" (p. 362). Damasio (1999, p. 152) cited Cole Porter's "I've Got You Under My Skin" as unwittingly capturing this important idea.

The aforementioned considerations have important implications for psychoanalysis and psychotherapy. When therapist and patient observe each other they are already participating in each others' respective actions, feelings, and thoughts. The development *from interaction to dialogue* was probably facilitated by this ability to simulate and imitate the actions and emotions of the other by means of the mirror neuron system. The anatomical proximity of the mirror neuron system to the speech centers has been interpreted as evidence favoring language development from the dialogical gesture language (Rizzolatti & Arbib, 1998). Gesture language and speech language in humans may still be closely related, as argued by Fonagy and Target (2007).

An important aspect of the training discussed here is the oscillation between implicit and explicit imitation and verbalization. It allows the candidate to accumulate experience of explicit imitation for use in the therapeutic situation in which implicit imitation predominates over explicit. Nebbiosi and Federici-Nebbiosi (2008) similarly reported on the combination of explicit

imitation outside the therapeutic situation and implicit imitation in the analytical interaction. Research findings (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003) and my own observations of psychotherapy training and supervision suggest that explicit, motor imitation intensifies feelings relative to simply watching a behavior take place.

The strong connection between inner and outer imitation is also demonstrated by the ease by which embodied simulation is converted to outer, motor imitation. It is striking to see how readily analysts and psychotherapists imitate patients during training sessions, despite never having tried consciously to do so with their patients. This is consistent with the growing evidence for an innate link between the perception and production of human acts in shared neural representations (Meltzoff & Decety, 2003). Another important finding reported by Meltzoff and Decety is that the pattern of cortical activation under observation with *an intention* to imitate is more akin to that of motor action than the mere observation of actions (p. 493). Attention and intention make a difference in the intersubjective field. Knoblauch's (2005) call for an expansion of clinical attention seems well justified.

Embodied Reflexivity

I have argued that humans seem to be born with separate but closely linked systems whereby we get to know our own body and those of others. This makes both sense of self, egocentric knowledge, and identification with others, altercentric knowledge possible. We can approach emotional problems, I believe, in terms of the dominance of egocentricity or altercentricity, of self-regulation or interpersonal regulation. Currently the theory emphasizes a third position, one Benjamin (1998) called *true observation*. Aron (1996) spoke of *dialectical objectivity*, where the observation is based on opposing subjectivities. "This third position is founded in the communicative relationship, which creates a dialogue that is an entity in itself, a potential space outside the web of identifications" (Benjamin, 1998, p. xv). This observing position has also been termed *the analytic third* (Ogden, 1994). Other concepts close to the notion of the analytic third are *mentalization* (Fonagy, Gergely, Jurist, & Target, 2002), *reflexive functioning* (Aron, 1998), and *intersubjective consciousness* (Stern, 2004). Aron stressed the importance of own body feelings for reflexive functioning while Stern underlines intersubjective ability. Emde (2009) coined the term *"we-go"* and Gallese (2009) the terms "we-centric space" and "we-ness" prompted by embodied simulation as supported by the mirror neuron system.

Thirdness, we-ness, or whatever we like to call it, rests, I assume, on a combination of our perception of our own body state and our ability to simulate and imitate other bodies. This assumption seems to be corroborated by developmental and neuroscientific research. Meltzoff and Decety (2003) reviewed research with a bearing on own body knowledge, imitation, mentalization, and theory of mind. They concluded that mentalizing is dependent not only on resonance and imitation but on own body knowledge as well:

> The adult human framework is not simply one of resonance. We are able to recognize that everyone does not share our own desires, emotions, intentions and beliefs. To become a sophisticated mentalizer one needs to analyse both the similarities and differences between one's own state and those of others. That is what makes us human. (p. 498)

In many neurotic states we find a pronounced altercentric perspective and underdeveloped ability to feel one's own emotions and needs. In disorders of mentalization like borderline states, we

typically see a pronounced egocentric perspective. Or, as Bateman and Fonagy (2004) put it, "Borderline patients have knowledge but not belief" (p. 218). In disorders of the self proper like psychosis, there is breakdown of the ability to care of one's self due to a serious disturbance of one's own body knowledge. And in some autistic states there seems to be a basic disturbance in the capacity for imitation and empathy (Braten, 1998; Hobson, 2002). In most of us, we find some ability to be in touch with our own affective states, feel empathy with others, and reflect upon similarities and differences, even when still struggling with our own problems. But we also find imbalance affecting all three dimensions. The training discussed here therefore seeks to deepen *and* balance attention to these basic aspects of experience both in the analyst/therapist and in the patient.

THE DEVELOPMENT OF THE TRAINING PROGRAM

Jacobs (2005) pointed to what he saw as "the neglect of nonverbal phenomena in psychoanalytic education today," while Shore (2003) suggested that the nonverbal implicit functions of the right brain be incorporated into psychoanalytic and psychotherapeutic training programs. The experiences presented next constitute a preliminary set of responses to these observations. The program, in addition to verbal discourse, focuses on embodied dimensions of the psychotherapeutic interaction, especially through the use of imitation.

The general training program consists of a two-year foundation course (seminar and supervision) and an advanced training program of training analysis, a two-year advanced seminar and supervision. Completion of the advanced training program takes at least five years.

In the two-year basic seminar, body practices and techniques occupy about half of the time. Priority is given to body practices focusing on exploring the candidates' own embodied experience. This includes exercises developed in schools of body work aimed at enhancing awareness of one's own body. Additionally it consists of exercises specifically designed to train attention to aspects of intersubjective experience central to the training program. The same patient is imitated in separate exercises. In one exercise candidates are asked to focus on their own authentic (egocentric) feelings. In another they are asked to imitate the "patient" and feel empathy. In a third they are asked to adopt an observing attitude. In this way candidates can experience in themselves how quite different and often contradictory reactions are stimulated in more or less the same embodied encounter. The rest of the basic seminar are devoted to the theories of the relational perspective, with a particular emphasis on how to differentiate the implicit embodied *and* the explicit symbolic dimension of the therapeutic interaction.

Whereas the basic seminar focuses more on the candidates' own embodied experience, the advanced seminar gives priority to working with cases. Downing (1996) demonstrated basic elements of the training and case supervision at his seminars on transference and countertransference in Oslo from the early 1990s. He asked the therapist whose case was under consideration to adopt the patient's position and then resume his own physical stance in relation to the patient. This turned out to be very effective and almost always evoked new and highly relevant feelings and thoughts. This strategy demonstrated that transference and countertransference were indeed as much embodied communication of emotions as they were carried by the words used to describe such experience, and pre-echoed what Wallin (2007) wrote years later: "In an enactment

of transference-countertransference, what is enacted, verbally and nonverbally, is a particular kind of relationship" (p. 270).

This enacting of the transference/countertransference, as Downing demonstrated it, suggested a new approach to understanding and dealing with the therapeutic impasse. It helped bring into focus the centrality of the nonverbal, embodied dimension of the therapeutic interaction and above all promoted, along with other body-oriented traditions, efforts to refine training practices at the Character Analytic Institute.

The approach to training to be described was originally designed to be used in the advanced training program. The guidelines were formulated as ways of working on cases in seminars. Some of the principles were presented at a conference workshop "Getting to Know by Imitation" (Nylund & Sletvold, 2002).

In the advanced seminar, which follows the two-year basic seminar, participants spend half the allotted time presenting and discussing cases from their own therapeutic practice. Prior to this approach, cases were submitted in the shape of written reports, including a brief case history and a full or partial transcript of a session. While case discussions were engaging and the candidates came up with many ideas, how well they had understood and addressed the challenges raised remained unclear. It was as if the written reports and especially the ensuing discussions created a *distance* to the actual interaction between the patient and the therapist. These experiences reminded me of one of Reich's (1945/1972) more extreme statements.

> If the analyst wants to arrive at a correct appraisal of his patient, he must begin by asking the patient *not* to speak. This measure proves very fruitful, for as soon as the patient ceases to speak, the emotional expressions of his body are brought into much sharper focus. After a few minutes of silence, the analyst will usually have grasped the patient's most conspicuous character trait or, more correctly, will have understood the emotional expression of the *plasmatic* movement. If the patient appeared to laugh in a friendly way while he spoke, his laughter might modulate into an empty grin during his silence, the mask-like character of which the patient himself must readily perceive. If the patient appeared to speak about his life with reserved seriousness, an expression of suppressed anger might easily appear in the chin and neck during his silence
>
> Let these examples suffice to point out that, apart from its function as communication, *human language also often functions as a defense.* The spoken word conceals the expressive language of the biological core. In many cases, the function of speech has deteriorated to such a degree that the words express nothing whatever and merely represent a continuous, hollow activity on the part of the musculature of the neck and the organs of speech. On the basis of repeated experiences, it is my opinion that in many psychoanalyses which have gone on for years the treatment has become stuck in this pathological use of language. (pp. 360–361)

Reich's view as expressed is this quote is in my mind extreme and one-sided, but none the less I see it as a relevant antidote to the one-sided privileging of verbal exchange prevalent in psychoanalysis for many years. I certainly do not recommend that the analyst "begin by asking the patient *not* to speak." However, adapted to a training situation we found Reich's suggestion fruitful.

A basic principle of the experiment introduced in 1999 was that all verbal information concerning a presented case, initially, should be avoided. More specifically, instead of giving written or verbal information, the presenter is asked to stand up and demonstrate their patient's posture. They are asked neither to accentuate nor caricature, but to be as faithful as possible to their

feeling of how the patient could actually have been standing. In the terminology of Nebbiosi and Federici-Nebiosi (2008) the instruction is to mime, not to mimic.

> Indeed, the mime does not want to make us laugh: he is not content with some distinctive features. We love mimes because—like poets do with language—they enable us to look at the world and people more in depth and with greater attention. Through mimes we discover the language of bodily rhythms: a world of meaning that would otherwise remain unrecognized. Mimes reveal to us a modality of relational knowledge that we possess and practice, but that we are unaware of. (pp. 223–224)

There are two reasons why candidates are urged not to mimic, not to caricature. For one, it is not "necessary" for conveying an impression of the patient. It has been amazing to see the amount of accurate information conveyed by body postures that seem very normal and not at all peculiar. The other reason, and this is critically important, is that we don't want caricatures, because they tend to depict features of the patient that are already more or less conscious to the therapist/candidate while downplaying more unconscious features.

Nor are participants asked to focus on particular aspects of the physical posture, like breathing or muscular tension. What we do encourage is to pay attention to "the total impression of the total expression" (Reich, 1945/1972, p. 362) in agreement with what Jacobs (2005) suggested.

> Just as the analyst listens with equal attention to all of the patient's verbalizations and tries not to fix any particular aspect of the material in mind . . . so he observes all of the patient's nonverbal behavior. . . . He takes in and registers what he sees, but does not focus on any particular bodily movements or facial expression. (p. 172)

Our practical experience over the past ten years seems to confirm the merits of this approach to case presentation. Often the presenters themselves are surprised that what they have conveyed about the patient are things they were not aware of. States intuited by participants are sometimes given further recognition by information available elsewhere.

To summarize, the program investigates three interrelated aspects of embodied experience. First, the experience of our own body and the bodily foundations of the self. Second, the embodied basis of intersubjectivity; simulation and imitation of the body states of others. Third, the emergence of a sense of objectivity from reflecting over similarities and differences between one's own state and that of others. Thus the training program focuses on embodied subjectivity, intersubjectivity, and dialectical objectivity (Aron, 1996), though the emphasis varies when working with cases in a seminar and in supervision. The overall aim of the program is to enhance the relational competence of the candidates.

The following is first a stepwise description of what the nonverbal case presentation looks like. Then follows a presentation of a way of rehearsing therapeutic interaction, and finally a description and discussion of a supervision model.

NONVERBAL CASE PRESENTATION

Step 1

The candidate whose case is to be presented is asked to stand on the floor as she or he imagines the patient would have been standing. While the presenter mimes her patient in a standing position,

the rest of the training group is asked to register their own reactions, feelings, and thoughts. They are specifically asked to pay attention to their own feelings and what they can see. Later, they will be asked to stand up and imitate the posture themselves. In other words, they are told to pay special attention to three aspects of their experience: (a) embodied reactions, (b) what they observe by looking at the presenter, and (c) how they feel imitating the presenter. After this nonverbal work, participants share their ideas among themselves. The presenter responds to the ideas but is not allowed to add information.

Step 2

In this next step we ask the presenter to enter the therapy room and sit or lie down as she and he imagines the patient would have done. Again the group is asked to observe and make note of their own reactions and feelings. No explicit imitation is done at this point. Participants are again asked to share their ideas and the presenter to respond.

Step 3

Once Steps 1 and 2 have been completed, the presenter is allowed to tell the group in word and writing about the patient.

To further illustrate how these nonverbal case presentations unfold in practice, I reproduce next some brief notes taken down during one of these presentations. I do not describe the patient, because it would miss the point of the exercise that we are looking at embodied, not verbalized experience.

Mary's case

Mary (one of the candidates) takes some time to decide how to represent her patient physically. When the decision is made, she gives a sign and freezes in that position. The group has been instructed to observe what they see and how they react emotionally. After a few minutes they are asked to stand up and adopt the same posture themselves, continuing to note what they feel. The group then sits down. Mary is not allowed to say anything, but listens and takes notes. The others are asked to put their experience in words and share with the group.

Comments:
Note of my own impression: Lost in reverie.
Candidate 1: Splitting, ambition, hiding oneself, "poor me."
Candidate 2: Pulling oneself together, sad, desperate, close to tears.
Candidate 3: Holding, sad and hopeless, wants to be seen and not seen at the same time.
Candidate 4: Resigned, brooding over emptiness, tense and rigid body.
Mary's comment (after the standing sequence):
The different impressions all confirm my impression and what I know.

Then Mary is asked to play her patient entering the room, sitting down, finding a position and moving in the chair for a few seconds (the group is still unaware of the sex of the patient). The

group is encouraged again to observe what they see and what they feel. They are not asked to imitate in this sequence themselves.

Comments:

Candidate 1: Looks younger, doesn't give anything away, stays on his own. Difficult to reach, easily hurt. Has no close friends, but is hoping to find some. Strongly dissociating.

Candidate 2: Self-conscious

Candidate 3: Dancing, rocking backwards and forward, controlled. In pretty bad shape. Unfriendly, difficult to help. Risk of regression. "I do it my way."

Candidate 4: Moves easily, stays much in his head.

Mary's response (before presenting written information and talking about the patient):

Everything was well observed, felt and thought!

We have observed that candidates find this nonverbal case presentation consistently more, or at least as, meaningful as the traditional approach based on verbal information. Many participants are used to more conventional psychoanalytical case seminars. We confirmed that when verbal information about a case was given at the start it tended to change the nature of the discussion. Participants started asking questions about aspects of the patient's life that drew attention away from what was actually presented. In this way, we found Reich's suggestion to "begin by asking the patient *not* to speak" very fruitful to our training situation.

The new procedure seems to offer something that isn't available in "talking seminars." There is a different atmosphere, a greater sense of humility and respect for the patient whose case is under examination. Along with this comes a sharpened focus on the resources and problems of the patient. The presenters are usually surprised by how much information actually gets to the group by nonverbal means, and how relevant it is to the case at hand. They are also surprised by their own ability to imitate patients. Many may never have seen their patient standing and protest ignorance at first. The procedure, it turns out, is not dependent on explicit knowledge of the patient's physical appearance. What seems decisive for accessing what one knows is to "try and suspend the will and surrender to the knowledge that our body has of the patient" (Nebbiosi & Federici-Nebbiosi, 2008, p. 224)

It is always exciting to see the amount and quality of the information candidates are able to pick up during the two short sessions, that is, the first in which the presenter stands immobile, and the next when she or he moves for just a few seconds. Participants discuss their ideas about the emotional state of the "patient," the kind of problems facing them, how it would feel to have this person in therapy, what the biggest challenges would probably be for the therapist, and how they could be addressed. Repeatedly, I have been struck by how much unconscious bodily information therapists seem to get from their patients. It confirms experiences reported by Nebbiosi and Federici-Nebbiosi (2008).

> For many years now, we have been using the tool of miming our patients in order to obtain a better understanding of them. This was done for the purpose of using a knowledge that resides in the analyst's body and of which he is completely unaware. (p. 224)

My understanding is that this knowledge is relayed by unconscious, other-centered participation in the body-emotional dialogue with our patients, probably made possible by embodied simulation/implicit imitation and mirror neuron activity.

Additionally, it has been fascinating to witness this unconscious information so easily made conscious and given verbal expression by attention to body feelings and imitation. This is consistent with research finding a close link between observation, imitation, and verbal reflection (see earlier on theoretical underpinnings; Carr et al., 2003; Meltzoff & Decety, 2003).

The training approach described here gives candidates ample opportunity to experience the transition from observation to embodied simulation and miming, between implicit and explicit imitation. It helps candidates separate egocentric from alter-centric feelings; in other words it helps to differentiate between personal countertransference stemming mainly from one's own past and induced countertransference stemming mainly from identifications with the patient (Downing, 1996). Adapted to a training situation, Reich's suggestion to "begin by asking the patient *not* to speak" turns out to be fruitful.

REHEARSING THERAPEUTIC INTERACTION

After this "diagnostic" sequence the next step involves rehearsing therapy interaction. One of the participants plays the therapist while the presenter continues to imitate his or her patient. They meet at the start of a session and take their positions in the room. When we introduced this procedure systematically we found that very short interaction sequences worked well. Important things seem to happen within the first few seconds of the patient and therapist meeting. In the early period of using this approach, I had no clear understanding of what was unfolding. Beebe and Lachman (2002) showed very convincingly, however, the relevance of microanalytic infant research for adult treatment. Stern (2004) systematically analyzed the basic meaningful interactive sequence in psychotherapy, the present moment that he postulates lasts between one and ten seconds.

Sequences of just a few seconds seem to encapsulate what we could term the basic unit of analysis of psychotherapy interaction. Thus, within a total duration of no more than about thirty seconds it is possible for both the therapist and the "patient" to give an immediate and relatively complete report of their respective experiences. Almost always, both have one or more meaningful stories to tell, often of relevance to the therapeutic challenges. For the therapist the story can be about her impressions of the "patient" and her feelings about herself. The posture she adopted may induce a sense of ease or give her discomfort, an urge to go on from that position or a need to change it. For the "patient" the story can be about how good it felt to meet this therapist, or embarrassment at being looked at, or the therapist coming too close for comfort. Or it may be about not having noticed much of the therapist at all. Whether they turn out one way or the other, meaningful stories almost always emerge from the first few seconds of the encounter between patient and therapist. These stories seem to speak directly to key issues for the patient, and to the interaction between the personalities of the therapist and the patient. In these first few seconds, usually no words are spoken. Sometimes, however, a sound or word becomes a natural and important element also of this first short interaction.

After this initial sequence of therapist–patient interaction, extended interaction sequences can be tried. Candidates can experiment with various ways of being with the patient. The presenter and "his patient" can try out and compare different therapeutic approaches. Experimenting with verbal comments and interpretations is an important part of this sequence. But the focus is just as much on the physical posture, the manner in which the therapist moves, and his or her emotional,

facial, and body expression in relation to that of the "patient." Again, the strong emotional impact of even apparently insignificant changes in the patient's and therapist's posture, ways of moving, expressions, and voice are particularly striking. Enactments could therefore be seen as a constant aspect of therapist–patient relations (Wallin, 2007), and the unconscious as expressed first and foremost in continuous embodied interaction.

When we rehearse therapeutic interaction we underline the purpose of the exercise: to explore different ways of being with the patient. The seminar work should be considered exploratory. It is not about finding the "right" way. Nonetheless, participants sometimes want to "help" the presenter tackle issues she has with her patient, or her patient's problems, and the presenter might welcome such help. When this occurs we find it wise to remind the group of the purpose of the work, which is not group supervision. We also find it fruitful to underline the difference between the work we do in the practical-theoretical seminar and real therapy and supervision. The presenting candidates should in this light be supervised by their ordinary supervisor on the cases they present, which is normally the case anyway because supervision is part of their ongoing training.

The therapy rehearsal gives the seminar participants an opportunity to experiment with different interventions. Whatever the experiments, no "real" patient risks being hurt. And much can be learned from seeing staged interventions, which might not seem particularly helpful or promising. On the other hand, it is always a pleasure to observe therapeutic interaction that feels good and promising to the therapist and "patient" as well. In any case, it is always important to keep in mind that we can never know for sure what is the "right" or "best" way to handle a therapeutic situation. One advantage of this type of training where several therapists work with the same "patient" is the opportunity to see that there is always more than one fruitful way to move ahead.

SUPERVISION

Supervision with one supervisor and one supervisee is organized slightly differently. Inspired by Aron's (2006) ideas of the seesaw and the triangle (presented in Oslo in January 2005), we place three extra chairs in a triangle. The first marks the therapist's position, the second (which can also be a couch) the patient's, the third is where the supervisee reflects over what went on in and between the therapist and patient. In this way the "therapy room" and the supervision room are kept apart as separate areas.

After the supervisee has given a fair description of the therapy situation she wants to look at, we ask her to first sit in the therapist's chair, before proceeding to the patient's position. Supervisees are encouraged to use words to convey their experience in both positions. This will usually include a clear emotional sensation of the therapist and of the patient's particular situation. After a short discussion we ask the supervisees to take the third position, keeping in mind their reactions to the two former positions. This tends to generate new perspectives and ideas and seems to strengthen the reflective or mentalizing capacity of the supervisee.

The next stage gives the supervisee and supervisor an opportunity to experiment with different types of therapeutic interaction. When the supervisee has rehearsed a new way of being with the patient, she moves to the patient position to get a feeling of what it feels like to be at the receiving end. When the supervisor demonstrates his own ideas, the supervisee takes up her position in the patient chair or on the couch, enabling her to feel in her own body how the intervention of the supervisor might be perceived by the patient.

It is not always necessary to use all the chairs, but it is always valuable to have the three positions in mind during supervision and be ready to ask the supervisee to physically assume the different positions. It helps to distinguish between the bodily staging in the here and now, and the discussion of the there and then of the therapy process. Body position enhances feeling and changes the basis for reflection.

An aspect of this approach is that it easily triggers personal issues for the supervisee. If the supervisor does not pay adequate attention to personal emotions activated in the supervisee, supervision will easily turn into a stressful and unproductive experience. This testifies to the finding that actually doing often triggers a strong emotional response. When the supervisor, however, pays attention to the supervisee's personal emotions the two have the possibility of exploring countertransference issues in-detail.

Clearly, the supervisee should be allowed to work on her personal issues in the training analysis, alongside the supervision. Here it is valuable to have a training analyst who is familiar with the kind of training and supervision the candidate is undertaking. All members of the teaching staff at the Character Analytic Institute, including supervisors and training analysts, are invited to a yearly "teachers' seminar." Some, I should add, are accustomed to more traditional forms of supervision.

A special aspect of the supervision model I have been sketching is its focus in turn on the state of the therapist, the state of the patient and their interaction. When the supervisee occupies the therapist's position she will empathize with the needs and feelings of the therapist and learn to bring the countertransference into focus and consciousness. In the patient's position the needs and feelings of the patient and the transference will be highlighted. The third position provides the breathing space to work on and strengthen the mentalizing capacity of the supervisee, as the focus in this position is on thinking about the relationship while the experiences evoked in the other positions are still fresh.

Supervisory needs obviously vary, depending not least on the therapy process itself, the personality of the supervisee, the patient—and the supervisor. But often, supervisees will display a lack of sensitivity to their own needs and feelings. They may have identified too strongly with certain features of the patient. Or they may have lost their empathic capacity and need to realign. And almost always there will be an opportunity to reflect over the therapeutic interaction. So one of the results of this approach to supervision is the strengthening of the thirdness or mentalizing capacity of the candidate, and—hopefully—of the supervisor.

To illustrate what this approach to supervision looks like I want to cite briefly a couple of cases.

A candidate in the basic training program is being supervised for the first time. He wants to explore problems in his relationship with a female client. The client is in her late 50s and started therapy after her husband left her. She felt bitter, hurt and had difficulties controlling her anger. The candidate is worried about how to work with her apparently uncontrolled anger.

He is then asked to sit in the therapist's chair and imagine the client sitting in the other chair. He should observe carefully how his body feels and what comes to mind. After a couple of minutes he reports feeling like something is expected of him, he feels pressured and uncertain as to how to go on. He also registers feelings of irritation and sympathy with the client.

The supervisee is asked to move slowly over to the patient chair, and explore in his own time how the patient physically comforts herself. A few minutes later he reports feelings of hope and expectation combined with critical evaluation.

Moving to the third position/chair the supervisee remains somewhat confused because he had expected to face an angry patient. After talking with the supervisor he realizes that what he experienced was basically a complementary relationship where the patient expresses, though not in words, how much help she expects the therapist to provide, expectations about which the therapist feels uncomfortable.

I provide this vignette to illustrate one of the merits of the approach: in a short time the supervisee manages to progress from his explicit thoughts about what is going on in the therapy at the moment to deeper, more implicit, embodied feelings and sensations of both the patient and therapist. This comes about mainly because the supervisee has explored his own embodied experience, not through the interpretations from the supervisor.

A candidate in the advanced program wants to address her sense of unease before the session with a certain patient. Sitting in the therapist's chair, she feels a mounting sense of discomfort, combined however with feelings of sympathy for the patient and a wish to help. Moving to the patient position she experiences a need to defend herself, to ward off approaching danger. She also experiences strong inner turmoil. In the third chair/position, she is surprised by her experience in the patient position. Her uneasiness at meeting this patient might be connected to the patient's tumultuous inner world.

Taking the patient position once more she comes into contact with a feeling of shame; her patient might have invested more than she realized trying to avoid strong feelings of inner turmoil and shame. She understands better her own counter-transference and starts to think of new ways to address the strong conflicts and inner turmoil of the patient.

A senior therapist has felt at an impasse with a patient for some time. The patient was apparently afraid of moving forward in his therapy and his life. He had a pronounced resistance to change so to speak. In the patient position the therapist to her surprise gets into contact with a sense of openness and longing to explore new terrain. In the therapist position she recognizes, also to her surprise, her old achievement anxiety resurfaces. Reflecting over these experiences in the third position she realizes that her patient's new willingness to broach change had unconsciously triggered her old achievement anxiety, and that the therapeutic impasse probably had more to do with her own countertransference than the patient.

These two vignettes serve to illustrate how a training approach that focuses attention on embodied experience helps the therapist to differentiate between her own dominant emotional state and the state of the patient, and to distinguish complementary from concordant countertransference experiences. In the analytic situation these feelings are necessarily intermingled because we have to deal simultaneously with our experience of the patient (empathy) and our reactions to this experience.

Generally I find this approach to supervision to enhance access to unformulated unconscious experience. Thereby allowing the thinking, reflection, and discussion that follow in the last part of the supervisory session to emerge from a broader and deeper experience, different from discussions based mainly on what is consciously available at the start of a supervision session.

In summing up I want to highlight the following advantages of the approach to the supervisee:

- Quicker access to the emotional core of the supervisee's most pressing issue.
- The creation of new kinds of attention to the most pertinent differences between the supervisee's and the patient's experience.
- An opportunity for the supervisee to look at how he works with the patient from the outside, and an opportunity to reflect from this third position on the patterning of their interaction.

- An opportunity to experience in one's own time and without interference (from the supervisor) ideas and actions taking form within one's own unfolding organization of an interaction, in contrast to someone else providing the ideas (the supervisor).

This model, at the same time preserves and expands the supervisor's ability to make suggestions to the supervisee, verbally and by demonstration of therapeutic options. This way of doing supervision is also gratifying for the supervisor because his (alter centric) participation by implicit imitation in the supervisee's staging of the way patient and therapist interact widens his experiential horizon.

I conclude by underlining what seems to me to characterize this approach to supervision from the standpoint of the supervisor. Often in supervision the supervisee will present his or her case orally or in writing and the supervisor offering a verbal response, followed by a discussion. Supervision using a one-way screen (popular among family therapists) or video is different, but the role of the supervisor, as a fount of new ideas, is still more or less the same.

Relationally oriented supervisors see their role more as one of stimulating emergent experiences and ideas in dialog, and less as a "font of new ideas." The model described here gives the supervisor an opportunity to take this supervisory focus further. The supervisor in this model above all looks for ways to help the supervisee deepen and expand *his or her* experience and understanding. In my experience it is important, especially early in the supervision session, not to discuss the contents of the analytic problem raised by the supervisee too extensively, limiting the discussion to clarifying what the supervisee wants to focus on. Sharing thoughts, be they ever so relevant and reasonable, can obstruct rather that facilitate the supervisees' exploration of their experience by drawing attention to what is already available to the consciousness of both supervisor and supervisee. I rather advise the supervisor not to think too much about the case, but focus on the supervisee's bodily and mental processes, encouraging progress by inviting the supervisee to give herself time to explore her sensations and response to assuming the part of the therapist, patient, and the third, reflective roles, respectively.

CONCLUDING REMARKS

The training program described and discussed has been evolving over the past decade. We have so far been able to do only limited evaluation of its lasting effect on analytic practice. Evaluations from some of the candidates who have completed the program are, however, promising. They especially underline the value of the experiential quality and the focus on details in the approach compared to more conventional training.

A recently published anthology titled *The Therapeutic Dance* (Sletvold & Børstad, 2009) features papers by some of those who have fulfilled the training. A number of the papers discuss clinical challenges concerning among other themes; shame (Skuterud), manipulation (Kulseng Berg), silence (Sorteberg), the difficult to like patient (Gravensteen) and the mute schizophrenic (Bang Jensen). These contributions describe and discuss promising ways to overcome therapeutic impasse by focusing in various ways on the nonverbal body–emotional interaction.

I have argued that analytical training can be enriched by adding an embodied dimension. My argument is based in part on what developmental and neuroscience research have brought into focus for understanding embodied experience, but mainly on analytic psychotherapy training and

supervision where an embodied conception of the analytic interaction is deployed. Our experience at the Norwegian Character Analytic Institute suggests that the embodied procedures described and discussed here help analysts and therapists develop their capacity to attend to the ways in which emotional body states are regulated in the therapeutic encounter, to the ways affect is mutually communicated, and to how emotional interaction patterns emerge and change.

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