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Somatic Experiencing: In the Realms of Trauma and Dissociation—What We Can Do, When What We Do, Is Really Not Good Enough

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We know that the deepest disturbances must be reached to foster the deepest changes and growth. But what do we do when some of our patients suffer relentlessly through dissociated, dysregulated states of catastrophic proportons, when these states are repetitive but not generative, when our psychoanalytic forms of holding, provision, and containment are just not good enough? After a number of years in psychoanalytic practice, the author trained in Somatic Experiencing (SE), a non-psychoanalytic, bio-psychological model for treating trauma. He presents a psychotherapy case that began before his SE training and continued during and after. He illustrates how SE perspectives and approaches can inform and enrich our psychoanalytic ways of looking, listening, and responding. He emphasizes how SE can supplement and enfold into psychoanalytic processes of intersubjective regulation, crucial for patients who are exquisitely vulnerable to severe overactivation (overwhelming anxiety, panic, terror, agitation, rage, explosiveness, etc.) and/or underactivation (freeze, numbness, emptiness, deadness, etc.). He discusses the relationship between SE and major psychoanalytic paradigms (Classical, Kleinian, Winnicottian, Relational, and Self Psychology), looking at points of convergence, divergence, synergy and tension. He shares a professional and personal journey of interweaving SE into psychoanalytic treatment.

Sue entered the session as she had so many before, tense and fragile, intending to tell me about yet another disastrous scene of upset and conflict with her husband. She managed to blurt out, "I lost my shit!" But with that, she lost her words. Redness rose quickly from upper chest to neck to face. She closed her eyes, covered her face with her hands, then doubled over, clutching her arms around her middle. With long lapses, she barely responded to my questions or comments. With breathing rapid and restricted, she remained highly activated yet immobile, eventually collapsing into a limp, demoralized state, ashamed, unable to look at me. By the end of the session, she would be able to tell the outlines of what had happened at home but remained totally unable to put into words or make any sense of her chaotic overwhelming experience.

The scenario in this session, two years into therapy, was all too familiar. When I first met Sue, then in her midthirties, an at-home mother of a four-year-old son and a two-year-old

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daughter, she was going through frequent catastrophic upsets, fights, and collapses at home. Both she and her marriage were falling apart. At first glance, she could look well put together, smiling warmly, attractively dressed, wearing colorful scarves, berets, jeans, and beautifully crafted dangling earrings, a stylish mix of hippie and new age. But her distress was always palpable, ranging from mild unease to fidgety anxiousness to utter overwhelm. And she was vulnerable to extended periods of labile and depressed moods, in addition to catastrophic eruptions.

In the early months of therapy, she was able to talk about certain subjects, such as her concerns as a loving and anxious parent and her frustrations about not having a career. But when trying to speak about the most urgent issues, the conflicts and catastrophic scenes at home with her husband around his extensive travels for work and around their sexual tensions, she would become totally overwhelmed.

As we know, psychoanalytic treatment is itself inherently disruptive. If growth is to occur, the painful and conflictual must be opened up and the internal status quo must be explored and challenged. Each analytic school has its own model for growth-promoting turbulence. However, there has been concern since the beginning that the treatment process itself can be detrimental for people with certain vulnerabilities, people such as Sue (Ferenczi, 1931). We know that some patients keep dissociatively falling apart without ever truly coming together, regression in disservice to the ego. This occurs when deeply disturbed states, which must be reached, become relentlessly overwhelming. Such states, reflecting structural vulnerabilities and deficits, often involving histories of trauma, have been conceptualized with various models and metaphors: regression and splitting of the ego, (Freud, 1938), collapse into paranoid-schizoid organization (Klein, 1946), primitive agonies and disintegration (Winnicott, 1974), annihilation anxiety (Little, 1966), fragmentation of the Self (Kohut & Wolf, 1978), and dissociative Tsunami (Bromberg, 2008).

While work with and within these states can be deeply meaningful and mutative, it ceases to be therapeutic when the patient merely escalates and/or collapses into them, over and over, with suffering that is old, but without generativity that is new. Each psychoanalytic paradigm has its own forms of response to help hold the patient when things get to be too much, and for too long. While models differ, they have in common some form of intersubjective regulation, some way that we lend our own resources to try to help the patient (re)gain internal cohesion and organization. As with Sue, despite our attempts to offer holding and containment, some patients continue to undergo relentlessly repetitive suffering and overwhelmed states, causing tremendous disruption to their outer and inner lives, as well as disintegrating their capacity to learn from treatment. In treatment with especially vulnerable patients, there is a central question with which we must continually grapple: What do we do when what we do is really not good enough? What do we do when the patient and the patient's life are falling apart, both in sessions and during the vast majority of their waking hours (and sleeping hours too for that matter) spent away from us?

This brings us to the origin and focus of this paper: A number of nonpsychoanalytic approaches to trauma emphasize ways to help patients sustain greater stability while facing into the unbearable, to therapeutically revisit the past without relentlessly and destructively reliving it (Levine, 2010; P. Ogden, Minton, & Pain, 2006; Rothschild, 2000; Shapiro, 2001; Van Der Kolk, 2014). These neurobiologically based models focus on the body and levels of the nervous system beneath words. They offer enormously important insights about working

with catastrophic states. However, psychoanalysis has looked to these approaches in only limited ways at this point.

SOMATIC EXPERIENCING

After twenty-two years as a clinical psychologist, twelve of those as a graduate analyst, I undertook a training program in Somatic Experiencing (SE). SE is a non-psychoanalytic, bio-psychological model originally developed by Peter Levine (1996, 2010) for understanding and treating posttraumatic stress disorder. It has been expanded to treat psychic/somatic/nervous system dysregulation more generally. SE provides approaches that are especially helpful in treatment with patients who are prone to states of intense overactivation (overwhelming anxiety, panic, terror, agitation, rage, explosiveness, etc.) and/or underactivation (freeze, numbness, emptiness, deadness, etc.).

When described psychologically, these overwhelmed states entail dissociation. When described neurobiologically, they involve dysregulations in the body and at the lower levels of the so-called reptilian and mammalian portions of the brain, where the survival oriented fight/flight/freeze responses are mediated (Porges, 2011; Van Der Kolk, 2014). These dysregulations also disrupt hippocampal and cortical functioning at the higher level, impairing both the encoding of events in temporal sequence and the most sophisticated capacities of reflective, symbolic, and integrative mental functions (Levine, 2010; Van Der Kolk, 2014). These are the very functions needed in order that the patient can therapeutically reprocess unbearable experiences and arrive at new coherent integrations with revised or expanded meanings.

Vulnerability to such catastrophic states or "system crash" (Harris, 2015) is precisely the raison d'être for SE. A central aim is to facilitate the development and enhancement of the patient's intrinsic regulatory capacities. SE is enormously helpful with highly vulnerable patients, so as to support psychic exploration and expansion, to render the inevitable dysregulation in psychoanalytic treatment tolerable and in the service of growth. SE offers focal approaches that can supplement and/or enfold into our rich but subtle psychoanalytic forms of helping patients with regulation.

Despite this, there are few efforts to bring together SE and psychoanalytic treatment. (See Eldredge & Cole, 2008, and Rappaport, 2012, 2015, for some notable exceptions.)[1] However, I believe that there are many avenues to weave SE into psychoanalytic treatment and to consider these from a wide range of psychoanalytic perspectives: Classical, Kleinian, Winnicottian, Self Psychology, and Relational. In what follows, I explore points of convergence, divergence, synergy, and tension between SE and psychoanalysis, addressing therapeutic options, therapeutic process, and therapeutic action. I also portray my personal journey with SE, attempting to interweave with and enrich my work as a psychoanalytic therapist and analyst. I discuss my work with Sue, tracing the therapy from the earlier phase before I began SE training, and then present process from sessions during and after my

[1] The reader is also referred to P. Ogden et al. (2006) regarding Sensorimotor Psychotherapy, another somatically based system of psychotherapy, which integrates somatic approaches (including many from SE), findings from neuroscience, psychodynamic therapy, cognitive behavioral therapy, and attachment theory.

training, as I have drawn upon SE to inform my psychoanalytic ways of looking, listening, and responding.

FIRST TWO YEARS OF PSYCHOTHERAPY WITH SUE

Prior to SE Training

Sue described the early years of her marriage to Steven as idyllic. They came together after college, fell in love, sharing in humanitarian ideals and love of the outdoors. They had their two children. She chose to be an at-home mother and he was a rising star in a highly technical field. But the dream began to collapse amidst Sue's intense and disorganizing anxiety, volatile states, and tremendous depression. Steven travelled extensively for work. Especially when he was on the road, but not only then, Sue would become intensely anxious about managing even routine daily tasks, such as deciding what to cook for dinner. She would feel overwhelmed nearly to the point of panic by stuff scattered about the house. The children's ordinary squabbling would tip her to the point of yelling at them harshly, leaving her in tears, tormented by guilt and shame. Amidst these scenarios, which could go on for several days at a time, in would step Steven from his travels. Upon arrival, he would be tired and would prioritize his attention initially for the kids. Sometimes Sue would just stand alone at the kitchen sink, crying over the dishes. She would feel convinced that Steven did not love or care about her at all, that he did not even know her. At other times, she would quickly escalate in upset, rage, and desperation. She would find herself yelling at him, swearing through her tears, chasing and grabbing at him, "losing my shit," as she put it. No longer thinking through anything, no longer thinking, she would do this even when the children were right there in the room, after which she would retreat to bed, curl up, and sob.

Equally triggering were some of Steven's attempts to initiate sexual activity, especially at times when Sue did not feel ready (tired, stressed, or not feeling connected). Again she would either escalate in anger or collapse in despair, in either case feeling convinced that Steven did not love or care about her at all, that he did not even know her, that all he wanted her for was sex. Sue felt overwhelmed and bewildered by all of this. When composed, she knew how much caring, love, and loyalty Steven showed her, even though he could be insensitive at times.

When we looked to her developmental past, no clues emerged in her initial bland positive depiction of life in her family. She did tell me of a sexual assault by some older boys when she was very young. She had a vague memory of their putting their hands and things inside her, in a room with funny smells. Tense in the telling, she said that she could not remember much and did not want to talk about it.

The first several years of therapy proved tumultuous. I referred her early on to a psychiatrist who prescribed medications for anxiety, depression, and mood stabilization. Although she showed little symptomatic improvement for quite some time, she felt extremely positive about her work with me. She said that I understood her, and she sensed my acceptance, interest, and genuine concern about her and her family life. I strove to remain present and engaged through the chaotic upheaval of her states and moods, trying to offer various forms of holding and containment. I also worked interpretively, helping Sue to move beyond the initial blandly positive narrative of her early life, accessing and then making connections to some early

profoundly disturbing experiences of emotional neglect, of having felt alone in acute suffering as a child. Her parents did not see or respond to her tremendous anxiety as a shy girl having to change schools every two years or so due to father's job relocations, and having to contend with her parents' seething hostility toward one another. They did not know that Sue was so anxious that she was throwing up on the way to school daily. Sue became able to see how she repeated her early experience as the abandoned sufferer not only concretely in the circumstance of Steven's work travel but also actively re-creating it by not letting him know when she was feeling especially upset (crying alone at the sink), and then by projecting onto him the utterly disconnected, unseeing figure from her early experiences.

By the end of the second year of therapy, she had clearly gained in insight, and she showed somewhat greater resilience some of the time. However, she continued to be exquisitely fragile and extremely vulnerable to her overwhelmed states—all of this, despite her feeling understood and cared about by me and despite trials of various medications.

CONTINUATION OF PSYCHOTHERAPY

During and After SE Training

In an all too familiar moment, as Sue yet again confessed to me, "I lost my shit!" and then began to disappear into the dissociative vortex, I was thinking, "We've been here so many times; this just isn't getting us anywhere." To my surprise, I felt myself lean forward and heard myself say, "You know what, maybe it would be better if you just didn't go there right now." To my even greater surprise, she actually began to reverse, like a film running backward in slow motion, starting to rise back up.

Once I took this in, I thought explicitly about principles emphasized in SE. Sue had been repeatedly going into such dysregulated states, first spiking rapidly into autonomic overactivation, then shifting quickly into immobility and shut down. That she would lose her bearings and lose her words was not surprising since such overactivation of fight/flight/freeze systems in the lower reptilian and mammalian brains can result in inhibition in functioning of the prefrontal cortex and Broca's area in the left cortex (Levine, 2010).

One pathway in SE toward recovery from this kind of crash of the internal neuro/psychic/somatic system is to facilitate outward social orientation toward the therapist.[2] So I emphatically suggested that Sue focus on the present, right here, right now, including me sitting in front of her and talking to her. She oriented toward me and the activation continued to subside. Soon she was sitting there composed and smiling. She was equally amazed with what had just happened, and what had just not happened.

When I asked about her experience of all of this, she said it was powerful, as if I had held out a rope and helped pull her out of a pit. She emphasized that I had noticed that she was disappearing into that old place, that I must have really gotten it, just how terrible that state is. She came back to the next session wearing a braided silver bracelet, symbolizing the rope.

[2] This is based in part on Porges's (2011) theory concerning the vagus nerve, part of the parasympathetic nervous system. According to his polyvagal theory, ventral vagal activity, which innervates muscles involved in social orientation, can function reciprocally to the dorsal vagal activity that innervates the last-ditch freeze, collapse response (the possum).

She would wear it everyday for many months, touching it at those times when she would start to feel overwhelmed. We see here the dovetailing of Winnicott's (1953) transitional object with resource development in SE (Levine, 2010). I also think of Thomas Ogden's (1994) notion of interpretive action in the rich meanings that my actions took on.

While my regulatory and titrating interventions here are an important part of SE (Levine, 2010), they do not reflect the heart of it. In contrast to these forms of intervention, which emphasize my agency, the core of SE guided work involves looking for and potentiating the patient's own incipient embodied attempts to re-regulate, attempts that are not yet conscious or effective.

One day, as Sue started to tell about a hard moment at home, and was beginning to lose it, I noticed her feet wiggling slightly. I simply asked if she noticed the movement in her feet. She had no idea that she was doing this. I suggested that for the moment she try to bring her focus away from her upper body where the disturbance was. When one suffers intense pain or discomfort inside the body, one's attention is naturally pulled right into it. While sensing inward can sometimes serve to deepen exploration, it will merely add fuel to the fire of an already overwhelmed somato-psychic system that is in desperate need of regulation. I asked Sue if she could bring most of her awareness to the feeling of movement in her feet, not trying consciously to do it, to change it, or to stop it. Just see what comes next (working associatively in the body). She noticed that she had been curling and uncurling her toes inside her shoes. Sensing that, she spoke of feeling grounded, feeling her feet on the floor. She was then able to tell me about the hard moment at home, still with intense upset, but now with coherence and without losing visual or mental focus in the room with me.

Sometimes wiggling toes are not just wiggling toes. We see here bottom up self-regulation, Sue's own system's intrinsic intelligence, potentiated by my asking her to attend to it. As therapy proceeded, there were two other gestures that became especially important. When heading into the vortex, she would often touch herself with one hand over her heart while still sitting up, and would clutch her arms around her abdomen once doubled over. She would perform these gestures but remain totally overwhelmed. I began to break in, suggesting that she try to bring most of her attention away from the sick feelings inside her body and focus mostly on the physical feelings of her hand on her chest. Her escalations would begin to reverse, as she felt comforted by the warmth, the contact, the feeling of support. It worked in a similar way when I would bring her awareness to the physical feeling of her arms wrapped around her sides, though it took a bit longer to re-regulate from the doubled over intensity.

In this way, her previously ineffective gestures of self touch became appropriated into expanding capacities to self regulate. These experiences of finding comfort also folded into exploratory work, searching for childhood memories of being comforted. Initially coming up "empty-handed," Sue wept. But there was no need for titrating intervention here because she was fully present in her tremendous sadness. She was engaged in an important process of grieving, now facing the childhood and family life that she actually had, so different from the initial bland positive version. A crucial point here about SE is that it is not about dampening intense emotions; it is about regulation of an overwhelmed nervous system when it spikes outside of its window of tolerance. In fact, the resourcing in SE is aimed at expanding the patient's capacity to access and experience greater intensities of emotion but without system crash.

Sue eventually traced back a similar feeling of emptiness she used to have as a girl when her mother seemed so clueless about her intense anxieties. Sue would sit in the kitchen, scrunched

up, not saying anything, while mother cooked, futilely hoping her mother would finally notice. This reminiscence enhanced her insight into her own unconscious repetition at those times when she would stand alone, crying, at the kitchen sink, not letting Steven know what a hard time she was having.

Sue's self-soothing gestures eventually evoked a precious memory of one time when her mother rubbed her tummy as Sue lay sick in bed (presumably a screen memory). Sue's own gestures of self-touch now became imbued with some sense of mother's comfort.

It is often only in retrospect that we can identify phases in a treatment. Looking back, the first phase of Sue's therapy had centered thematically on her experiences of feeling utterly alone in intense distress, and along with this, important work on strengthening her self-regulatory capacities. Her enhanced inner resources enabled us to move into a second phase, focused on sexual intrusion and abuse, again working with both the early origins and the reactivation in her present life.

Her initial vague report of an incident of boys putting "things" inside her in a room with funny smells would eventually come to light as a highly disturbing episode at age seven in the garage. As the bits and pieces of this incident began to emerge from dissociative seclusion, Sue would come into sessions intending to talk about it but would become completely overwhelmed, requiring focus on stabilization rather than exploration.

She came in one day upset about photographs of a sexual assault on the Internet. It was the infamous Steubenville rape case in which high school football players sexually assaulted a teenage girl who was drunk and unconscious. They videotaped the incident and put it on the Internet. But before Sue could even begin to tell what she had seen, redness was rising quickly. I intervened in familiar ways, helping her navigate through cycles of activation/freeze and re-regulation. Only when she seemed settled enough did I invite her to tune in to her body and see what came next. She noticed an empty feeling in her chest and then began to cry as she described what she had seen in still photos. The girl was passed out drunk, still clothed. One guy was holding her arms down, another guy was holding her legs apart. Sue knew from the scandal on the news that they went on to take her clothes off and digitally rape her. Sue told me that she started shaking her head when she had seen it. I asked how. She began shaking her head back and forth vigorously. She said she had gotten up and stomped around the room. She had felt out of control when she had done this, not knowing if it was a good idea. I told her that I thought her body was doing just what it was meant to do. Her head was saying, "No!" and I mirrored her head movement. We both sat there shaking our heads. Sue beamed. I spoke about her stomping as her system working, mobilizing energy for fight or flight, giving expression, taking action, stomping on those guys or stomping away.

Nodding in agreement, Sue was still quite upset, but most important, she was now energized and present. As she continued telling what she saw and heard, including the guys putting their fingers inside the girl, she told me that the same thing had been done to her. With this came waves of emotion, fear and tears, redness rising, hands to her face, covering her eyes. But then I noticed her hands on her cheeks and asked her what that felt like. She began to lightly stroke her cheeks and spoke of an intense desire to comfort the girl in the photos. She had a visual image of placing her hands on either side of this girl's face, telling me this was a "double double," comforting for both of them. Sue wanted to hug this girl. Then she spoke of feeling drawn to reading about or watching "such things, so people will know." I exclaimed, "There should not be silence!" She replied, "Right!" with tears welling up, registering that I was also speaking to her

as a child. We spoke of how she had so needed someone to want to know, to comfort her, to protect her.

In *working through* her reactions to the photos of abuse, Sue was also *working on* her own childhood trauma, which was in the same associational network. We were potentiating the completion of incipient gestures of attachment, self-protection, and self-soothing in response to the Steubenville photos, the very responses that had been blocked many years ago in the garage.

Central to principles of SE, these completions of truncated actions and, most important, her experience of her own agency in so doing, are powerfully re-regulating. At this point in the session, now in an animated and empowered state, Sue shared a fantasy of speaking up to those guys on the Internet: "So you thought it wasn't wrong, it wasn't rape? How would you feel if you passed out drunk and woke up and saw photos of someone with their finger up your ass!" She felt powerful and playfully pantomimed strutting in her chair, as if walking down the street with her resources strapped on. Feeling grounded and resourced, she spontaneously initiated exploratory work, bringing up her sexual issues with Steven, reflecting on the linkages. When she would feel taken by surprise in his approaches late at night, she recognized now the same visceral reaction she felt when recalling the abuse at seven—curling up, tightening, wanting to say "No!"

We see here Sue preparing to revisit her own trauma. It came up in a session soon after, as she spoke of how disturbed she had become recently when Steven had merely put his arms around her from behind. She again recognized the same embodied, frightened, self-protective responses from the garage. She cried profusely and went through several waves of intense upset, but at this point she did not need regulatory assistance from me. She expressed confusion about the abuse episode, what exactly happened. Interspersed was a vague and confused memory of the one time her father spanked her. This memory would soon become revised, but at this point, she thought maybe it was on a separate occasion when he had seen her and a little boy her own age engaged in benign play, "I'll show you mine if you show me yours." She remembered her father seeing her with no clothes on and becoming angry. In recalling him spanking her, Sue cried and covered her face in shame.

As the session proceeded, she began to clarify that the incident in the garage involved three older boys. The boys stood her on her head (recall the earlier session with wiggling toes striving to find the ground). But as soon as she uttered, "A garage has tools!" she became unable to speak, struggling for the rest of the session.

She returned in the next session composed, saying that she had developed a clearer sense about what had happened. But we did not go straight to it. One method, utilized by some SE practitioners to titrate activation, is to invite the patient to begin the narrative not with the traumatic experience itself, but after it had ended, once the patient knew she was safe (Heller & Heller, 2001). We began not in the garage, but afterward when she would lie in bed at night generating restorative fantasies. She recalled imagining herself being taller than the three boys, talking down to them about what they did to her. As she put it, "I'm getting them to feel not human and ashamed, the way they made me feel with the tools." The central point here, she could now say the word, "tools," with plenty of emotion but no dysregulation. She also imagined herself telling their mothers what they did, and then they all got in big trouble. As she shared all of this with me, she was glowing with a sense of empowerment. We stayed with this state of self for some time in the session, again to consolidate and integrate into the

associational network with the garage her own restorative fantasies, which included completion of self-assertive actions; accessing positive attachment; and the ensuing feelings of empowerment, triumph, and safety (Levine, 2010).

Next in the session, Sue reopened and reworked the memory of her father spanking her. Though she had initially thought this a separate incident around some consensual play with an age-mate, now she recalled the spanking as having occurred right after she walked from the garage into the adjacent laundry room, not wearing her dress, encountering her father there. She could now locate the memory of the spanking in place and time.

Revisiting the trauma in a sufficiently regulated state, Sue could now not only find new coherencies in memory but also open up foreclosures in meanings (a quintessential illustration of the synergy of SE and analytic work). An initial image emerged of a punishing father, who had seen exactly what had happened in the garage and then spanked Sue for it. But then she shifted, feeling with greater conviction that he must not have seen the abuse but rather had seen only that she had been undressed around boys, and in spanking her, he wanted to assure that she would not do this again. Now she could see his spanking as an attempt to protect her, albeit misguidedly. Another fantasy emerged: If father had been able to see what the boys had done to her, he would have spanked them, not her. He would have protected her, and he would have told their parents. Sue was touched and cried, with a sense of father's caring for her. And this rang true to both of us, not merely some idealized wish. Finally, she was amused to realize that this then giant figure of a father was, at the time, a bit younger than she herself at the time of this session, noting how helpful it was to see him as human and fallible. The shift of the internal father from giant and punishing to human and protective paralleled her process with some feelings of self-blame. She began with, "Why didn't I prevent what had happened in the garage?" But in the reprocessing, she developed a stronger sense that this was truly not her fault, not her shame.

Two weeks later, Sue decided she was ready to revisit the garage. When she had thought about it between sessions she had some extremely hard moments, likening it to "standing at the edge of a black hole, feeling helpless, like I was about to fall in." But then she would imagine sitting in the chair in my office and she would be okay. I suggested that this very feeling of helplessness at the edge might be part of the memory itself (implicit memory). She agreed and tried to begin the story. But as soon as she mentioned the word "metal," she went through waves of activation. Along with doubling over and wrapping her arms around herself, I noticed her beginning to close her legs together. I asked her to sense this in her legs. As she could now take time to feel and carry through her own impulse to protect herself (an impulse that had been blocked by the boys holding her legs apart), her nervous system came back into regulation, and she became able to speak. She cringed and uttered, "Yucky!" I reflected back her disgust and verbalized, "Get this awful thing away from me!" I told her that her disgust was her system again trying to protect itself through aversion. She was moved to tears, recognizing how helpless she had been with them holding her upside down, one boy grabbing each leg, holding them apart. She spoke again of the metal, then a huge wave of activation. She began to lose visual focus and covered her face, and cried. I kept talking with her, helping her keep one foot in the present. She went on to describe the coldness of the metal, and the feeling of her palms and the top of her head on the floor, as she was held upside down. She continued for a while recalling more sensory details, of course extremely upset, but generally present, not lost in dissociation. She described the feeling of the metal, the cold, the physical discomfort, though not intense pain.

Through her tearfulness, she recalled in a now coherent narration how they took turns holding her legs apart and inserting the metal inside her. As we were coming into the latter part of the session, we shifted from the story to talking about what it was like for her to tell it. She felt very good to be able finally to talk about it. She said, "I feel near to these things being just memories."

In revisiting this memory a number of times, I inquired about other feelings that might be harder to acknowledge, such as arousal, curiosity, or fascination. Sue was not aware of having had any such feelings either during or in connection this incident. I also watched for embodied signs of arousal or excitement amidst her activation when revisiting the memories but could see no such indications.

Therapy continued for another two years. Sue became able to retell and talk about the garage incident with a mix of sadness, anger at the boys, anger and disappointment with her parents for allowing this situation of being alone unsupervised with older boys, and compassion toward herself. It was no longer overwhelming for her to talk about any aspect of it.

Gradually we shifted away from the focus on the two themes that had been, but were no longer, triggering her catastrophic states: feeling alone and unseen in states of distress, and sexual intrusion. As her insight and resolution about these two issues evolved, and as her turmoil waned, Sue wanted to talk more about other things, especially ideas regarding career in some area of human services. At the point when we terminated, she had not had any truly catastrophic states for well over a year. She smiled in telling me how well she was managing things on her own when Steven was away. Upon his returns, there were no more dramatic scenes, either internal or interpersonal. Regarding their sex life, she said she was no longer troubled by intrusions from the past. She giggled as she told me that she finally could see why Steven liked "make-up sex" when feeling disconnected, as she was beginning to enjoy it too.

Sue initiated termination, having worked out what she felt she needed to. She continued to be a somewhat anxious person with areas of insecurity that probably could have benefited from continued therapy. But she was doing well in love and play, and was in process of transition from at home mother to seeking a satisfying career. By a follow-up session six months later, she was working as the director of a homeless shelter and finding it highly satisfying.

DISCUSSION

While our deepest work often occurs amidst intensities, and we fail if the treatment is too safe, we also fail if it is too dangerous. Though we may differ greatly by personality or paradigm as to what threshold is considered *too* dangerous, we all bear the responsibility to facilitate treatment that is ultimately reprocessing rather than relentlessly retraumatizing.

While SE lends itself to this concern, the interweaving of SE into psychoanalytic treatment brings together two radically different theoretical and clinical perspectives. In contrast to psychoanalytic treatment, where we focus intently on narratives, fantasies, and associated emotions and meanings, SE focuses primary attention on body sensations, urges, emotions, motions, and images. SE prioritizes bottom-up processing, centering upon interoception (sensing into the body). Analysts may object that they do attend to the body. SE therapists may object that they do deal with verbal articulation and meaning. Both statements are true. But there are essential differences between the two rich traditions in their respective emphases on

introspection versus interoception, on ideational versus sensorimotor channels. Furthermore, psychoanalysis and SE differ in how they each look to the body, the former focusing on deepening exploration through attention to the patient's and analyst's visceral experiences (Aron & Anderson, 1998; Lombardi, 2008; Sommer Anderson, 2008), the latter prioritizing attention to dysregulation and regulation, in the process of exploration (Levine, 2010).

Even when we look toward the common goal of helping patients to revisit and reprocess the unbearable, SE offers forms of assistance quite different from any in the psychoanalytic canon. While both forms of treatment include intersubjective regulation, they do so in importantly contrasting ways. Consider the therapist as auxiliary ego, container, good-enough mother, or selfobject. Although the patient must make active use of us, it is the agency of the therapist that is emphasized. We might call this *other-assisted regulation*. By contrast, SE focuses on the patient's own nascent attempts to regulate, and then potentiates those. As we saw with Sue, these can include incipient fight, flight-or-freeze responses, truncated attachment seeking gestures, or various attempts by the body and lower nervous system to re-regulate (through self touch, movement, grounding, etc.). Here the agency of the patient is emphasized, with therapist as potentiator, not provider. We might call this *other-facilitated self-regulation*. This latter approach can foster more rapid development of regulatory capacities than the typically longer slower psychoanalytic process of internalization of holding and containing. While there is a depth in the internalization process unique to psychoanalytic treatment, with some patients, enhancement of self-regulatory capacities earlier in the treatment is crucial to prevent excessive iatrogenic injury and nongenerative repetition.

Despite the dramatically differing approaches (or perhaps by virtue of the differences), SE can interweave in such a way as to powerfully enhance analytic treatment. This was reflected in both the *progress* and *process* in Sue's therapy. Her *therapeutic progress*, clearly facilitated by my SE informed responses, can be conceptualized psychoanalytically as revisions in her inner object world, greater ego strength, replacement of dissociative defenses with higher level defenses, or increased cohesiveness and vitality of the Self. Her lessened vulnerability to transference of old neglectful and abusive figures onto Steven reflects her enhanced capacity for mentalization (Fonagy & Target, 1998), intersubjectivity (Benjamin, 1998), "standing in the spaces" (Bromberg, 1996), or an optimal balance of depressive along with paranoid-schizoid modes of organization (T. H. Ogden, 1986).

To put it another way, after relentlessly repeating her past, Sue was finally able to engage in remembering and working through (Freud, 1914). Prior to therapy, unresolved, unmetabolized early traumas had left her vulnerable to the triggering of chaotic and overwhelming bits and pieces of childhood experiences of emotional neglect and sexual abuse that had been stored, but not yet organized, within implicit memory. These bits and pieces included disturbing body sensations and emotions, truncated and sometimes frenetic behavioral graspings toward self protective action or attachment, and attributions of malevolent meanings transferred onto Steven. SE informed interventions were instrumental in helping her to revisit the early traumas in therapy, but now with sufficient time, resources, titration, and a regulated nervous system (with all parts of her brain available), so that she could reprocess and integrate these old bits and pieces into a new containing coherence. This also enabled her to flexibly reconsider old fixed meanings, a process of retranscription (Modell, 2000). But the essence of trauma treatment entails the forming of a coherent transcription for the first time. With this, Sue was no longer so vulnerable to being hijacked in the present by her past.

Turning now from therapeutic progress to *therapeutic process*, we can consider ways that SE might interweave into treatment across the spectrum of psychoanalytic paradigms. For a Winnicottian, my SE informed interventions with Sue involved serving as environment mother (see Eldredge & Cole, 2008). The Winnicottian therapist's holding functions have been eloquently likened to "protective postponement and dosed stimulation" (T. H. Ogden, 1986), dovetailing precisely with Levine's (2010) emphasis on titration when working in areas of trauma. In addition, a particular Winnicottian moment was my metaphorically holding Sue through my close attention to her own self-embrace.

The Classical paradigm shares with SE concern about the patient becoming overwhelmed in treatment, described respectively as excessive regression (Cooper, 2000) or autonomic dysreguation. After all, Strachey (1934) instructed us to interpret at points of urgency, not emergency (when the ego is too beleaguered to even take in, let alone make productive use of interpretations). Furthermore, SE mediated enhancement of regulatory capacities constitutes, in psychoanalytic language, the development of ego functions.

Turning to Self Psychology, SE informed responses are quintessentially in service of building capacities for self-soothing and of enhancing cohesion, vitality, and robustness of the self (Kohut & Wolf, 1978). Furthermore, my SE guided interventions are translatable in contemporary Self Psychology as forms of optimal responsiveness (Bacal, 1995) or facilitative responsiveness (Fosshage, 1997). Fosshage refers specifically to provision of regulatory interactions insofar as they support the patient's cohesion and recovery from fragmentation.

A potential linkage between Kleinian theory and SE is in Thomas Ogden's (1989) conceptualization of a position that precedes both the Paranoid-Schizoid and the Depressive: the Autistic-Contiguous. This mode of psychological organization is primitive, the infant having only an inchoate sense of self, emerging from pre-symbolic, sensory-motor experience (e.g., sensory contiguity felt on the skin and rhythms of movement). Anxieties at this level, parallel to those evoked by later traumas, manifest as sense/fear of disintegration of the self, similar to Winnicott's (1974) portrayal. T. H. Ogden (1989) described the early infantile anxieties in terms of fears of "leaking, dissolving, disappearing, or falling into shapeless unbounded space" (p. 68). Recall Sue saying, "I lose my shit" and "standing at the edge of a black hole, feeling helpless, like I was about to fall in." While infantile and later traumatic anxieties are not identical, the similarities are not surprising. Both are mediated largely by the lower brain and experienced largely in bodily and sensori-motor channels. This is so for the infant in that ontogeny recapitulates phylogeny in development of the neurologic system. This situation is mirrored in later traumatic experiences where the phylogenically primitive parts of the brain hold sway, as higher cortical and hippocampal functioning is derailed (Porges, 2011; Van Der Kolk, 2014). A specific entry point for SE in T. H. Ogden's (1989) thinking is evident in his description of as a man who would repeatedly press his head into the couch, seeking to contain intense anxieties of the Autistic Contiguous mode through sensory contiguity. This pressing of the head is precisely the kind of gesture to which SE would bring to the patient's awareness. Recall my helping Sue become aware of her foot movement, which led to contiguity with the floor.

Perhaps the tightest knit between the warp of SE and the woof of psychoanalysis is in Relational Theory. In our role as co-regulator of the tension in treatment between safety and danger/risk (Bromberg, 2008; Greenberg, 1986), this balancing act is mutual but not symmetric, as the therapist bears the responsibility. Co-regulation in treatment is a theme central to a range of contemporary psychoanalytic theorists, particularly those that emphasize the nuances of early

attachment (Beebe, 2014; Holmes, 1994; Slade, 2014; Stern et al., 1998). Regarding regulation of danger specifically, Bromberg (2008) spoke of "shrinking the Tsunami":

> The affect evoked by trauma is not merely unpleasant but is a disorganizing hyperarousal that threatens to overwhelm the mind's ability to think, reflect, and process experience cognitively. Affective dysregulation so great that it carries the person to the edge of depersonalization and sometimes self-annihilation is not describable by the term anxiety. Continuity of selfhood is at stake, which is why shame contributes its own terrible coloring. (p. 339)

> Except for highly unusual situations, the therapeutic reliving and cognitive processing of unsymbolized traumatic affect does not create an experience that is genuinely traumatic even though the patient and analyst may both feel at times close to the brink. … What makes it not real trauma? The scenario is enacted over and over with the therapist as if the patient were back in the original trauma, which one part of the self is indeed reexperiencing. But this time there are other parts of the self watching to make sure that they know what is going on … for a seriously traumatized patient the experience is frequently one of being dangerously "on the edge". (Bromberg, 2008, pp. 340–341)

Bromberg's emphasis here is precisely paradigmatic to SE. Corresponding to "other parts of the self watching" is the emphasis on titration and regulation in SE so that other parts of the brain are "watching" (i.e., that cortical functioning is not overly disrupted by dysregulation at the reptilian, mammalian, and body levels). Back to Bromberg, while accessing the self states connected most closely with trauma, other states are also available from which to watch. SE can interweave in psychoanalytic treatment in order to help patients develop greater capacity to stand in the spaces (Bromberg, 1996) and to bring this enhanced capacity in revisiting their traumas.

Another point of convergence for SE with Relational Theory is in the matter of enactment. With sufferers of significant early attachment trauma, the patient's early object world tends to be populated with the victim, abuser, and savior (Davies & Frawley, 1992; Seligman, 1999). In the course of therapy, if the patient suffers in overly intense, protracted, and repetitive (i.e., nongenerative) ways, and if the therapist is not oriented toward and not able to help sufficiently, then the therapist is participating in reenactment, playing the role of the abuser and/or nonhelpful bystander.

The fit between SE and Relational Theory is evident not only *therapeutically* but also *metapsychologically*. While the emphasis on the body in SE may resonate with Freud's (1923) ego being "first and foremost a bodily ego" (pp. 23–25), SE dovetails much more closely with Relational models of the mind, both based on dissociation. SE resembles Freud's early thinking based on seduction theory but not his eventual structural model (Davies, 1996).

I have so far noted areas where SE and different psychoanalytic perspectives converge or interweave. But there are also areas where the stitching is not so smooth. I have seen cases in which SE trained therapists (including myself) bring in regulatory interventions, not in response to the patient's needs, but more in reaction to the their own anxieties. Regulation can derail exploration rather than facilitating it. It can be easy to mistakenly view highly intense emotion as dangerous dysregulation (but they are not the same thing), just as it can be easy to confuse whose threshold of tolerance for activation is being challenged.

Another area of possible dissonance is in working with the transference. The forms of responsiveness from SE may bias toward positive or idealizing transferences and make it more difficult for negative transferences to emerge. Therapists utilizing SE interventions would need to be watchful for subtle signs of negative transference and for our own becoming

overly invested in being only the good mother. Sue expressed only occasional and mild disappointments in me, and our attempts to explore these were not particularly fruitful. Perhaps my SE informed responsiveness, while helpful in many ways, made potential negative transference experience harder to reach.

An additional place of rough stitching is in the use of suggestion in SE, such as my firmly calling upon Sue to attend to certain aspects of her experience and away from others. The therapist drawing upon SE would need to be watchful for enactment of an infantilizing or authoritarian figure, watching and listening carefully to the patient's responses.

CONCLUSION

Elvin Semrad, an inspired and inspiring psychoanalyst and teacher for decades in Boston, used to ask his patients all the time where and how did they feel it in their bodies. SE encourages us to include the body by observing it and asking and talking about it, to bring the body more into the psychoanalytic dialogue, or perhaps more accurately, to regard it as equally constitutive of the dialogue, as are the patient's words. Semrad also taught us that the purpose of analytic work is to help patients to acknowledge, bear, and put into perspective their emotions and painful experiences (Rako & Mazur, 1980). I find SE instrumental as I struggle to help certain patients bear what has been unbearable so that they can sustain themselves in the process of acknowledging, exploring, and putting in perspective.

I wrote this paper as part of my personal journey, starting out as an analyst and only later undertaking SE training. My attempt to interweave the perspectives on treatment from the worlds of psychoanalysis and SE has been and continues to be extremely meaningful and generative for me, both personally and professionally. I believe that the psychoanalytic field would be enriched by further elaboration of this synergy.

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