

https://dspace.org/

Minding the body : questions of embodiment and the practice of psychoanalytic psychotherapy.

Gubb, Karen Louise

2014-07-23
http://hdl.handle.net/10539/14985

Downloaded from a DSpace repository. https://dspace.org/

Article: PPSA Mervin Glasser Postgraduate Student Prize Winner 2013

Re-embodying the analyst

Karen Gubb
University of the Witwatersrand

Abstract

This paper focuses on comments made by patients about the body of the analyst in therapeutic exchanges. The paper begins by exploring the nature of the asymmetry between analyst and patient and its theoretical foundations in psychoanalysis. The question is then posed as to whether considering some of the specific features of the form and timing of the references to the analyst's body in light of this asymmetry may help therapists understand the dynamics of particular therapeutic dyads. Making use of the existing literature and clinical material to support the argument, the paper suggests that using the nature of the therapeutic frame as a preliminary aid to interpretation may cast light on the extent to which references to the analyst's body can be understood as resistances to the defining features of the therapeutic frame, and in so doing illuminate aspects of the transference-countertransference dynamics.

Introduction

For a long time, due to the belief that a 'non-tendentious' psychoanalytic technique (Freud, 1923, p. 252) fulfils scientific principles, any examination of the analyst's influence acting upon the patient was neglected (Thoma, 2009). As intersubjective models develop and expand psychoanalytic theory, and there is more focus on the dyad in the room, the therapist is compelled to become more aware of her[1] own body and the important information which the patient's interaction with it can provide (Cornell, 2009). While this shift in paradigm has raised awareness of the fact that there are two bodies in the therapy room, there is still relatively little written about the impact of the analyst's physical body and appearance on the patient and the therapeutic process. This relative neglect is not surprising given the understandable focus on speech and thought in 'talking cures', as well as a general social emphasis away from the physical body in professional arenas where engagement is usually intellectual and little personal information is shared by the professional.

While such an asymmetry is common in professional relationships, what is of interest in this paper is the particular one-sidedness of the psychoanalytic exchange in which the patient is regularly expected to reveal personal and intimate material while the analyst[2] does not reciprocate in the exchange. References to the analyst's body by the

---

[1] The feminine is used in the paper, but is assumed to encompass both the masculine and the feminine

[2] Many of the concepts used in this paper find their roots in classical psychoanalysis – not so much to the setting of the couch, but instead to the psychoanalytic approach to the frame, transference and interpretation. The argument presented in the paper has applicability to both psychoanalysis and to psychoanalytic psychotherapy. For this reason, the terms 'analyst' and 'therapist' will both be employed in the paper.

patient during psychoanalytic psychotherapy occur within this broader context of asymmetry, and gain particular meaning because of this asymmetry which is designed as an integral part of the psychoanalytic frame.

Following a consideration of the asymmetry of the therapeutic setting, this paper provides an historical account of the place occupied by the therapist's body in the therapy room. It begins by reviewing how and why the therapeutic situation was designed to keep personal information about the analyst to a minimum and argues that this results in the analyst's body acquiring a particular significance. The paper briefly reviews the limited literature on the impact of profound physical changes in the analyst's physical body in psychoanalytic treatment, or differences in body size between the patient and the therapist.

The paper then explores how any particular patient might uniquely engage with their analyst's body during a therapy. Clinical material is presented in the form of three vignettes in which patients' thoughts about their therapist's body specifically emerge. These vignettes illustrate that patients' references to the analyst's body are an important and rich source of information about the transference and countertransference dynamics at work in a particular therapy.

The paper concludes with a discussion of some theoretical issues that arise out of the case material concerning the clinical usefulness of paying attention to the intersubjective nature of the therapeutic relationship, how this is reflected and represented in the way the particular patient engages with the analyst's body, and how the therapist may respond to the resulting complexities of interpretation.

The asymmetry of the psychoanalytic therapeutic setting

The analytic situation, with its therapeutic frame, is an unusual setting in which a patient seeks help within a context that is significantly different from other forms of human interaction and caregiving. In this setting the patient is expected to reveal all manner of intimate and personal material while the analyst is expected to engage with neutrality and anonymity. In psychoanalytic literature the analytic concepts of 'neutrality' and 'anonymity' are varyingly understood and seen as either interchangeable or distinctive terms. Laplanche and Pontalis (2006), in their review of the development of the term 'neutrality', explain how the term was initially used to describe the non-judgmental stance of the analyst in relation to the patient's material. The definition was later expanded to include the idea that the analyst should not make himself felt in his own 'psycho-social specificity' (p. 272). In his discussion of analytic anonymity, Aragno (2008) describes Freud's (1912, p. 118) recommendation for analysts to be 'opaque' to their analysands, reflecting back only what is shown to them, and by implication not revealing anything about themselves. This asymmetry is fundamental to the practice of psychoanalysis as it emphasises the nature of the exchange and produces a form of interaction that is different to others. Importantly, it creates an arena in which to lure the unconscious of the patient. The classical approach to neutrality is thus the idea of the blank slate onto which the patient projects. Contemporary theorists have increasingly come to insist upon an acknowledgement of the person of the analyst in the room, and complex debates have consequently emerged regarding what happens to analytic neutrality if the analyst as a person is acknowledged (Burka, 1996; Renik, 2007). Despite these differing views, however, there is agreement that it is important for the focus to remain on the patient. What always remains is the asymmetry in the material that the analyst and patient reveal.

Many widely accepted elements of therapeutic practice emphasise impersonality in order to foreground that this relationship is not an exchange of confidences between analyst and patient. The room is set out in a way that is different to rooms of medical professionals, the analyst deliberately withholds personal information, and there is the 'oddness' of the transferential relationship (Van Zyl, 2003). Into this peculiar context is brought the 'fundamental rule' whereby the patient is instructed to say whatever comes into her mind. Thus the analytic space, which is at once so private, is also a space in which nothing of the patient's is private at all and in which the analyst reveals nothing personal in response to the patient's revelation of very intimate material. Freud emphasised that the most difficult thing the patient is asked to do is to talk aloud about things that might feel too disagreeable or too indiscreet to express (Freud, 1917). It is a safe assumption that some of the most difficult of these disagreeable thoughts and feelings to give voice to are those regarding the analyst themselves (Adler & Bachant, 1996), and yet that is what patients are required to disclose.

This asymmetry suspends many of the common ways in which human beings engage, and emphasises that psychoanalytic psychotherapy is a form of relating which is different to most others. This unusual way of relating is resisted by patients, manifesting in attempts to personalise the relationship and thereby remove the difference or distance patients experience between themselves and their analyst. The analyst's body acquires a density and becomes a potential place for the patient to try to discover something personal about the analyst. It is accessible to the patient in a unique way in the therapeutic setting – it is in plain sight all the time in face-to-face treatment, and at the beginning and end of the session in psychoanalysis proper. The analyst's body is one signifying presence that will allow the patient to individuate the analyst. In fact, in the absence of other signifiers, the physical appearance of the analyst may become 'hyper-signified' by the patient. In this way the analyst's body becomes a privileged place from which the patient attempts to

draw personal information – to 'read' the analyst's body – because most other forms of personal expression are prohibited.

The use of the couch in psychoanalysis further highlights the structured asymmetry of the psychoanalytic therapeutic setting. The reclined position of the patient in classical psychoanalytic treatments is a legacy of psychoanalysis's beginnings when hypnosis was still the method of treatment used, but the positioning of the patient on the couch with the analyst out of view was continued by Freud even after the psychoanalytic method replaced hypnosis. The reason Freud continued to use the couch was that he did not want his facial expressions to 'lead' his patients; instead he wanted to foster the development of the transference as much as possible (Adler & Bachant, 1996; Eissler, 1993; Lable, Ackerman, Levy & Ablon., 2010; Seeley, 2005; Wolf, 1995). Freud believed that knowing too much about the analyst interfered with the patient's use of the analyst as a transference object and impeded the psychoanalytic process (Freud, 1913). When the analyst is not visible to the patient the development of the transference is believed to be encouraged: the inability to see the analyst's facial expressions, body movements and overall demeanour encourages the patient to explore unconscious constructions of the analyst rather than to focus on the external and visible aspects (Lable et al., 2010).

This analytic seating arrangement privileges the auditory over the visual modality in psychoanalysis even more than is true in other forms of talk therapy (Seeley, 2005). However, even when psychoanalytic psychotherapy occurs face-to-face and the therapist is in the patient's line of sight, therapists still endeavour to keep as much as possible about their personal lives private and unknown to their patients. It is common for psychotherapists to try to avoid revealing anything significantly personal through their attire and to keep the clinical space, and their own appearance, free from individualising visual cues which may alert patients to some aspect of their personal lives (Seeley, 2005).

Therapists can try to dress neutrally, not have anything personal on display, and behave neutrally. It is not, however, possible to control and exclude the appearance and size of their physical bodies. The intimacy of the therapy situation is not only in the emotional, psychological and verbal domain, but also in the physical. Patient and therapist repeatedly sit together in a comparatively small space in a way in which their bodies echo each other (Burka, 1996).

The psychotherapeutic asymmetry is uncomfortable and unfamiliar to the patient and at key moments may produce vulnerability which the patient will try to reduce by 'equalising' the situation. I am arguing that because of the therapist's attempts to achieve relative impersonality, and the patient's desire to move to a more personal relationship, the patient may be extremely sensitive to the analyst's appearance, tone of voice, gestures, posture, moods and even their office in order to gain clues about the therapist's person. Simply because a patient is looking straight at the therapist's body, however, does not mean that they will perceive that body objectively, nor does it predict how the patient will use the therapist's body unconsciously (Burka, 1996). The patient builds up both conscious and unconscious images of the analyst that are comprised of subjective features as well as components of reality (Eissler, 1993). How the patient perceives any 'realities' about the analyst is important grist for the therapeutic mill, and the patient's reaction to these 'realities' must be analysed and interpreted in the psychoanalytic session. An analyst's actual appearance, manner, way of speaking and surroundings are all important and play a role in any therapy, but the exact effect that they have and the particular type of role that they play will be unique to each patient and may differ at different points in any given treatment (Eissler, 1993).

An unintended consequence of the desire not to reveal anything private, together with the analytic setting, is that the analyst may unwittingly become disembodied and depersonalised. As described above there is

commonly a wish by the patient to resist what the framing of the therapeutic relationship does to relating, and commenting on the analyst's body may be a way to re-embody the analyst. This paper focuses particularly on physical characteristics of the analyst's body which are fairly stable and unchanging, and while the analyst's style of dress and office furnishings are important, they are not the object of investigation here. When fully understood, the form and timing of these references to the body may helpfully reveal transference dynamics.

The analyst's body in the psychoanalytic literature

There is little focus on the role of the analyst's physical body in the psychoanalytic literature (Burka, 1996). Such literature tends to fall into two categories. The first concerns the theoretical implications related to particular forms of visible change in the analyst's body. Secondly, a theoretical basis for the clinical use of material about the analyst's body in psychotherapeutic practice is offered.

Visible changes to the analyst's body

The majority of the literature regarding the role of the analyst's body discusses occasions when the analyst's private life enters the therapeutic space in a dramatic way consequent to profound changes to the analyst's body, such as when the analyst is pregnant or becomes significantly ill.

Most of the literature about the effects of an analyst's body changing during pregnancy focuses on how it affects, and often sharpens, the transference. Many writers suggest that the fact of the pregnancy may trigger deep infantile conflicts, sometimes earlier than might otherwise have occurred in a particular treatment (Eissler, 1993; Paniagua, 2004;

Richman, 2006). For example, the pregnancy might highlight old sibling rivalry issues or remind the patient that the analyst has a private life which excludes the patient. These writings explain why an analyst becoming visibly pregnant may re-activate in patients the developmental stage during which they began to separate from their mothers and became aware of the painful reality of the father's relationship to the mother. When patients respond intensely to the analyst's pregnancy analysts may experience countertransference guilt, which might make them reluctant to address the Oedipal issues being raised (Linderholm, 2009). Balsam (2012) writes about the suspicion and anxiety that the plasticity of a changing woman's body might evoke. Whyte's (2004) review of the literature on analysts' pregnancies explores these themes, but also includes how patients of different gender or sexual orientation may respond differently to the pregnancy. Whyte therefore examines not a general response to the analyst's pregnancy but rather the importance of different responses from particular patients.

In contrast to the literature on the analyst's pregnancy, the majority of literature concerning changes to the analyst's body following illness focuses on the ethical considerations of self-disclosure, enactment, absence and whether the analyst can and should keep working while they are ill (Fajardo, 2001; Galatzer-Levy, 2004; Kahn, 2003; Robutti, 2010; Rosner, 1986; Silver, 2001; Torrigiani & Marzi, 2005). Plotkin (2000) includes some comment on how an analyst's absence due to illness might impact an older patient who might experience fear of the same illness, or how a patient may experience anger about the analyst's absence. The analyst's body is of interest in this literature in terms of the general themes that may be evoked by illness rather than in terms of the potential meanings of individual and unique responses.

The published work about the pregnant or ill analyst thus focuses predominantly on a general range of possible meanings, but does not

look specifically at how a particular patient might respond to the changes in the analyst's physical body. It therefore deals with the fact of the change rather than the question of how and why the patient might make reference to it in particular circumstances. It also demonstrates that in the circumstances of profound physical changes, such as pregnancy and illness, even the safety of the analytic frame is not able to maintain analysts' impersonality and limit patients' access to their bodies.

Clinical use of material about the analyst's body

Nearly a century ago Ferenczi (1928) addressed the question of the importance of the patient's observations about the analyst's appearance. He believed that such comments may reflect critical feelings about the analyst, and he highlighted the need for the analyst to pay attention to such comments and be sensitive to their possible meanings. More recently Blechner (2009) suggested that it is important for the analyst to notice comments on, and engagements with, the analyst's body by the patient and to make sense of these. His particular focus is on how these comments might signify the presence of an erotic transference and may take the form of flirting. He helpfully states that, as with any other transference, the analyst should accept the patient's feelings with curiosity and *explore* an erotic transference fully before it is interpreted. I would like to suggest that this approach is helpful when dealing with any comments about the analyst's body, whether they are reflective of an erotic transference or otherwise.

Ferenczi also commented on the importance of urging clients to express their observations about the analyst: 'Every patient without exception notices the smallest peculiarities in the analyst's behaviour, external appearance, or way of speaking, but without previous encouragement not one of them will tell him (sic) about them' (Ferenczi, 1928, p. 93).

Tintner's (2007; 2009; 2010) experiences of losing weight led her to appreciate how this affected her patients and, following Ferenczi, how essential it is to ask for observations about one's body directly. She explains how patients might be hesitant to share their perceptions of the therapist and adds that therapists may also be disinclined to elicit these. She stresses that the therapist may not even be aware that there is something to ask about: the patient's perceptions may emphasise issues that the therapist cannot bear to think about. She suggests that the patient's observations of the analyst's physical body may be used to access and express underlying unbearable feelings, and for these unbearable feelings to be known and talked about.

Tintner's suggestion that the therapist should directly ask patients for their observations is made in the context of a significant change in her physical appearance. The risk of her suggestion is that therapy becomes led by the therapist's agenda. If there are significant and obvious changes to the therapist's appearance that the patient fails to notice or comment on, it may be important to discuss this. There is an important difference, however, between noticing how comments (or the lack of comments) reflect dynamics and moving to unprovoked and unnecessary self-disclosure. Conversely, failing to engage with comments a patient does make may lead the patient to believe that the therapist is not able to hear the patient.

In one of her papers addressing how the therapist's physical size and weight impacts patients, Tintner (2009) refers to a publication by Margaret Little (1990), who discusses her experience with two different analysts. The first did not engage with Little's comments and observations about the analyst's declining health and Little (a medical doctor) was left feeling frustrated, silenced and very angry when the analyst suddenly died, proving her observations correct. The second analyst discussed Little's comments openly and even confirmed Little's observations about his health. Little describes how helpful this felt and

how it removed her from the previous double-bind in which she was faced with two conflicting realities – on the one hand she was required to say whatever was on her mind, but on the other hand the lack of reply from the therapist left her feeling that the subject was off limits and that she was being rude by divulging her observations (Little, 1990). Little's work emphasises how important it is for the analyst to engage with the patient's comments about the analyst's body.

Clinical examples

The first vignette I would like to present to illustrate my thinking comes from the treatment of a paranoid patient. This vignette demonstrates the usefulness of asking patients to reflect on their observations about their therapist's body. This young man had applied for a full-time position at an organisation, but had only been offered a temporary placement as an intern with a view to his suitability for full-term employment being assessed. He had found this experience painful and humiliating and a real blow to his self-esteem, and he worried that others would see that he had not 'made the grade'. He began to have temper outbursts at home and his family encouraged him to enter therapy. Mr A, as I will call him, struggled to settle into treatment and asked many questions about 'this thing called therapy' and how it worked. During our third session he interrupted his own account of how things were going at work to ask me about my badly scarred hand. He told me that he found it distracting and demanded to know what had happened. I asked him about what he thought had happened to my hand and he replied that he was trying to work out whether my hand had been scarred by violence inflicted on me, or by me inflicting violence on another. I interpreted that he was not able to work out if I was safe or frightening, and whether I would help or harm him. The conversation moved to how this was true in all of his relationships and how for him the world is full of people and things that cannot be known or trusted. A few sessions later

Mr A again turned the subject to the scar on my hand. He was angry that I would not tell him what had happened and was frustrated by what he experienced as my withholding of information. He said repeatedly that he couldn't understand why I 'wouldn't just tell him'.

Mr A's frustration at me not 'just telling him' what had happened surfaced his experience of the therapeutic asymmetry and of the frame as frustrating and persecutory. His frustration when I was not forthcoming with information was a clear resistance to the therapeutic frame, but also revealed something about the way he operated in his world. He struggled to work out where he stood with people and that made it hard for him to trust anyone. He was mistrustful of therapy from the outset (which was likely exacerbated by his family requesting that he go into therapy), and it was almost impossible for him to trust me until his questions were answered to his satisfaction. He was afraid that he had been sent to a persecutory therapist he could not trust, but then paradoxically found that he was dependent on that same therapist. This was very difficult for him to bear. His questions about my scarred hand and the fantasies he had about it seemed to represent an attempt to determine whether I was friend or foe, and reflected his internal dynamics and the paranoid way in which he experienced the world. The desire to know whether my hand had been damaged or had done the damaging represented the split in his mind in which he saw people as either victims (like himself at work) or as persecutors (like his bosses). More importantly, however, fixating on my scarred hand was a way for Mr A to resist the dependence he had developed on me. If he could keep alive the idea that I was a dangerous, frustrating perpetrator, he could avoid his wish to know me more intimately and keep his view of the world alive.

In Mr A's search to find 'me' by searching for clues in my body, he was projecting a part of himself into my body. It became the task of the

therapy for him to try to work out, with my help, what of that projection was of him, what was of me, and what was of him in me.

The second vignette illustrates how references to the therapist's body often occur in a throw-away manner 'at the door', and how these can make the therapist very uncomfortable. A colleague told me of a patient who returned to therapy after an absence of three years. As the patient (whom I will call Ms B) walked into her first session after the break she commented that the therapist must have been happy in the three intervening years as she had put on weight. The therapist felt unable to reply. This is an illustration of experiences which are not uncommon for therapists. Comments which occur at the start and end of sessions are often silencing.

Ms B made her throw-away comment as she entered the room. She may have felt small, anxious and vulnerable as she did so. It could be assumed that needing to return to therapy had put her in touch with the feeling of needing her therapist and made her feel she had failed in some way. She was possibly also attacking her therapist's happiness while demonstrating her own unhappiness by needing to return to therapy. Her comment could be read as evidence of defending against such feelings and resisting the asymmetry of the therapeutic relationship by attempting to re-embody, and in this case belittle, her therapist by calling her 'fat' which is generally an insult when said by one woman to another. In her comment, Ms B appeared to be projecting her vulnerable, 'unattractive' feelings into her therapist. This example foregrounds the particular vulnerability of the frame during moments of transition. More relevant to the current argument, however, was my colleague's reference to how she felt about the personal content, which opens the question of the countertransferential dimension of body comments.

The second of my own patients I would like to discuss, Mr C, demonstrates how comments about the therapist's body may occur at the close of a session. This was a difficult therapeutic relationship defined by a lack of emotional connection. The young man had enormous potential at work and had been given extraordinary opportunities, but was a procrastinator and was never able to achieve the success that his potential promised. It was only after a session in which I spoke to him in a very direct way about how he was engaging in his world, and with me, that he was able to admit that he had no interest in those things that others wished for him. His resistance to the therapy process was also acknowledged. He seemed relieved to have been able to admit this, and relieved that I seemed to understand rather than judge his lack of ambition. When I opened the door at the end of the session, he noticed my scarred hand for the first time (having been in therapy with me for over a year). He seemed shocked to see the scar and wanted to know what had happened. He asked whether I had been hurt since our last session, which was clearly impossible. It seems in this case that I needed to really 'see' the patient and understand his resistance in order for him to be able to see me in my physicality.

Mr C seemed to only be able to notice my body at a point in the therapy when the transference had shifted and he felt that he could be more honest and real. It is significant that his comment came at the end of the session, perhaps when it could not draw too much of a response.

Discussion

The past two decades have seen a marked shift in our conceptualisation of psychoanalysis from a one-person to a two-person process (Sapountzis, 2009). Intersubjective psychoanalysis now recognises that the analyst's physical appearance is an important contributor to the therapy process (Burka, 1996) and that careful attention should be paid

to the patient's references to the therapist's physicality. It is important to note that references to the body do not all do the same work or have the same meaning in every therapeutic process.

The case of Mr A highlights the usefulness of asking for the patient's thoughts and fantasies about the therapist's body, and how this reveals information about the therapeutic dynamics and what the patient is projecting onto the analyst's body. Had I simply answered Mr A when he asked about the scar, and not encouraged him to share his thoughts, I would have missed his fantasies of me as a perpetrator of violence. His lack of information about me allowed for the production of his fantasies, and in that way lured his unconscious processes into the open.

The therapy with Mr A also demonstrates how, in the absence of other cues, the therapist's body becomes hyper-signified. Mr A openly struggled with our relationship and how it was defined by the frame, and he tried hard to know me personally, making particular use of my hand in his attempts. With reduced availability of other information, his attention on the little that he did know was intensified and my scarred hand became his focus. The concentration on my hand was a way in which he could protest against the therapeutic setting which he found so frustrating. When he could not get the information that he desired from me verbally, he looked for other ways in which to do so and tried to read it off my body.

If the therapist does not allow the patient's thoughts and feelings about the therapist's body to be talked about, it is likely that the patient will assume the topic lies in a spectrum from rude or impertinent to forbidden, because of the social view that it is intrusive to talk about the person of others, particularly their bodies. When patients are asked directly about their feelings towards the therapist's body, they frequently deny noticing or feeling anything at all (Little, 1990). A therapist's reactions to this may include relief, surprise, confusion,

amusement or scepticism. If she pursues the issue and encourages exploration, a myriad fantasies often emerges (Lowell & Meader, 2005). Allowing Mr A to share his fantasies about my scarred hand gave me access to his split and paranoid world, and underscores the helpfulness of exploring the meaning behind such comments before interpreting them (Blechner, 2009).

If the analyst is supposed to be a 'neutral' receiver of a patient's projections and fantasies, talking about the analyst's body is an obvious way for the patient to try to get the therapist to break this neutral and impersonal way of engaging. The patient makes things personal in order to keep them less one-sidedly intimate. Mr A's demands for information are an example, an attempt to get me to share personal information so that the exchange could be more reciprocal and therefore more comfortable for him.

The manner in which Mr A and Mr C engaged with my hand is illustrative of Burka's (1996) idea of the therapist's body as analytic object. Burka (1996) makes use of Green's (1975) concept of the analytic object to understand the role of the therapist's body. In her description she combines Ogden's (1994) concept of the analytic third with Green's notion of the analytic object and proposes that the analyst's body as an analytic object is co-created by the intersubjectivity of the analyst and patient. Such an object is neither strictly internal nor strictly external but exists in shared unconscious space between the patient and the therapist. Samuels (1989) raises a similar point: 'What I am trying to convey is that, in analysis, the analyst's body is not entirely his or her own and what it says to him or her is not a message for him or her alone' (1989, p. 164). The physical body of the analyst is always present, but not always an analytic object. It only manifests as such when it becomes the carrier of meanings that had not existed prior to a particular moment in a treatment. Its meaning

and the dimensions it takes may change at different points in the treatment.

When the therapist's body does become a focus it develops into something that has a substantive impact on treatment outcome. Burka (1996) proposes that the body assumes the position of an analytic object under some conditions and not others. This may be out of the analyst's control, such as during the dramatic and unavoidable physical changes of illness or pregnancy. The analyst's body may also only emerge as an analytic object in response to certain intersubjective transference-countertransference dynamics. The analyst's body therefore only becomes an analytic object under certain conditions, but there are conditions under which the chances that it becomes an analytic object are higher than others.

My scarred hand became an analytic object for much of Mr A's therapy (especially in the early stages), but gained significance and became an analytic object for Mr C only after a particular therapeutic interchange allowed him to notice it. For Mr A, my hand represented information to which he was not privy, and which reinforced that he was not accepted and included as he wished to have been. This emphasised his split worldview. Mr C's observation of my hand signified a growing closeness and a more real and accurate appraisal of each other in the relationship. My scarred hand is one of my unusual and outstanding physical features and may thus opportunistically become an analytic object in therapies with my patients more than hands might do for other therapists. Other therapists will be embodied in different ways. Responses to my hand will not feature significantly in every treatment and requires that certain conditions (like those described with Mr A and Mr C) arise.

The case of Mr C illustrates a paradox provoked by the hyper-signifying of the analyst's body. Due to the absence of other cues, the

patient focuses more on the analyst's body than they might do in other circumstances. In some cases however, they may only be able to see the analyst's body accurately (i.e. notice what is really there) when they are able to experience the analyst as a separate and real person (and in turn, this might only happen when they experience being seen in that light). In other words, when there is nothing else to see, the patient sees the therapist's body, but they may resist seeing the body of the therapist in its uniqueness until there is a shift in the transference-countertransference dynamic which makes the resistance no longer necessary. Only when I was able to demonstrate being able to see Mr C psychically was he able to see me physically. This intersubjective dynamic allowed for a therapeutic breakthrough. In this case, it was the avoidance of the physical rather than a focus on it which reflected the resistance to the therapeutic process. This case highlights the context and therapy specific nature of references to the body, and their unique relationship to the transferential elements of a particular case.

The cases of Ms B and Mr C illustrate the common occurrence for comments about the therapist's body to occur at opening and closing session moments. It is equally common for the therapist to find such comments silencing. I would suggest that this is true for a number of reasons. Firstly, there may be a temptation to return to the 'whole' patient and avoid the 'heat' of the transference. Returning to the relative safety of a therapeutic exchange, and avoiding the directly personal, might feel more comfortable for the therapist. Secondly, if the comment is made as the patient walks into the room, it may feel as though the session has not yet started and the therapist and patient are not yet 'doing the business' of psychotherapy. If the remark is made as the patient leaves the room, there is no time to engage with it since the session is over. Bringing the comment up at another point may feel defensive to the therapist, and they may worry that talking about the comment gives the patient insight into the therapist's hurt feelings. A third reason why such comments may be hard to pick up on is that they

may be hurtful, insulting or surprising. Therapists are trained to engage with negative comments about themselves as therapists, but criticisms about them as embodied beings might be particularly difficult to engage with and interpret. Personal comments about the interpersonal interaction, thoughts or attitudes are the everyday products of therapy, but comments about one's appearance may feel penetrative and the therapist may feel less practiced at responding appropriately.

The questions that Mr A asked about my hand brought up strong countertransference feelings. The scar is as a result of being badly hurt in an accident in which I was a victim. It was rather shocking to me, and hard to hear, that someone might think that I had received the injury in the role of an aggressor. The damage had come from outside, and I had no responsibility for it, so when it was viewed through a lens of me being responsible and violent I felt aggrieved and my instinct was to answer Mr A's question defensively. Managing and digesting these countertransference feelings allowed me instead to ask him for his thoughts and fantasies. This led to a useful conversation which would have been foreclosed had I simply answered him directly. It also gave me insight into how he might unconsciously provoke and anger people around him.

While it is true that the therapist's physical appearance is an integral part of the therapeutic setting, it often does not receive the same kind of consideration as other aspects of the setting such as time and money. Perhaps this is because it seems to approach the subject of the personal and of self-disclosure by the therapist. It also reflects a paradox that occurs in the therapy room: the therapist is not a person until the session has started (or at least not one with whom the patient can engage), but once they start the session they are no longer a real person but are instead constituted by the patient's fears, fantasies and projections.

As the vignettes illustrate, patients' comments on the body of the analyst may be a form of symptomatic response which reveal something about the patient's unconscious dynamics, and the analyst's body becomes a site into which these dynamics can be projected. The defence of projection is understood as a failure of mentalization (Grenell, 2008), so the comments and the meanings behind them need to be mentalized by the patients with the aid of the analyst. In this way the patient can begin to take back the projection and be helped to see what is of them in the analyst and what is in fact separate to them.

The short vignettes discussed illustrate the complexity of the therapeutic relationship and the analyst's physical body in that relationship. The therapist's body maintains its impersonal status in order for the patient to keep projecting into it, yet it is simultaneously continuously communicative, and frequently communicates much more than the therapist would like it to. The therapist defends against the patient having any knowledge of her body while the patient remains curious about it. The therapist's body is thus something for the patient to project into as well as to find reality in.

Conclusion

The physical body has always been present in psychoanalysis. Indeed, psychoanalysis began with Freud exploring the psychological mechanisms at work in patients who presented with physical illnesses for which no identifiable biological cause could be found (Breuer & Freud, 1893; Gubb, 2010; Rangell, 2000). This was the body of the patient. Despite increasing attention by analysts to the space between the patient and the analyst, the patients' projections and other material are still usually interpreted from a unidirectional perspective. Specifically, they are treated as metaphors or symbols that communicate core aspects about the patient's conflicts and fantasies,

and the role of the analyst is to understand these projections and interpret them to the patient. This paper offers a challenge to engage with the bodies in the therapy room in a different way: by acknowledging, firstly, that there are *two* bodies in the room and, secondly, that these are inescapably *physical* bodies which lend themselves to psychic significance. Doing so allows the analyst to be re-embodied. The way in which the patient engages with the analyst's body offers useful information about the therapeutic process.

In order to work with comments or enactments focused on the therapist's body, it is useful to look at the nature of the comment, its timing, and to interpret what it appears to mean to the patient. As with all clinical material, when a patient makes reference to, demonstrates a preoccupation with, or comments upon the analyst's body, it is incumbent upon the therapist to reflect on the significance of the timing of the comment and on what might be going on in the transference-countertransference relationship.

Normal social interaction contains unspoken rules about normative behaviour. These rules tell us how to behave and tell us what we may and may not say. The social injunction around making personal comments – particularly negative comments – about the body might further explain why it is difficult for a therapist to respond. There is shame and meaning attached to our physical appearance. When a patient focuses on the body in this way, it may be an attempt to move themselves out of the discomfort created by the analytic setting. The act of the patient making themselves more comfortable in this way may have the intended or unintended effect of making the therapist less comfortable.

The paper has argued that the body of the analyst always acquires salience, and indeed a special salience, due to the absence of other cues and personal information. Analysts bring aspects of their embodiment

into the room without even being aware of these, and are often less aware of the impact of their bodies than of their minds. The frame also inadvertently moves the body out of the room. By paying attention to how patients bring the analyst's body back into the room, the analyst is re-embodied and through that process is able to gain more nuanced insight into the dynamics occurring in a particular therapy.

References

Adler, E., & Bachant, J. L. (1996). Free association and analytic neutrality: The basic structure of the psychoanaytic situation. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 44*, 1021-1046.

Aragno, A. (2008). The language of empathy: An analysis of its constitution, development, and role in psychoanalytic listening. *Journal of the American Psychoanalytic Association, 56*(3), 713-740.

Balsam, R. H. (2012). *Women's bodies in psychoanalysis*. New York: Routledge.

Blechner, M. J. (2009). Erotic and antierotic transference. *Contemporary Psychoanalysis, 45*, 82-92.

Breuer, J., & Freud, S. (1893). *On the psychical mechanism of hysterical phenomena: Preliminary communication from Studies on Hysteria*. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 2, pp. 1-17). London: The Hogarth Press.

Burka, J. B. (1996). The therapist's body in reality and fantasy: A perspective from an overweight therapist. In B. Gerson (Ed.), *The therapist as a person: Life crises, life choices, life experiences and their effects on treatment* (pp. 255-276). Hillsdale, NJ: The Analytic Press.

Cornell, W. F. (2009). Stranger to desire: Entering the erotic field. *Studies in Gender and Sexuality, 10*, 72- 92.

Eissler, K. R. (1993). The maligned therapist, or and unresloved problem of psychoanalytic technique. *Journal of Clinical Psychoanalysis, 2*, 175-217.

Fajardo, B. (2001). Life-threatening illness in the analyst. *Journal of the American Psychoanalytic Association, 49*, 569-586.

Ferenczi, S. (1928). The elasticity of psycho-analytic technique. In S. Ferenczi, *Final contributions to the problems and methods of psycho-analysis* (pp. 87-101). London: Karnac.

Freud, S. (1912). *Recommendations to physicians practicing psycho-analysis*. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 12, pp. 111-120). London: The Hogarth Press.

Freud, S. (1913). *On beginning the treatment (further recommendations on the technique of psycho-analysis I)*. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 12, pp. 121–144). London: The Hogarth Press.

Freud, S. (1917). *Introductory lectures on psycho-analysis*. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 16, pp. 241-463). London: The Hogarth Press.

Freud, S. (1923). *'Psycho-Analysis' and 'Libido Theory'*. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 18, pp. 233-259). London: The Hogarth Press.

Galatzer-Levy, R. M. (2004). The death of the analyst: Patients whose previous analyst died while they were in treatment. *Journal of the American Psychoanalytic Association, 52*, 999-1024.

Green, A. (1975). The analyst, symbolization and absence in the analytic setting. *The International Journal of Psychoanalysis, 56*, 1-22.

Grenell, G. (2008). Affect integration in dreams and dreaming. *Journal of the American Psychoanalytic Association, 56*, 223-251.

Gubb, K. (2010). The sense of bodily symptoms. *Psycho-Analytic Psychotherapy in South Africa, 18*(2), 32-56.

Kahn, N. E. (2003). Self-disclosure of serious illness: The impact of boundary disruptions for patient and analyst. *Contemporary Psychoanalysis, 39*, 51-74.

Lable, I., Kelley, J.M., Ackerman, J., Levy, R., Jr, & Ablon, J.S. (2010). The role of the couch in psychoanalysis: Proposed research designs and some preliminary data. *Journal of the American Psychoanalytic Association, 58*, 861-887.

Laplanche, J., & Pontalis, J.B. (2006). *The language of psychoanalysis*. London: Karnac Books.

Linderholm, G. M. (2009). The analyst's pregnancy: An examination of the developing triadic relationship. *Psychoanalytic Quarterly, 77*, 1321-1324.

Little, M. I. (1990). *Psychotic anxieties and containment: A personal record of an analysis with Winnicott*. Northvale, NJ: Aronson.

Lowell, M. A., & Meader, L. L. (2005). My body, your body: Speaking the unspoken between the thin therapist and the eating-disorder patient. *Clinical Social Work Journal, 33*(3), 241-257.

Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. In *Subjects of analysis* (pp. 61-95). Northvale, NJ: Aronson.

Paniagua, C. (2004). What has happened to the body in psychoanalysis? *The International Journal of Psychoanalysis, 85*, 973-976.

Plotkin, F. (2000). Treatment of the older adult: The impact on the psychoanalyst. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 48*, 1591-1616.

Rangell, L. (2000). Psyche and soma: Leaps and continuities. *Journal of Clinical Psychoanalysis, 9*, 173-200.

Renik, O. (2007). Intersubjectivity, therapeutic action, and analytic technique. *Psychoanalytic Quarterly, 76S*, 1547-1562.

Richman, S. (2006). When the analyst writes a memoir: Clinical implications of biographic disclosure. *Contemporary Psychoanalysis, 42*, 367-392.

Robutti, A. (2010). When the patient loses his/her analyst. *Italian Psychoanalytic Annual, 4*, 129-145.

Rosner, S. (1986). The seriously iII or dying analyst and the limits of neutrality. *Psychoanalytic Psychology, 3*, 357-371.

Samuels, A. (1989). *The plural psyche*. London and New York: Tavistock / Routledge.

Sapountzis, I. (2009). Revisting Searles' paper 'The patient as a therapist to the therapist': The analysts's personal in the interpersonal. *Psychoanalytic Review, 96*(4), 665-684.

Seeley, K. (2005). The listening cure: Listening for culture in interculture psychological treatments. *Psychoanalytic Review, 92*, 431-452.

Silver, A. S. (2001). Facing mortality while treating patients: A plea for a measure of authenticity. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 29*, 43-56.

Thoma, H. (2009). Transference and the psychoanalytic encounter. *International Forum of Psychoanalysis, 18*, 237-249.

Tintner, J. (2007). Bypassing barriers to change?: Bariatric surgery, case material. *Contemporary Psychoanalysis, 43*, 121-134.

Tintner, J. (2009). Getting real: From inquiry to enactment and beyond, courtesy the analyst's physical self. *Contemporary Psychoanalysis, 45*, 530 - 544.

Tintner, J. (2010). The incredible shrinking shrink. In J. Petrucelli (Ed.), *Knowing, not-knowing and sort of knowing: Psychoanalysis and the experience of uncertainty* (pp. 281-294). London: Karnac.

Torrigiani, M. G., & Marzi, A. (2005). When the analyst is physically ill: Vicissitudes in the analytic relationship. *The International Journal of Psychoanalysis, 86*, 1373-1389.

Van Zyl, S. (2003). The creature on the couch versus the citizen on the street. *Journal for the Psychoanalysis of Culture and Society, 8*(1), 88-98.

Whyte, N. (2004). Review of the literature. *Psychoanalytic Psychotherapy, 18*, 15-26.

Wolf, E. S. (1995). Brief notes on using the couch. *Psychoanalytic Inquiry, 15*, 314-323.

I would like to acknowledge and thank my supervisor Prof. Susan van Zyl for all her input and mentoring and in helping me find my 'voice'.

I would also like to thank Prof. Carol Long and her writing group for all their thoughts and encouragement during the process of writing this paper and for always being such a safe space.

Karen Gubb is a psychoanalytic psychotherapist in private practice in Johannesburg. She is completing her PhD entitled 'Minding the Body' at the University of the Witwatersrand, and has a special interest in the psychoanalytic intersection of body and mind. She is currently the Chairperson of the South African Psychoanalysis Initiative (SAPI).