

THE INTERSUBJECTIVE FIELD OF HEALING – BEYOND TECHNIQUE

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INTRODUCTION

Recent advancements within neuroscience confirm that the therapeutic alliance (i.e., the collaborative relationship between patient and therapist) plays a major role in the outcome of therapy, even more so than technique. A primary component of the alliance is the emotional bond that is formed and the regulation of feelings between patient and therapist. With an emphasis on the therapeutic relationship, the phenomena of transference and countertransference are seen to be fundamental to the process of psychotherapy. Although, we as Rolfers attend to the physical nature of our clients, issues of transference and countertransference are present in our work with others.

Dr. Rolf's real passion related to human potential. In addition to improving posture and relieving chronic pain, she was intent on increasing vitality and feelings of wellbeing in her clients. Her unique vision continually informs us regarding how genetics, trauma, habit, and culture shape the human form and that each person's shape constitutes their personal history and suffering.

It is no wonder that she was invited to present her work at the Esalen Institute in Big Sur, California along with others who were pushing the envelope of psychology. She did not want to teach her students to be manipulators but rather educators. The root origin of the word education is *educare*, which means to care for, nourish, cause to grow. In the 1960s and 1970s, Esalen was the laboratory for the human potential movement. Such greats as Fritz Perls (Gestalt Therapy), Will Schutz (Encounter Group Therapy), Charlotte Selver (Sensory Awareness), Alexander Lowen (Bioenergetics), were all making their contribution to realizing human potential. There are two premises that set Structural Integration apart from other healing systems: the body is a plastic medium and gravity is the therapist. Dr. Rolf was the first person to suggest that just as a body can be misshaped from habit and trauma, it can be reshaped with the skillful use of touch. She keenly observed that a somatization of one's negative experience shows itself as undifferentiated shape in human structure. Through differentiation of the bound myofascial tissues a more efficient and authentic form can emerge. In the formative years of Rolfing® it was not uncommon to hear such remarks from her clients as, "she has freed my soul"; "I was able to let go of my grief"; "The little things that used to stress me out no longer do".

Dr. Rolf wrote an introduction to Rolfing for the *Psychotherapy Handbook*, which Rosemary Feitis (1978) notes, "is succinct and cagy":

Rolfing is not primarily a psychotherapeutic approach to the problems of humans, but the effect it has had on the human psyche has been so noteworthy that many people insist on so regarding it. Rolfing is an approach to the personality through the myofascial collagen components of the physical body. It integrates and

balances the so-called “other bodies” of man, metaphysically described as astral and etheric, now more modernly designated as psychological, emotional, mental, and spiritual aspects. The amazing psychological changes that appeared in Rolfed individuals were completely unexpected. They inevitably suggest that behavior on any level reflects directly the physical energy level initiating physical structure. The psychological effect is far greater than one would expect to induce in the brief encounter of ten hours of work, which is the normal cycle for Rolfing integration. This effect can be understood if we see it as the emergence of a different behavior pattern resulting from the very much greater competence of physical myofascial organization. Rolfing postulates on the basis of observation that a human is basically an energy field operating in the greater energy of the earth; particularly significant is that energy known as the gravitational field. As such, the individual’s smaller field can be enhanced or depleted in accordance with the spatial relations of the two fields. It would seem appropriate, at this point in time, to state that following Rolfing a man’s greater awareness suggests to him that his energy has been increased. In fact, Rolfing has simply freed his energy, made it possible to utilize his energy more efficiently. (pp. 26-27)

I assert that Dr. Rolf’s perspective was a “relational” one. Obviously, she referenced gravity as the therapist, but the process of guiding the client to a better relationship with the forces of gravity requires a relationship of Rolf practitioner and client. The rapport of Rolfer and client is analogous to the psychotherapeutic relationship of transference and countertransference; where the issues of the client (transference) and the issues of the therapist (countertransference) play a significant role in the outcome of intervention. More recently, contemporary psychoanalysts have reinterpreted the transference-countertransference phenomena in therapy in terms of intersubjectivity.

INTERSUBJECTIVITY

The term intersubjectivity refers in the most basic sense to the interaction between two subjects: myself and another person, or self and other (I/Thou). The study of consciousness within Western science and philosophy has been polarized between “either/or” investigations; either investigations of third-person (“It”), objective, correlates (e.g. cognitive and neuroscience), or investigations of first-person (“I”), subjective, experience and phenomena (e.g. introspection and meditation).

The second-person perspective (“Thou”) has mostly been overlooked in Western philosophy of mind except in the notion of intersubjectivity. Most notably, Jewish philosopher-theologian, Martin Buber (1878-1965) recognized that human beings have two responses available to the world: to relate to what is present either as an object (“I-It” relationship) or as another responsible being (“I-Thou relationship). The essence of human being was relationship, and Buber gave ontological status to the “between”, a mysterious force, creative milieu, or presence from which the experience of being a self arises. “Spirit is not in the I but between I and You” (Buber, 1970, p. 89).

Being intensely engaged in relationship with another person is one of the greatest joys of being human. Meeting, and being met by, another human being provides vitalizing effects. So why not have a theory of mind that shifts our perspective – from looking at the world as a collection of objects, or even as a collection of subjects, to a view that sees relationship as fundamental?

Most philosophical and psychoanalytic references to intersubjectivity have more to do with the explicit, conscious linguistic communication of one left brain to another left brain. A more embodied perspective of intersubjectivity has to do with an implicit, nonverbal communication of one right brain to another right brain as first experienced with our mother or primary caregiver (Schore, 2003; Seigel, 1999). The language of mother and infant is nonconscious, and consists of signals produced by the autonomic, involuntary nervous system in both parties. This implicit view of intersubjectivity is what is most meaningful to me and will be explored more fully.

The psychoneurobiological model of emotional development embraces the early developing right brain perspective of intersubjectivity. “For the rest of the lifespan the right brain, which is more connected into the limbic than the later-developing left, is especially involved in unconscious activities and spontaneous emotional communication. Because this hemisphere is dominant for ‘subjective emotional experiences’ (Wittling & Roschmann, 1993), the interactive ‘transfer of affect’ between the right brains of the members of the mother-infant and therapeutic dyads is thus best described as *intersubjectivity*” (Schore, 2003, p. 76; italics added).

PERSONAL ACCOUNT

Soon after completing my Basic Rolfing Training in early 1979, Dr. Rolf passed away. While attending a memorial service at the Sacramento Street Rolfing Center in San Francisco, I met Dr. Peter Levine. Within a few weeks I was doing individual therapy with him. Unlike most therapeutic approaches, he guided me into my body and interior realms of sensation, feeling, and emotion. Little did I realize how “bottled up” I was with my felt sense. My clinical practice was also being affected. There had been no guidelines in my basic Rolfing training to prepare me for what I was experiencing then. As my inner world continued to blossom, I was getting more activated with each client treatment. Sensations of hot and cold, tingling, profuse sweating, accompanied by feelings of confusion, anxiety, frustration, and agitation were common themes for me. I was unable to differentiate whether I was feeling what my client was feeling; or my feelings were being influenced by what my client was feeling; or that I was feeling my own feelings. Almost daily I would phone Peter and ask him what I should do with all of my feelings and activation. His response: “This is a good thing... Notice what you are feeling right now... That’s it, that’s it... Just settle into that...” Although Peter’s voice of support and reassurance were soothing, my inner struggles continued.

With hopes of understanding and bringing resolve from my discomforts, I pursued various continuing education courses and trainings including, numerous Rolf Institute

workshops and the Advanced Training; craniosacral workshop with Dr. John Upledger; visceral manipulation with Drs. Jean Pierre Barral and Didier Pratt; Ericksonian hypnotherapy with Stephen Gilligan and Bill O'Hanlon; and biodynamic craniosacral with Franklyn Sills. Each of these perspectives broadened my technical skills but didn't address the intersubjective field. In addition, I explored numerous psychotherapies such as Freudian, Jungian, Gestalt and Reichian. These were invaluable in developing my intrasubjective realm, however none of my therapists were well suited in establishing an intersubjective relationship with me.

Up to this time I hadn't realized the degree to which my countertransference issues influenced my therapeutic relationships. In the mid 1990s I taught a five-day Rolfing workshop on the relationship of bodily shape and inner states. One of the students asked me to do some work with her as a demonstration of this interrelationship of shape and state. I requested that she keep her clothes on and lie on the treatment table. As she lay supine, I asked her what she was experiencing. She stated that she was feeling a restriction of her breathing. At this time I had not made any physical contact with her but was seated some six feet away. I had the thought and vision to place my hands along the right side of her diaphragm. Suddenly, she began to hyperventilate and reported feeling compressed in the region of her body that I had visualized working with. Feelings of panic and disorientation ensued followed by freezing sensations in her pelvis and legs. By then, the whole classroom became cold, especially me. My body was freezing in the very areas that she was reporting freezing sensations. I placed a blanket over her and asked her what she needed from me. She asked for support of her lower back. As I placed both hands under her lumbar region her legs began to vibrate. I encouraged her to allow the vibrations she was feeling to move into the other regions of her body. Within a matter of seconds her whole body was trembling. I then asked what emotion she was experiencing. She said she felt sad and began to cry. As she continued crying, her trembling ceased and the feelings of cold were replaced with warm sensations. Ah! I, too, was feeling waves of warmth and a sense of relief from my earlier immobility. As she continued to settle into herself and the table, I asked her if she'd be willing to share what she was thinking or feeling just now. She spoke of early sexual abuse and how she had always been afraid to contact the feelings in her body that were associated with her trauma. Rather than experiencing her shame and disgust, she chronically braced her legs and pelvis to avoid having her feelings. For the first time in her adult life, she reported having "flowing-like-feelings" in her pelvis and legs. As she got off the table and moved around the room she expressed a grace and ease. It appeared as though she had received a combination of sessions Four, Five, and Six of the Basic Rolfing series. This whole process took less than thirty minutes.

I did nothing with my physical touch to start this deep process for her. But what I did do was "transmit" to her body-mind-brain from my body-mind-brain an implicit communication or stimulus that precipitated the session. Wow! I not only have to be present physically for my clients, but also emotionally and mentally. I must be mindful on all levels.

There is so much emphasis placed on attending to our client's needs in the therapeutic relationship. Naturally, we have to be there for them, they are paying us to assist them in their healing. But what do I do with my own physical, emotional, and mental issues (countertransference) as they arise while attending to another? Do I contain my charge of activation within my sessions and let them out later through exercise, drugs, alcohol, sex, kicking the dog, or yelling at my wife? Or do I somatize it and have to receive frequent bodywork in order to gain a sense of relief? Or do I dump my intrapersonal issues within the clinical setting? The bigger question for me is how do I find a style of working that affords me, as well as the other, feelings of wholeness and wellbeing at the completion of a session. This requires certain working models of self, personality, and therapeutic relationship that I want to explore here.

Prior to Dr. Rolf's passing she envisioned three different schools of Rolfing: scientific/anatomical, emotional/psychological, and energetic/metaphysical. Which school did I fit in? As a former Advanced Faculty Member of the Rolf Institute, I felt well versed in the scientific/anatomical arena. I had also explored the energetic/metaphysical domain through psychic healing, Native American Shamanism, and many years of Aikido practice. None of these explorations fulfilled my need to know and understand how to be present for and work with my countertransferential issues in the clinical setting. Clearly, the emotional/psychological realm was calling me.

In the fall of 2003, I enrolled in a doctoral program in Somatic Psychology at the Santa Barbara Graduate Institute. I became immersed in prenatal and perinatal psychology, attachment theory, human development, affect regulation, psychoneurobiology, and authentic movement. It was in the summer of 2004 that I met Dr. Allan Schore, a clinician and researcher, who is considered a world authority within the field of psychoneurobiology (an integration of psychology, neurology, and biology). His theories provide a deeper understanding of the critical relationship between affect regulation and the organization of the self. His writings speak to my clinical experiences and provide a framework for negotiating issues of transference and countertransference within the therapeutic relationship.

ATTACHMENT THEORY AND AFFECT REGULATION

During the course of the Decade of the Brain (1990-2000), the fields of cognitive, social, and affective neuroscience experienced a growth spurt in knowledge, due in part to advances in brain-imaging technologies. The ability to not only theorize about brain development, but also to observe it during critical phases of infant development has revolutionized not only the aforementioned fields of neuroscience, but also psychobiology, psychophysiology, psychiatry, psychology, and the social sciences. I think what best characterizes the advances of the Decade of the Brain in the life sciences has to do with the acceleration of interdisciplinary research that has allowed for an integration of data from different fields of study. Each of these fields is seeking to more deeply understand the human condition.

A common area of interest to researchers in the psychological, biological, medical, and social sciences, as well as to clinicians in psychiatry, psychology, and social work, has to do with affect regulation and dysregulation. As Schore (2003) states, “Affective processes appear to lie at the core of the self, and due to the intrinsic psychobiological nature of these bodily-based phenomena recent models of human development, from infancy throughout the lifespan, are moving towards brain-mind-body conceptualizations. These models are redefining the essential characteristics of what makes us uniquely human” (p. xiv). I recall that in the 1970s, when I entered into self-exploration and personal growth, “waking up” and becoming conscious was the movement and focus of the times. Not so today – “The self and personality, rather than consciousness, is the outstanding issue in neuroscience. So much of our behavior emerges from processes to which we have little conscious access” (Davidson, 2002, p. 268). The interest is more attentive to the nonconscious processes, beneath conscious awareness, where brain-mind-body operations occur automatically.

These nonconscious processes take place within the lower and central brain structures. These are referred to as the brain stem and limbic system respectively. The brain stem mediates basic elements of energy flow, arousal and alertness, and the body’s physiological state – temperature, respiration, and heart rate. “The limbic regions are thought to mediate emotion, motivation, and goal-directed behavior. Limbic structures permit the integration of a wide range of basic mental processes, such as the appraisal of meaning, the processing of social experience (called ‘social cognition’), and the regulation of emotion...Although each element contributes to the functioning of the whole, regions such as the limbic system, with extensive input and output pathways linking widely distributed areas in the brain, may be primarily responsible for integrating brain activity” (Siegel, 1999, p.11).

During the first two years of life, the infant’s right hemisphere develops at an accelerated rate, especially in the right orbito-frontal regions. It is here that there is a convergence of hypothalamic, limbic, amygdala, and temporal lobe structures. These regions process the implicit and affective information coming into the infant from both its inner and outer environments. At this stage of early life, the infant is relatively unable to self-regulate and naturally seeks external regulation from its primary caregiver. The mother, or primary caregiver, must serve as an external affect regulator for the infant’s arousal states. The role of the “good enough” mother is to provide affective attunement and resonance to her infant’s highly aroused affective states of pleasure and joy; and conversely, the mother facilitates a down regulation of negative affective states. These hyper-aroused and hypo-aroused affective states of experience help shape the activity of the brain and the strength of neuronal connections throughout life. “The brain’s development is an ‘experience-dependent’ process, in which experience activates certain pathways in the brain, strengthening existing connections and creating new ones. Lack of experience can lead to cell death in a process called ‘pruning.’ This is sometimes called a ‘use-it-or-lose-it’ principle of brain development” (Siegel, 1999, p. 14).

Drs. Schore, Siegel, and others concur that the regulation of emotion is the essence of self-organization. As Siegel says, “Lack of mental well-being may often be a

result of emotion dysregulation” (Siegel, 1999, p. 274). It is very clear to me that the dyadic relationship between mother and infant establishes the behaviors of autoregulation and socioemotional relationships for the developing infant. This right hemispheric implicit communication remains plastic throughout one’s life span and “is dominant for the implicit cognitive processing of facial, prosodic, and bodily information embedded in emotional communications, for attention, for empathy, and for the human stress response” (Schoore, 2003, p. xv). Just as the infant requires the mother to be its external regulator when distressed, we as adults need relationships that afford regulation (interactive repair) from our dysregulated states. It is within the therapeutic relationship that our need for interactive repair can be made possible. “The intuitive empathic therapist psychobiologically attunes to and resonates with the patient’s shifting affective state, thereby co-creating with the patient a context in which the clinician can act as a regulator of the patient’s physiology” (Schoore, 2003, p. 48). These theoretical perspectives speak to my clinical experiences. It is through body-brain attunement with the client that I gather the most relevant information about what a client needs in order to find balance, connectedness, and a sense of wholeness. My success has everything to do with contacting the feeling, sensory, and emotional aspects of my client.

Over the past thirteen years, basic knowledge of brain structure and function has vastly expanded, and its incorporation into the developmental sciences is now allowing for more complex and heuristic models for human infancy. As such, the field of psychoneurobiology has emerged as a way of understanding the mechanisms that underlie infant mental health. Schoore (2003) has detailed the neurobiology of a secure attachment, an exemplar of adaptive infant mental health, and has focused on the primary caregiver’s psychobiological regulation of the infant’s maturing limbic system, the brain areas specialized for adapting to a rapidly changing environment. Because the infant’s early developing right hemisphere has deep connections into the limbic and autonomic nervous systems and is dominant for the human stress response, the infant-mother (attachment) relationship facilitates the expansion of the child’s coping capacities. The attachment model suggests that adaptive mental health can be fundamentally defined as the earliest expression of flexible strategies for coping with the novelty and stress that is part of human interactions. This efficient right brain function is a resilience factor for optimal development over the later stages of the life cycle.

Optimal development has mostly been addressed by the psychological sciences, but with the advances in brain research, developmental neuroscience is now in a position to offer more detailed and integrated psychoneurobiological models of normal and abnormal development.

Perhaps the most important scientist of the late twentieth century to apply an interdisciplinary perspective to the understanding of how early developmental processes influence adult mental health was John Bowlby (1969). Almost three decades ago he claimed that attachment theory can frame specific hypotheses that relate early family experiences to different forms of psychiatric disorders, including the neurophysiological changes that accompany these disturbances of mental health. Attachment theory has become the dominant theoretical model of development in contemporary psychology,

psychoanalysis, and psychiatry; it is the most powerful current source of hypotheses about infant mental health. Bowlby inspired deeper explorations into how an immature organism can be shaped by its primary caregiver, usually the mother, through its attachment bond with her. In his view, developmental processes are the product of the interaction of genetic endowment with a particular “environment of adaptiveness, and especially of his interaction with the principal figure in that environment, namely his mother” (p. 180).

He concluded that the infant’s emerging social, psychological, and biological capacities cannot be understood apart from its relationship with the mother. He observed that the mother-infant attachment is “accompanied by the strongest of feelings and emotions, happy or the reverse”, (Bowlby, 1969, p. 242), that this interaction occurs within a context of “facial expression, posture, tone of voice, physiological changes, tempo of movement, and incipient action,” (p. 120), “that attachment interactions allow for the emergence of a *biological control system* which functions in the organism’s ‘state of arousal’” (pp. 152-157), “that the instinctive behavior which constitutes attachment emerges from the co-constructed environment of evolutionary adaptiveness has consequences that are ‘vital to the survival of the species’” (p.137), and “that the infant’s ‘capacity to cope with stress’ is correlated with certain maternal behaviors” (p. 344).

These last two factors, adaptiveness and coping capacity, are obviously central components of infant mental health. In essence, Bowlby, Schore, and others have contended that attachment theory is a regulatory theory. Because regulation theory integrates both the biological and psychological realms, it can also be used to further models of normal and abnormal structure-function development, and therefore adaptive and maladaptive infant mental health. In attachment transactions the secure mother, at a non-conscious, intuitive level, is constantly regulating her baby’s shifting arousal levels and therefore emotional states. “Emotions, and the experience of emotion, are the highest-order direct expression of bioregulation in complex organisms. Leave out emotion and you leave out the prospect of understanding bioregulation comprehensively, especially as it regards the relation between an organism and the most complex aspects of an environment: society and culture” (Damasio, 1998, p. 84).

This psychobiological interaction between mother and infant is where the interface of nature and nurture occur. It is now known that our genetic potential (nature) can be realized through our environmental experience (nurture). During the “shared moment” with mother and infant “when mutual eye contact is established, both participants know that the loop between them has been closed...and this is the most potent of all social situations” (Schore, 1994, p, 61). Face-to-face interactions, occurring at two months of age, are highly arousing, affect-laden, short interpersonal events that expose infants to high levels of cognitive and social information. In order to regulate these high positive arousals, mothers and infants synchronize the intensity of their affective behavior within lags of split seconds.

In physics, a property of resonance is sympathetic vibration, which is the tendency of one resonance system to enlarge and augment through matching the

resonance frequency pattern of another resonance system. In essence, when the mother-infant dyad is in resonance, the attuned mother's role is to amplify, contain, and modulate her infant's affective displays through differentiation and self-reflection of her own affective states. But the primary caregiver is not always attuned, and during these moments of misattunement, disruption of the attachment bond usually happens. According to Schore (1994), it is at these times that the re-attuned, comforting mother and infant thus dyadically negotiate a stressful state transition of affect, cognition, and behavior. This recovery mechanism underlies the phenomenon of "interactive repair", in which participation of the mother is responsible for repair of stressful misattunements.

Emotions and their regulation are thus essential to the adaptive function of the brain, which is described by Damasio (1994):

The overall function of the brain is to be well informed about what goes on in the rest of the body, the body proper; about what goes on in itself; and about the environment surrounding the organism, so that suitable survivable accommodations can be achieved between the organism and the environment.
(p. 90)

Bowlby hypothesized that the maturation of the attachment control system is open to influence by the particular environment (nurture) in which development occurs. "Current neurobiological studies show that the mature orbitofrontal cortex acts in 'the highest level of *control* of behavior, especially in relation to emotion' (Price, Carmichael, & Drevets, 1996, p. 523) and plays a 'particularly prominent role in the emotional modulation of experience'" (Mesulam, 1998, p. 1035 in Schore, 2003, p. 41). In particular, the orbital prefrontal areas are especially involved with attachment functions. This region acts as a convergence zone, where cortex and subcortex meet. It is also closely associated with the limbic system, which is responsible for the rewarding-excitatory and aversive-inhibitory aspects of emotion; and to the hypothalamus, which is responsible for the autonomic nervous system (ANS), sympathetic, and parasympathetic responses. Because of its unique connections, processed information concerning the external environment (e.g., visual and auditory stimuli emanating from the emotional face of the object) is integrated with subcortically processed information regarding the visceral environment (e.g., changes in the emotional or bodily sensing state). In particular, the early maturing right cortex is dominant for selectively attending to facial expressions, for the processing, expression, and regulation of emotional information.

One of Schore's (2003) major conclusions in his ongoing work on the regulation of feelings or "affect regulation" is that primitive mental states are more than early appearing mental or cognitive states of mind that mediate physiological processes. They are more characterized as psychobiological states, and therefore the therapist with a developmental framework is not exploring primitive states of mind, but primitive states of "mind-body". The right brain is centrally involved in unconscious activities, and just as the left brain communicates its states to other left brains via conscious linguistic behaviors, the right brain nonverbally communicates its unconscious states to other right brains that are *tuned* to receive these communications. Freud asserted that, "it is a very

remarkable thing that the unconscious of one human being can react upon that of another, *without passing through the conscious*" (p. 49). He also proposed that the therapist should "turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient...so the doctor's unconscious is able...to reconstruct [the patient's] unconscious" (p. 49). He called this state of receptive readiness "evenly suspended attention." Schore goes on to say,

Studies of empathic processes between the "intuitive" attuned mother and her infant demonstrate that this affective *synchrony* is entirely nonverbal and that resonance is not so much with his mental (cognitive) states as with his psychobiological (affective-bodily) states. Similarly, the intuitive empathic therapist psychobiologically attunes to and resonates with the patient's shifting affective state, thereby co-creating with the patient a context in which the clinician can act as a regulator of the patient's physiology. (p. 48)

"In other words, the energy expending sympathetic and energy conserving parasympathetic components of the ANS regulate somatic aspects of not only stress responses but emotional states" (p. 9). This adaptive function is stressed by Porges (1997):

Emotion depends on the communication between the autonomic nervous system and the brain; visceral afferents convey information on physiological state to the brain and are critical to the sensory or psychological experience of emotion, and cranial nerves and the sympathetic nervous system are outputs from the brain that provide somatomotor and visceromotor control of the expression of emotion. (p. 65)

SUMMARY

The theoretical perspectives I have presented are not a substitute for developing skillful and precise Rolfing abilities. My intent has been to provide a language to better understand the interactive processes we experience with our clients. It has been my experience that the unresolved or disrupted states associated with the mother-infant relationship can be accessed and amplified through skillful and precise Rolfing. The practitioner must provide support, safety, containment, and titrate his intervention. When the client's issues are accessed, there is an opportunity for renegotiation of the dysregulated states within the therapeutic dyad whereby the practitioner resonates, attunes, and synchronizes with the client.

What else must a practitioner do to successfully negotiate these deep processes? I find Schore (2003) most succinct:

Our own ability to "enter into the other's feeling state" depends upon our capacity to tolerate varying intensities and durations of countertransferential states marked by discrete positive affects, such as joy and excitement, and negative affects, such

as shame, disgust, and terror. This range of our affect tolerance is very much a product of our own unique history of early indelibly imprinted emotionally-charged attachment dialogues, since it is these primordial interactive experiences that profoundly influence the origin of the self. For this reason, I believe personal psychotherapy is a prerequisite for anyone entering the field. (p. 56)

How does a somatic therapist integrate the psychologist aspects of self? I think John Conger (2005) quotes Jung beautifully:

The part of the unconscious which is designated as the subtle body becomes more and more identical with the functioning of the body, and therefore it grows darker and darker and ends in the utter darkness of matter; that aspect of the unconscious is exceedingly incomprehensible...one must include not only the shadow—the psychological unconscious—but also the physiological unconscious, the so-called somatic unconscious which is the subtle body. You see, somewhere our unconscious becomes material, because the body is the living unit, and our conscious and our unconscious are embedded in it; they contact the body. Somewhere there is a place where the two ends meet...and that is the place where one cannot say whether it is matter or what one calls “psyche”. (p. xxiii)

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