I had expected that bringing together psychoanalysis and Somatic Experiencing (SE) might be controversial. That expectation was certainly not disappointed. Although Bass resonated with much of my thinking, he also challenged the whole idea of integrating these two forms of treatment. Leddick provided extensive critique, though more about how I drew upon SE, not so much the fact that I did. While Lombardi appreciated aspects of my work with the patient, he utterly rejected the whole notion of drawing upon SE, viewing it as mechanistic, simplistic, narrowly behavioral, and merely about modulation. To address these critiques, I revisit here the clinical process with Sue, highlighting how SE is about so much more than just modulation. SE can deepen our forms of analytic holding and can help patients (re)connect with their bodies in ways that are emotionally alive, intimate and healing. In revisiting the clinical process, I draw upon Levine, Blakeslee, and Sylvae’s in-depth discussion of SE: its goals, principles, and techniques. Though I agree with Bass’ and Lombardi’s concerns about “integration” of psychoanalysis and SE, I do not propose integration of the two, but rather interweaving of one into the other. In essence, I seek here to continue to illustrate how SE can interweave into our work, enriching our psychoanalytic ways of looking, listening, and responding.
I would like to thank the discussants for engaging with my work and enriching the dialogue between psychoanalysis and Somatic Experiencing (SE).

I am honored that Peter Levine, the founder of SE, is one of the discussants, and I am grateful to his two co-authors, Blakeslee and Sylvae, SE Faculty and members of Levine’s Legacy Team. They elaborated on areas central to SE that I merely touched upon, notably memory systems and threat response patterns as they are linked to contemporary neurobiological models. They also contextualized dissociation in terms of these models. They expanded on therapeutic principles, techniques and goals in SE, linking these to clinical process in my paper. I will comment further on their ideas as they interweave with issues raised by the three psychoanalyst discussants.

I am grateful to Bass for his resonance with my ideas and his creative questioning. I am grateful to Leddick and Lombardi for their close reading and extensive critiques. I was initially surprised and dismayed by Leddick’s depiction of my work as oscillating between SE and psychoanalytic, and as foreclosing of analytic process, and by Lombardi’s view of my SE-informed ideas as mechanistic, naïve, oversimplifying, behavioral, and insufficient. Their responses were quite different from the more affirming ones I have received when presenting earlier versions of this paper. Then it occurred to me that in my efforts in the paper to articulate and illustrate principles and approaches from SE, I did not bring my voice into it enough, and I did not elaborate on the analytic process sufficiently. I will convey here more of my experience and more about the analytic process, as I address the central issues raised.
To begin at the beginning, regarding the first two years of treatment, I will expand here on my summary statement in the paper about “trying to offer various forms of (analytic) holding and containment.” During this early phase, Sue discussed many different themes including: concerns about her children, struggles in mothering, meaningfulness of playing music, frustrations in trying to start an at-home business while being so anxious, etc. Overall, she expressed a wide range of emotions. I, too, felt a wide range: fond, curious, concerned, playful, attracted, joyful, sad, frustrated, angry, etc. But, by far most intense were my feelings in response to her repeated and refractory catastrophic states: afraid (for her, her children, her marriage, and for the treatment), confused, helpless, overwhelmed, guilty, inadequate, ashamed, burdened, frustrated, etc.

Throughout the first two years, and beyond, I strove to remain present with whatever I was going through internally, to process it as best I could, and to draw upon it to speak and try to reach Sue. I would talk to her, in her doubled over states, putting into words the feelings of confusion, anger, helplessness, overwhelm, shame, emptiness, betrayal, aloneness, inability to think, etc. Thus, I tried to be with her in her suffering and to provide containment in the Bionian sense (Bion, 1963), or

\[1\] Leddick was “...struck by how little space there is in this dyad for imagining more help and support for Sue's maternal functioning.” However, the lack of space about motherhood was not in the treatment, it was in the paper (being limited to journal length). Sue and I did talk extensively about her experiences as a mother (similarly in regard to her experience of my offering her a rope).
mirroring that is marked, in Relational terms (Aron, 2008). Although she felt that I understood her and was helpful, I was painfully aware of her ongoing vulnerability to “system crash” (Harris, 2015). I inquired when I heard even indirect indications of her feeling disappointed, but this was not generative. She maintained a transference that was either idealizing (Kohut, 1971) or unobjectionably positive.

In addition to my attempts to contain, by speaking to deeply disturbing feelings, I was also guided by the therapeutic function of holding. As I quoted Ogden (1990), holding involves “protective postponement and dosed stimulation” when there is concern about excessive impingement. I made a conscious choice to go with Sue’s postponing our addressing her history of sexual abuse. I was concerned about her fragility and her vulnerability to protracted intense anxiety and to highly disorganized states. As long as she was not bringing it up explicitly, I opted to wait until later in the treatment when Sue would hopefully have progressed developmentally in internal structural cohesion and solidity.

One could argue, as Leddick did, that I got it precisely wrong here. Leddick asserted that by not directing our attention to the sexual trauma during the early phase of treatment, I was unconsciously colluding with Sue’s dissociation, and underestimating the severity of the early sexual trauma. Leddick stated, “...the analytic pair enact a version of the scenes Sue describes with her husband and with her parents in childhood, in which Sue suffers silently hoping her mother (husband/analyst) will finally notice her suffering and respond.” Furthermore, Leddick emphasized Sue’s psychological capacities “to symbolize her experience as soon as Levit threw her a rope.”
In my view, I did not at all underestimate the severity of Sue’s trauma, but rather that Leddick overestimated Sue’s capacities, relative to her vulnerabilities. I agree that Sue had the ability to symbolize, but such capacities are highly state dependent, and her integrative/reflective functioning was obliterated whenever we turned toward areas of trauma (as she collapsed into a trauma vortex, as discussed by Levine, Blakeslee, and Sylvae).

It was a complex clinical choice, regarding Sue’s history of sexual abuse, between holding (by not pressing toward focus on it before she was ready) vs. containing (by naming and addressing the abuse and deep anxieties associated with it). Both are legitimate psychoanalytic responses. The point I emphasize here is not as much about who was right, Leddick or me, but rather, to illustrate that I was thinking, working and functioning psychoanalytically, contrary to Leddick’s characterization of me.

Regarding the first two years of therapy, it was often very difficult for me to bear my anxieties and feelings of guilt and inadequacy in the face of Sue’s ongoing catastrophic states. I felt the countertransference as the non-helpful bystander to the neglected and abused child (Lord, 2008). But I believe that, at least to a reasonable extent, I hung in there with Sue, with myself, and with the process. We sat through many overwhelming storms together. I am not inclined to think that Sue felt there was no home in the therapy for the helpless child, as Bass speculated. While I agree with Leddick that my clinical faculties and range of tolerance were indeed challenged, I regard these as part of an analytic process; I do not agree with
her implication that these reflect critical failures or deficits on my part that then necessitated a grasping for SE in a compensatory way.

My perspective on the initial two years, as well as my understanding of the relationship between the subsequent SE and analytic work, were enriched by Lombardi’s discussion. Although I disagree entirely with his conclusions about SE, I want to first elaborate on ways in which I find his ideas expansive and helpful.

To begin with his critique of the initial phase of treatment, he asserted (and I agree) that there was a need, which I failed to meet (until later when I would draw upon SE), to work with Sue in the area of her relationships with her own body, and the disturbances at the level of the self. Levine, Blakeslee, and Sylvae similarly asserted the need to work with the body, prior to cognition or emotion (interoception before introspection). Lombardi stated, “... a dissociation from the body can be hypothesized. The patient seems to lose not only her shit but, generally, the connection with her body ... if she remains unaware of it, the intervention of the analyst must make it observable in order to stimulate change. If the analyst does not detect and interpret these movements, the patient will be left in a state of dissociation from her own physical body. In that case, she will not be able to make any sense of her internal chaotic experience ...”

When I look back at how I tried to reach her in the first two years, I spoke primarily in the language of emotion, but, as Lombardi articulated, Sue was thrust into a more primitive, pre-symbolic level in which the body is where it’s at. While we need to use words in analytic work, direct somatic experience is the relevant
parlance for such primitive states. In these first two years, I was not speaking her language, at least not yet.

This brings us to the body, to my SE-informed work, and to Lombardi’s depiction of working with the body psychoanalytically. He referred to SE as my path to working with the body. I would agree. Where I disagree is his view of SE, and of my interweaving it into analytic work, as mechanistic and simplistic. I will address this both experientially and theoretically.

First, experientially, I continued to feel deeply engaged with Sue and with our process, while drawing upon SE. I understand that neurobiological language can sound mechanistic. But my experience was anything but. As an example, consider the moment when I guided Sue to shift her focus from the intense disturbance in her upper body and to feel her arms wrapped around herself. Neurobiologically speaking, I was helping her with intense dysregulation in the reptilian and mammalian parts of her brain and in her body. In SE terms, I was facilitating her experiencing her own self-comforting and attachment seeking behavior. Psychoanalytically, I was channeling and giving implicit expression of my wish to hug and comfort Sue. I felt as though I were embracing her with her arms. In essence, I was drawing upon SE in order to provide analytic holding (Winnicott, 1975). In so doing, I was helping her become “anchored in the present,” which is, as Lombardi stated, “essential for the analytic couple.”

That SE did not mechanize or de-animate my involvement in the analytic process, was recognized by Bass, describing me as sensitive, compassionate
(suffering with) and committed. Lombardi, himself, noted “... the capacity of emotional contact displayed by Levit as he sustains Sue’s evolutionary pathway.”

It did not surprise me that bringing in SE was vitalizing, rather than mechanizing, because SE as a treatment model is not mechanistic, nor is it behavioral, as Lombardi characterized it. SE is all about opening up to internal experience in a full deep way (not merely about modulation, as Lombardi concluded). Levine (2010) coined an acronym to represent multiple channels of experience, SIBAM: Sensation (especially interoception, focusing into the body), Image, Behavior, Affect, and Meaning (which I would expand to narrative).

Psychoanalysis has traditionally foregrounded Meaning/narrative and Affect. As Levine, Blakeslee, and Sylvaè conveyed, SE prioritizes Sensation, but also uses Image, and Affect as points of entry, and looks especially to incipient self-protective Behaviors, when working in areas of trauma.

How does this relate to psychoanalytic ways of looking to and working with the body, such as those articulated by Lombardi and by other analysts whom he cited? This is a complex question that I can only begin to address here. Lombardi referred to the analyst’s task of helping the patient (re)establish vital connections to the body through awareness and through interpretation. These correspond to Levine’s Sensation and Meaning channels of experience, respectively. A major difference (as discussed by Levine, Blakeslee, and Sylvaè) is evident in that the SE therapist would be less likely to interpret, but rather would wait for meanings to emerge through the bottom-up process of tuning into the body and seeing where things go somatically, emotionally, imagistically, and behaviorally. Of course as an
analyst, I am a believer in interpretation. But it was my background in SE that guided me to ask Sue to tune in and stay with the empty feeling in her chest, to see what comes next, which led to deep, emotionally rich exploration of her present moment and of her developmental past. In this sense, SE not only facilitated my path to the body, it facilitated Sue’s path to her body. Contrary to Lombardi’s view, that my initially asking Sue to feel her hand on her chest was mechanistic, and that SE is only about modulation, SE also involves going back inside the body, exploring associations, deepening emotions, and thereby getting to the heart of the matter.

Perhaps this important and central aspect of SE, sustained and deepening interoception, as emphasized by Levine, Blakeslee, and Sylvae, is not so different from Lombardi’s ways of helping patients explore and connect with their bodies.

From Lombardi’s perspective, SE has nothing to offer to analytic ways of working with the body, and runs the risk of desiccating an otherwise rich, vital analytic process. In my view, and in my experience, SE does not dry things up.² Not only does SE provide a vitalizing connection into the body, it also offers ways of working with overwhelmed states that are entirely different from analytic modes of intersubjective regulation. As I have emphasized, sometimes patients remain flooded, despite our best analytic efforts. When I helped Sue temporarily bring her

² Of course SE can be applied in a desiccating way, just as any therapeutic approach can (including psychoanalytic). But SE, when practiced in its pure form, or when interwoven into analytic treatment, can be engaging and deepening for both patient and analyst, while helping to (re)connect with the body.
attention away from overwhelming somatic disturbance, to focus on her wiggling feet, alleviation of autonomic dysregulation enabled her to connect with her emotions, rather than just being flooded by them. This facilitated the repair of Sue’s dissociative fragmentation, so she could feel her feelings, sense her body, and think her thoughts with coherence. Is this so different from Lombardi speaking of “the saturation of sensorial elements,” and the analytic process of digestion and desaturation, in order to restore her capacity to think? I believe that my interweaving SE dovetails with analytic work, rather than desiccating it, as Lombardi viewed it, or oscillating with it, as Leddick claimed. The interweaving of SE into the psychoanalytic, as I discussed in the theoretical section of my paper, can also be conceptualized in terms of my analytic efforts to provide optimal responsiveness (Bacal, 1995) or facilitative responsiveness (Fosshage, 1997), and co-regulation of the tension between safety and danger (Bromberg, 2008; Greenberg, 1986).

Furthermore, this SE-informed/analytic work, over time, fostered Sue’s development of enhanced capacities for holding herself together, even amidst intense and painful emotions, and for sustaining more full and rich integration of mind and body. These are capacities essential for reverie, mentalization, etc.

Regarding another aspect of analytic process, I agree with Bass and Leddick that Sue and I did not work through the transference. I would say that the transference evolved from dependency/idealization, as Sue healed and grew psychologically, to something like an unobjectionable positive transference. We worked in the transference, but not extensively with the transference. Though I
inquired, we never accessed much in the way of bad object experiences involving me. A central question here, raised by Bass, is whether the interweaving of SE inherently inhibits working with the transference, and by Leddick, whether this reflected my inexperience in interweaving SE. To this I would add a third possibility, that this may have been more about the specific interaction of Sue’s dynamics and mine. I think it is hard to say. Sue was certainly invested in keeping me as the good object, and I know in myself my own investment in being one. That being said, I do not believe that the interweaving of SE inherently precludes transference work. SE does serve to enhance our analytic provision and holding. But, SE notwithstanding, don’t we always face the paradoxical task of providing, while also becoming both good and bad objects for our patients?

Relevant to this discussion of transference is Bass’ challenging my stating, “...if the patient suffers in overly intense, protracted, and repetitive (i.e. non-generative) ways, and if the therapist is not oriented toward and not able to help sufficiently, then the therapist is participating in re-enactment, playing the role of the abuser and/or non-helpful bystander.” Bass read this as my saying we should try to avoid enactments. That was not my intention. Rather, in the spirit of Ferenczi (1930), I would say, that if our analytic technique is not sufficient for certain patients, then we need to stretch our ways of working. Enactments inevitably happen. But we should not unduly contribute to them by limiting our technical approaches, due to orthodoxy.

Finally, I want address the question raised by Bass about “integration” of SE with psychoanalysis, parallel to Lombardi’s concern about “dis-homogenous
integration.” I strongly agree with their concerns, which is why I never used the term, “integration,” in my paper. I spoke of interweaving. I agree here with Leddick that we need to maintain our psychoanalytic center, while bringing in ideas from outside of it, such as SE, in order to enrich our psychoanalytic ways of looking, listening, and responding.

I want to thank all of the discussants for their generative contributions to the dialogue between psychoanalysis and SE.

References


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