

Intersubjectivity and the Practice of Rolfing®: An Excerpt

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The following article is excerpted from William Smythe's master's thesis, "Intersubjectivity and the Practice of Rolfing®," which was accepted in 2007 for his master's project at Santa Barbara Graduate Institute, where he obtained his MA in Somatic Psychology. His thesis was divided into two parts: a literature review and a community project. Because of its length, we have left out a significant portion of the literature review and also the entire section describing his community project. We encourage interested readers to seek out his entire thesis online, where it is archived with the Ida P. Rolf Library of Structural Integration (<http://pedroprado.com.br>).

Introduction

Although Rolfing® has primarily emphasized the need to work with a person's structural and neurofascial network, I chose in my thesis project to shed light on the more subtle aspects of the work—the therapeutic relationship, sensation, affect, imagery, and so on. I particularly wanted to emphasize what goes on within the intrasubjective world of the practitioner as they conduct a session. My clinical and teaching experience has led me to understand that much of what brings about discomfort and pain within a Rolfing® session has most to do with the practitioner's inner state of mind-body, i.e., practitioner's expectations on where along the healing spectrum the client should be by now. Obviously, this is how the aspects of transference/countertransference and intersubjectivity come into play when doing a somatically based work. I believe that the practitioner of any healing modality *must be in touch* with their intrasubjective world first, before they are able to receive, understand, empathize, or resonate with another—knowing that one's path of personal growth

is a process, not an event, and the client (and self) must be supported in this ongoing journey. The process of touching and being touched engages all aspects of our being—physical, emotional, psychological, and spiritual. We can no longer separate ourselves from our clients as an object needing fixing, but rather engage with them in a relational field where thoughts, feelings, and personal history of client and therapist are intermingling.

The following is exactly what was published in the author's thesis, except where noted.

Literature Review

It is well known 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 this alliance is the emotional bond that is formed and the regulation of feelings between patient and therapist (Cozolino, 2006; Schore, 2003; Siegel, 1999; Stern, 2004). "When different approaches to therapy are compared for effectiveness, the general agreement is that the perceived quality of the client-therapist relationship has the highest correlation with reported treatment success" (Cozolino, 2002, p. 51). More recently, contemporary psychoanalysts have reinterpreted the transference-countertransference phenomena in therapy in terms of intersubjectivity (Stern, 2004). Although, we as Rolfers (Structural Integrators) attend to the physical nature of our clients, issues of transference and countertransference are present in our work with others.

Dr. Rolf's passion was 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 how genetics, trauma, habit, and culture shape the human form and that each person's physical shape constitutes her personal somatic history and suffering (Rolf, 1977).

It is no wonder that she was invited to present her work at the Esalen Institute in Big Sur, California, along with other practitioners and researchers who were pushing the envelope of psychology. She did not want to teach her students to be physical manipulators, but rather to be educators. The root origin of the word education is *educare*, which means to nourish and cause to grow (Montagu, 1973). 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) and were all making their contribution to realizing human potential. There are two premises that set Structural Integration apart from other healing systems: 1) The body is a plastic medium, and 2) 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" (E. Hutchins, personal communication, June 15, 1979).

In her book, *Ida Rolf Talks About Rolfing® and Physical Reality*, Dr. Rosemary Feitis (1978) quotes Dr. Rolf's introduction to Rolfing® for the *Psychotherapy Handbook*, which Rosemary Feitis describes, "as succinct and cagey":

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 want to argue 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—intersubjectivity. Dr. Nicholas French (2007), Certified Advanced Rolfer and a Diplomate Jungian Analyst, states it this way:

Over the years I've been studying our work, I've come to believe that however well we apply the principles Dr. Rolf pioneered, in the end it is the client's trust and acceptance that permits her or him to open at a very deep level and allow real physical change to happen. If that is true, our effectiveness is intrinsically related to the quality of the practitioner-client relationship. Any way we can enhance our understanding of the total relationship is of immense importance. This is where psychology is valuable. (p. 39)

Although Dr. Rolf was the originator of structural integration, many other schools teaching her ideology have been established over the past twenty years. In their educational programs little, if any, attention is given to the intersubjective dynamics of transference-countertransference. For this reason, I believe the whole field of Structural Integration is in need of educating their students on the importance of knowing and understanding how to work within the relational field of intersubjectivity.

I will be reviewing the literature on intersubjectivity from four different perspectives. First I will discuss Martin Buber's (1970) philosophical contribution. Second, I will discuss the psychological perspective of transference-countertransference as it relates to intersubjectivity. Third, a neuroscientific view

of intersubjectivity will be examined. And fourth, I discuss attachment and affect regulation theory as it pertains to our definition of intersubjectivity.

Philosophical Perspective

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) also known as third-person ontology, or investigations of first-person (I), subjective, experience and phenomena (e.g. introspection and meditation) also known as first-person ontology (Buber, 1970).

The second-person perspective (Thou) has mostly been overlooked in Western philosophy of mind except in the notion of intersubjectivity. Most notably, philosopher-theologian, Martin Buber (1878-1965) recognized that human beings have two responses for viewing the world. One can relate to what is present either as an object, an I-It relationship, or one can respond as another responsible being, as an I-Thou relationship. The essence of human being and existence is our relationship to each other and to the external world of objects, and Buber gave ontological status to liminal space, a mysterious force, creative milieu, or presence from which the experience of being a self arises. Buber (1970) states that:

Spirit is not in the I but between I and You. It is not like the blood that circulates in you but like the air in which you breathe. Man lives in the spirit when he is able to respond to his You. He is able to do that when he enters into this relation with his whole being. It is solely by virtue of his power to relate that man is able to live in the spirit. (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 and as the space where things happen?

Psychological Perspective

Although transferences and countertransferences manifest themselves in all relationships—personal, professional, and therapeutic—it is generally assumed that these terms are used to describe the psychoanalytic relationship of therapist and client. Transference is the technical term used to describe an unconscious transfer of experiences such as thoughts, feelings, and attitudes, from one interpersonal

situation to another. Freud (1927/1972) suggested that the transferring of both thoughts and feelings could unconsciously occur between people and settings. He described transference as “new editions or facsimiles of impulses and phantasies” (Freud, 1923/1953, p. 82) originating in the past.

More recent contributions to the discussion of transference acknowledge that the therapist’s *real* characteristics always shape the nature of the transference (Hoffman, 1998; Renik, 1993). In other words, if a therapist is quiet and detached from the patient, a transference may develop to that therapist as removed, cold, and not interested in the patient’s process. “While the transference may stem in part from early attachments of childhood, it is also influenced by the therapist’s actual behavior. Hence, every relationship in the clinical setting is a mixture of a real relationship and transference phenomena” (Gabbard, 2000, p. 13). There are both positive and negative expressions of the transference. Strong feelings of attraction and love or rage and revulsion can be directed to another person because of earlier life conflicts. To the skilled psychotherapist, the transference represents therapeutic material to be understood.

Malan (1979) described countertransference as transference from therapist to patient or a corresponding response to transference. While transference is discussed and analyzed as part of the therapeutic process, countertransference is contained and monitored by the therapist. Freud initially mentioned the existence of countertransference (CT) in 1910 (Freud, 1910/1959) and since that time definitions have branched into three directions: First, Freud’s classical definition focused on the analyst’s unconscious and neurotic reactions to the patient’s transference (Kernberg, 1965). Second, the totalistic definition includes all conscious and unconscious reactions the clinician has toward the client (Heimann, 1950). The third perspective (Gelso & Carter, 1985; Gelso & Hayes, 1998; Langs, 1974), which might be labeled the moderate perspective, maintains that CT represents the counselor’s reactions to the client that are based on the counselor’s unresolved conflicts (Hayes & Rosenberger, 2002).

The moderate definition is broader than Freud’s classical view in that CT reactions are not solely viewed as a result of the client’s transference. In fact, they are not always viewed as negative. Although there have been debates and musings about CT for over fifty years, there has been little research done on CT to support or refute its theories. Recently, however, Hayes et al. (1998) reported the therapist’s needs, family issues, cultural issues, and counseling-specific

issues (e.g., termination) represented the most common sources of CT. They found that some CT reactions were provoked by more concrete stimuli, such as approaching termination, or the client experiencing death wishes, but in the majority of cases CT reactions were initiated by the therapist's subjective perception of the client as being similar to the counselor, or the therapist's concerns about how well the client was doing in the counseling. In other words, the therapist's phenomenological reality was the chief determinant regarding when and where CT reactions would be stimulated.

In field research conducted by McClure and Hodge (1987), they developed an approach for measuring CT that was grounded in the therapists' distorted perceptions of their clients. In the study, 12 counselors and 36 clients completed a personality survey measuring the counselor's perceptions of themselves, clients' perceptions of themselves, and counselors' perceptions of their clients. CT was identified when the counselors perceived the clients to be more like themselves than client profiles indicated and conversely, when the counselors perceived the clients to be less like themselves than was indicated by client profiles.

In using the measurement strategy, McClure and Hodge (1987) examined the relationship of CT and counselors' likes or dislikes of clients. Interestingly, when counselors had positive feelings toward their clients they tended to misperceive their clients as being similar to themselves. When counselors had negative feelings toward their clients, they tended to misperceive their clients as being very dissimilar from themselves. What does this mean? Hayes & Rosenberger (2002) respond with:

An important theme emerging from this overall body of research is the empirical documentation of the various ways that CT may be manifested in counseling, particularly along cognitive, affective, and behavioral dimensions. In terms of cognitions, CT has been shown to take the form of distorted perceptions of clients, inaccurate recall of client material; reactive, defensive mental activity; blocked understanding; uncertainty; and changes in treatment planning. On an affective level, state anxiety has been the most commonly studied CT reaction in laboratory studies, and it has consistently served as a useful indicator of CT. Field studies, however, are beginning to demonstrate the wide range of possible emotions that could denote CT, including anger, sadness, boredom, and nurturing feelings. Behaviorally, CT has typically been operationalized as counselor avoidance or withdrawal, both in laboratory and in field studies. (p. 9)

In her book, *Modes of Therapeutic Action*, Martha Stark (1999) presents an integrative model of therapeutic action that takes into account many of the different schools of thought about the psychotherapeutic process that is healing. She holds that most psychotherapeutic models can be categorized into three distinct types of therapeutic action while advocating enhancement of knowledge, provision of experience, or engagement in relationship as the primary therapeutic agent. Each of these three models view issues of transference and countertransference in a slightly different fashion.

Classical psychoanalytic theorists conceive of the patient's psychopathology as deriving from within the patient's nature, in whom there is thought to be an imbalance of forces. This inner structural conflict is seen as the thrust of the work, and the goal of treatment is the strengthening of the ego by way of insight (Stark, 1999). "Interpretations, particularly of the transference, are considered the means by which self-awareness is expanded" (Stark, 1999, p. xvi). This earlier view of the talking cure emphasized the importance of the transference and is considered Model 1, a one-person psychology (subject/object), in Stark's three kinds of therapeutic action. Obviously, this first model represents a classical Freudian view, "because Freud never had any 'relationship' whatsoever with an analyst. His, of course, was a self-analysis" (p. xvi).

Many analysts, both here and abroad, were dissatisfied with a model of the mind that spoke only to the relationship of the patient's inner conflict of Id, Ego, and Superego. What about the relationship between patient and therapist? Stark elucidates Fairbairn contending that "the individual had an innate longing for object relations and that it was the relationship with the object and not the gratification of impulses that was the ultimate aim of libidinal striving" (p. xvi). Stark (1999) goes on to say:

Both the self-psychologists and the European (particularly the British) object relations theorists were interested not so much in nature (the nature of the child's drives) but in nurture (the quality of maternal care and the mutuality of fit between mother and child). (p. xvi)

With the emphasis on nurture, rather than nature, the therapeutic action shifted from an insight-oriented approach to a corrective experience by way of the real relationship approach, also known as Model 2 within Stark's (1999) postulation. Freud's one-person psychology, emphasizing libidinal drive and aggression, was supplanted by more relational needs such as validation, soothing, admiration, and empathic recognition, to name a few (Stark, 1999; Stern, 2004).

Carl Rogers (1942), one of the pioneers of humanistic psychology, emerged with his client-centered therapy which was the antithesis of an analytic theory-based evaluation of the patient. Rogers believed that it was through warmth, empathy, acceptance, and unconditional positive regard that clients improve. In essence, Rogers' approach modeled good parenting. His emphasis on congruence between therapist and client foreshadowed the focus on empathic attunement in object relations and intersubjective forms of psychotherapy (Kohut, 1984; Stolorow & Atwood, 1979). Rogers' perspective of the therapeutic relationship can be described in terms of Stark's Model 2 whereby the therapeutic emphasis is on empathy and corrective experience. "When we say that the therapist provides the patient with a corrective experience, we are suggesting that the therapist offers the patient something that the patient should have received reliably and consistently as a child, but never did" (Stark, 1999, p. 17). In Model 2, the patient was seen as suffering from structural deficit—an impaired capacity to be a good parent unto himself. The therapist shapes his/herself into the good object for the patient, a corrective provision, the opportunity for a "new beginning" (Balint, 1968), a new relationship as a corrective for the old one.

The process by which the therapist provides being a good object for the patient requires the therapist to empathically attune to the affect the patient is experiencing. The therapist must also enter deeply into the patient's affect so that the therapist can understand something about its meaning for the patient and/or its context (Stark, 1999). Empathy, as originally conceived (Kohut, 1971; Atwood and Stolorow, 1984), was thought to "involve the therapist's immersion in the patient's internal experience by way of the therapist's decentering—as best she could—from her own experience" (Stark, 1999, p. 51). In his earlier writings, Stolorow (1978), made reference to the clinician's need to decenter from his subjectivity in order to immerse himself empathically in the patient's subjectivity.

A skilled therapist shifts back and forth between responding interpretively (Model 1) and responding empathically (Model 2). How does a Model 3 therapist respond? Stark (1999) says it clearly, "whereas the empathic (Model 2) therapist decenters from her own experience, the authentic (Model 3) therapist remains very much centered within her own experience" (p. 46). The Model 2 therapist provides a kind of selflessness for the patient whereas the Model 3 therapist involves the use of self (her countertransference) by remaining very much centered within her own experience of self.

Stark goes on to say:

In sum, as an empathic selfobject, the therapist takes on the patient's experience only as if it were her own—but at least it is relatively uncontaminated by the therapist's subjectivity. Conversely, as an authentic subject, the therapist takes on the patient's experience as her own—but it is always contaminated by the therapist's subjectivity. (p. 47)

A more simple distinction would be that the therapist of a Model 2 action will become empathically attuned to the patient, and a Model 3 therapist, through her authenticity, will become engaged with the patient. This is more akin to Stolorow's coining of the term *intersubjectivity* in which he views the therapeutic relationship as involving two subjects (patient and therapist), not subject (patient) and selfobject (therapist). Stark (1999) describes Stolorow's later writings where:

...he conceives of the therapist's stance as involving a dialectical interplay between the therapist as an empathic selfobject (ever straining toward a prolonged empathic immersion in the patient's internal world) and as a co-participating subject (very much centered within herself and ever attuned to her own experience)—a dynamic tension between the therapist as decentered and the therapist as very much centered. (p. 54)

This is the Model 3 view of intersubjectivity where both therapist and patient bring their authentic selves into the relationship. There is an ever increasing number of contemporary theorists who believe that what heals the patient is neither insight (Model 1) nor a corrective experience (Model 2), but rather an interactive engagement (intersubjectivity) with an authentic other—the therapeutic relationship itself (Stark, 1999).

The psychodynamic theories of therapeutic change are based on the premise that the past plays a huge role in determining the present. Obviously, past events influence present moments, but the same attention to present experience has not held center stage in psychotherapy. It is the present where phenomenal, subjective experience exists and most psychotherapies agree that therapeutic work in the here and now is where the greatest opportunity for change occurs (Stern, 2004).

How does a therapist find the balanced ground of meeting the client's subjectivity with their own subjectivity, whereby he does not fall prey to the oscillations between positive and negative affective states? The answer is in finding the right relationship through boundaries. "Boundaries, by definition are flexible, present centered and essential for a trusting

relationship. Boundaries allow for openness and expansion of the self. Without boundaries, there can be no real relationship, only isolation or merger" (Rand, 2001, p. 1). Within an intersubjective perspective of therapy, one can postulate that the boundaries between self and other would be blurred, but in fact, they remain clear and permeable—"a differentiated self is a condition of intersubjectivity...without it there would be only fusion" (Stern, 2004, p. 77).

[Two sections have been omitted here: approximately 3300 words, in which the author examines a neuroscientific view of intersubjectivity and then discusses attachment and affect regulation theory as it pertains to intersubjectivity.]

Closing Comments

How does the practice of Rolfing® fit within the philosophical, psychological, neuroscientific, attachment, and affect regulation perspectives of intersubjectivity? Stern (2004) makes a distinction between the explicit and implicit agenda. He describes the explicit agenda as the verbal content of the session; in talking therapies, the agenda is what the client talks about—the past, future, dreams, fantasies, and problems. In somatic therapies, I suggest, the agenda is what the client describes as bodily aches, pains, imperfections, injuries, and traumas. In a psychotherapeutic model the search is for meaning; in somatically based work, the search is for relief of physical symptoms. Simply stated, the explicit agenda contains the narrative of the session while the implicit agenda is seen as the context of the session; the place where the regulation of the therapeutic alliance is foreground. Within this agenda are issues of transference and countertransference, safety, containment, holding environment, and the "real" relationship. Stern (2004) says that:

The regulation of the immediate intersubjective field is the aspect of the implicit agenda that most interests us. The implicit agenda is fundamental in the sense that it contextualizes the explicit agenda. It constrains it and determines what can be talked about. (p. 120)

The regulation of the intersubjective field requires the therapist to use his body as the container. Furthermore, Dosamantes (1992) says "physical containment by the therapist of the patient's disavowed experience needs to precede its verbal processing" (p. 362). As Damasio (1999), Schore (2003), Siegel (1999), and Stern (2004) have suggested, the regulation of one's affect is at the heart of human development. In Schore's (1994) writing on the psychophysiology of countertransference, he "points out that countertransference dynamics are appraised

by the therapist's observations of his own visceral reactions to the patient's material" (p. 451).

My clinical experience supports Smith's (1985) ideas that in body-oriented therapies transference and countertransference phenomena occur "sooner and sometimes more powerfully or dramatically" (p. 151), than in strictly talking therapies. I also agree with his assertion that in non-psychotherapy body-work, practices such as Rolfing®, Feldenkrais, Alexander Technique, Tai Chi Chuan, Yoga, and Aikido are all valuable pathways to personal growth. "What these methods can do is greatly enhance body awareness, increase the options of aliveness in the body, and change old body habits which are dysfunctional" (Smith, 1985, p. 152). I do find Smith rather dogmatic, however, in his perspective that what these methods fail to do is "provide directly for the symbolic processing of previously blocked or inhibited emotion...*It is this emotional energy processing which is at the core of body-oriented psychotherapy*" (p. 152). I would agree with this assessment if the somatic practitioner avoided his or her own pains and fears by the mechanical application of body techniques only. This is not an I-Thou, *person to person* approach, but rather an I-It, *person to object* relationship. The willingness of the Rolf practitioner to empathically attune to and somatically process the client's physical suffering can lead to valuable insight, knowing, and understanding for the client. I am not suggesting that good bodywork is a substitution for good psychotherapy, but rather that a somatic practitioner that is working within an intersubjective context can greatly facilitate regulation of the client's affect resulting in an intrapsychic balance and feelings of well being. Many of my clients have participated in or are presently involved in psychotherapy. Each client expresses an appreciation for our therapeutic alliance whereby they: increase their body awareness and aliveness, change old bodily habits, resolve traumatic injury, **and** make interconnections between their thoughts, images, feelings, and emotions. Citing Jackson, Neafsey (1990) concluded, "The key to understanding the cerebral cortex, then, appears to be the body" (p. 147).

The consideration about the division between psychoanalytic therapies and the body, movement, and expressive therapies supports Descartes' error, "the separation of the most refined operations of mind from the structure and operation of a biological organism" (Damasio, 1994, p. 250). The comprehensive understanding of the human mind requires an organismic perspective; one that views the body, the brain, and the mind as contained within a whole organism and fully interactive with a physical and social environment. Theoretical discussions about what

kind of therapeutic intervention, a psychotherapeutic or a somatically based one, best accesses the unconscious self is best expressed by Stern (2004):

At this point in time, no one can claim a royal road to the unconscious. The dream, free association, the present moment, body sensations or expression, and actions are all, if not royal, still good enough routes into the mind, including the unconscious and the implicit. (p. 147)

My intent in reviewing the aforementioned perspectives of intersubjectivity has been to provide a language to the Rolfing® practitioner, to better understand the interactive processes we experience with our clients. 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 psychological aspects of self? 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)

The second half of this thesis, a large section describing and discussing the author's community project, has been omitted.

Author's Summary

Since completing my thesis research, discussions of intersubjectivity have been renamed interpersonal neurobiology. Interpersonal neurobiology attempts to paint a picture of the "larger whole" of human experience and development by extracting the wisdom of a number of different scientific disciplines such as mirror neuronal theory and neural plasticity. These investigations continually support the view that the human being is in a process of change throughout the lifespan and the need for clinicians to pay attention to bodily responses within themselves and their clients. The importance of biology, which is the body, and its associations with the unconscious are at the forefront of these explorations. A very exciting time for us engaged in structural integration... they are coming our way! Thank you for the opportunity to share my curious meanderings in providing a scientific basis for our work with the human family.

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