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CONTEMPORARY, SOMATICALLY ORIENTED PSYCHODYNAMIC TECHNIQUES IN WORKING WITH PATIENTS EXPERIENCING MENTALIZING DIFFICULTIES

[1] private practice – an independent research group

technique
psychodynamic/psychoanalytic therapy
sense impressions

Summary

The article describes the psychotherapeutic work of five psychodynamically/ psychoanalytically trained therapists with five patients of different ages. All the described patients experienced difficulties in communicating their emotional experiences in words, it was also difficult for them to think about them. According to the concept of mentalization, consistent with contemporary trends in neuropsychology, such communication problems draw attention to the role of the body and emotions in the functioning of the verbal mind. Therapists undertook a number of interventions with patients, the common element of which was an attempt to apply clinically modern psychoanalytical concepts regarding work techniques that go beyond the level of verbal interpretation of content. The authors refer, inter alia, to works emphasizing the role of the body-mind relationship, non-verbal communication, specific verbalizations of schizophrenic patients, the concept of the reference process and the so-called "Interpretation of shells", the contours of affect and the musical aspect of dialogue, intersubjective co-creation of experiences, the role of sensory experiences, and issues related to the personal involvement of the therapist and her/his behavior. The authors believe that embedding the techniques of working with non-verbal material in certain concepts makes the interventions more effective and safer for both sides of the therapeutic relationship.

One of the challenges of modern psychotherapy is searching for the most effective therapeutic interactions tailored to specific problems. Since numerous meta-analyses [1, 2, 3, 4] have clearly confirmed the overall effectiveness of psychotherapy as a method of treating mental disorders, the attention of researchers and clinicians has focused on identifying therapeutic techniques and approaches best suited to given problems [5]. More and more often it is possible to successfully indicate the methods that work well in the treatment of the most common mental disorders – depression [6], anxiety disorders [7] or phobias [8].

Perhaps a more difficult challenge is trying to develop therapeutic interventions that work for personality disorders and psychotic disorders. There are reports showing the

overall effectiveness of psychotherapeutic work in this area, however, the clinical picture of patients suffering from complex personality disorders or psychotic disorders is less uniform than in the case of narrowly defined diseases. Among the approaches effective in the treatment of personality disorders and psychotic disorders there are psychoanalytical and psychodynamic therapies [9]. In clinical practice, a more important problem than identifying the most adequate therapeutic **approaches** is, however, identifying the most useful **techniques for** working with patients, especially those who pose the greatest challenges – such as people with personality disorders or psychotic disorders. One of the reasons for the difficulties in identifying appropriate techniques in working with such people are communication problems resulting from the specificity of these disorders.

In simple terms, communication can be understood as the process of transmitting meanings, in healthy circumstances involving verbal meanings and relatively well related emotional meanings. The basic medium of communication are abstract representations (e.g. words) that are relatively closely related to emotions. In the classic techniques of psychoanalytic psychotherapy, i.e. talking treatment, we rely on the idea of reorganizing emotions through verbal exchange: it is work at the level of representations related to these emotions [10].

In our therapeutic practice, we meet people who find it difficult to benefit from therapy which uses techniques mainly at the level of representations. Their communication problems from a psychoanalytical perspective can be explained by Bion's theory of thinking [11]. Bion noted that the psychotic area of the mind is deficient in how thoughts can accommodate emotions. In healthy functioning, the basic emotional experience (which comes from the sensory experience) becomes sufficiently clothed in thought. The possibility of giving an abstract meaning to sensory-emotional arousal gives it a mental representation. Mental representations are linked in networks of associations and chains of cause and effect, which allows, simply put, to "think logically about emotions." In psychotic functioning, the pressure of sensory-emotional arousal makes it elude the attempt to assign a clear abstract meaning. The emotion remains insufficiently clothed in mental representation, or is partially and inconsistently related to it.

It seems that such an approach to communication problems, emphasizing the role of emotions in the functioning of the verbal mind, remains consistent with contemporary trends in neuropsychology – the observations of researchers dealing with mentalization in this area are particularly valuable [12].

From the perspective of clinical work, however, the most important seem to be the attempts to translate these theories into the practice of psychotherapeutic work. This work is a review of trials of the clinical application of contemporary psychoanalytical concepts regarding **work techniques that go beyond the level of verbal content interpretation.** According to the authors dealing with this topic, the **key role of the body** is clearly emphasized both in **understanding the patient's messages** and in **undertaking effective interventions** . In the group of psychotherapists identifying with the broadly understood psychodynamic approach[1] we have studied, discussed and analysed a number of publica-

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tions containing suggestions of psychotherapeutic techniques adapted to the communication problems of patients in whom it is difficult to obtain improvement due to the reorganization of verbal representations alone. We referred to works emphasizing the role of the body-mind relationship [13], the role of non-verbal communication [14] and specific verbalisation of schizophrenic patients [15], the concept of the reference process [16] and the so-called "envelope interpretations" [17], the contours of affect and the musical aspect of dialogue [18], intersubjective co-creation of experiences [19], the role of sensory experiences [20, 21], and issues related to the personal involvement of the therapist and her / his behavior [22, 23, 24]. Below is a brief overview of clinical illustrations of some of these techniques, summarized with brief conclusions.

Example 1: Envelope interpretations

An example comes from working with a teenage patient, Ania, experiencing a breakdown in the sense of continuity and regression to very early emotional states. Attempts to reach Ania through more traditional psychoanalytical interventions by interpreting the content and searching together and creating meanings of the verbal material led to a retreat into persistent silence and stiffening in our relationship.

According to Waddell [25], the process of "maturing" to adulthood is a time of strong anxiety about identity, gender identity, self-esteem, school achievement, friendship and appearance, highly destabilizing and a toxic mix. Due to this process, adolescent patients do not have a stable, consistent sense of self, they can function like psychotic people. Lombardi [13] noticed that some adolescents either do not have certain networks of connections between feelings and thoughts, or are unable to use the previously established networks, because they have been broken as a result of adolescence. Such adolescents experience themselves in a way in which the perception of time and space breaks down, any given thing can become anything else, because the differences between categories are blurred [13]. Communicating emotional experiences in such patients, according to Keinan [17], may manifest itself beyond words, in the non-verbal sphere, in which the spoken words fulfil primary functions and are sensual, based on resonance, rhythm and sound. Then the language usually loses its linguistic function, words begin to act as a protection, allowing to divert attention from the outside and inside world, causing the build-up of something like a "secondary skin", becoming a verbal armour to protect, keeping the sense of self in the face of annihilation anxieties [17].

What can support a patient in a primitive state of mind is the ability to tune in, enter into dialogue with him/ her, and foster analytical development that allows him/ her to emerge from formless infinity [13]; reaching it through interpretations that will match archaic elements, "envelope interpretation" , which is to provide a sense of continuity, sensual boundaries, a sense of being wrapped and held [17]. Such interpretations could provide a new understanding of something the patient thought but had no representation in his/ her mind because it was hidden.

Ania, a teenage patient, was referred for psychotherapy by her parents who were worried about her outbursts of anger at home, withdrawal from peer contacts and strong

social anxiety. During the joint consultation with the girl and her parents, the therapist felt a lot of tension and anxiety. The therapist got the impression that family members were in a symbiotic relationship. The father did not allow thoughts about the development and growing up of his daughter and introduced a strong fear of the threatening world, presenting him as very dangerous, and the mother also made sure that the family members remained in the closest, glued contact with each other. The mother also told about the recent death of her parents, with whom she was very close. During the statements of her parents, Ania took a mocking attitude, seemingly trying to be indifferent to the content. At first, she was reluctant to start therapy and emphasized that she had agreed to the consultation only under pressure from her parents. However, she decided to try, because she was troubled by a strong fear of the surrounding world, especially panic attacks in public places. During consultations, it was found that puberty was a time of intense conflict, great confusion and tension in Ania's experience. The girl felt stuck between childhood and adulthood. In the first stage of psychotherapy, the therapist and Ania tried to observe the content introduced by the patient, presenting the world around her as a hostile, persecuting and threatening place. However, the therapist's attempts to comment on Ania's fear of change and growing up, as well as her confusion and horror, led to repeated long moments of silence in which the therapist felt that she was losing emotional contact with the girl. The therapist felt that the countertransference experiences (above all the feeling of being lost and tense) allowed her to touch the difficulties experienced by the patient, but Ania did not accept these contents when the therapist named them with her comments, which effectively prevented constructive psychotherapeutic work. Ania kept the conversation at the most superficial level, thus avoiding situations that would increase anxiety. Using the indications of Keinan [17], the therapist began to refer not so much to Ania's fears, but rather to the very process of existence in the external world and to a simple description of feelings or mood, saying, for example: "Today in the office is quiet", "Now it is easier",“ You are more colourful today ". The purpose of these comments was to maintain the consistency and continuity of experiences in the face of the patient's pressing fears. After some time, Ania, reacting to these interpretations, began to talk about her difficult relationships with her peers and family, whom she hated and admired at the same time. Then the therapist and Ania could start looking at her experiencing ambivalent feelings, her pain, despair or internal chaos. The patient could more often talk about her aggressive fantasies about destroying those who exposed her to shame and humiliation and aroused fear of rejection, and this allowed to explore her difficulties in the area of representation, using a more standard psychotherapeutic conversation.

This short description does not take into account many important issues in working with Ania, focusing on the need to rebuild the damaged "mental envelope", the "accommodating" factor, giving the ability to maintain the coherence and continuity of experiences, in order to be able to develop and understand later in the work own experiences and reflect on them with words.

Example 2. Somatic countertransference and the role of the body in cooling emotions

One possible way to reach patients with communication difficulties is to take a greater account of the role of the body in the formulation of the interventions; not only the patient's body, but also the therapist's body. Emotions are rooted in sensory experiences. Efficient communication, in which verbal representations are combined with emotions, must therefore mean an efficient body-mind relationship, because it is based on the connection of the bodily emotional core with mental contents, i.e. with abstract representation. A specific form of "reflection" can be a psychoanalytic technique that allows contact with the corporeal core of the patient's experience. The concept of "reflection", introduced by Bion [11] and developed by contemporary psychoanalysts, incl. Ogden [19], is a sensual experience of emotional experiences that should be transformed into elements such as images, commonly found in dreams. Ogden [19] develops this concept by emphasizing the sensual dimension of the thoughtful state – he describes the dreamlike state of mind, which includes not only images, fantasies and fleeting images, but also sensory experiences. In a thoughtful state, the therapist remains open to the flow of non-verbal communication of emotions, even when they are not cloaked in abstract thoughts and words. In this context, Lombardi [13] introduces the concept of somatic countertransference: that is, a situation in which the therapist experiences at the bodily level sensations related to the sensual-emotional level of the patient's experiences. Lombardi points to the concept of communication via projective identification as the theoretical foundation of the concept of somatic countertransference and speculates about the involvement of mirror neurons in the occurrence of this phenomenon [26]. The research by Lachmann and Beebe [27], who show that in relationships there is a mutual, two-way, partially or completely unconscious adjustment on the sensory level, regardless of the content of verbal exchanges, can be a strong empirical support for Lombardi's concept.

Ms Beata, a patient diagnosed with borderline personality disorder, episodes of depersonalization and psychotic dissociation, engaging in numerous auto-aggressive behaviors and hospitalized several times, came to the therapeutic session 10 minutes late. Stiffly, her muscles tense, she sat down in the armchair and began to cry desperately. The strength of the patient's emotions made a striking impression on the therapist, and his body immediately stiffened. After a few moments, the therapist said, "I can see that you are full of feelings. Why don't you try to tell me where the intensity is from? The patient replied: "I talked... talked to my grandmother. And she told me about these abortions again. Blood... blood everywhere... I'm all covered in their blood. I should be dead, not them! I knew, I knew all the time, I shouldn't have lived, all my dreams about God, about punishment, I deserve it. I'm the one to blame (sobbing desperately). The patient was uttering the sentences faster and faster, sobbing excruciatingly. The therapist felt pressure to say something to the patient immediately, to find a good comment that would give meaning to her pain. However, he realized that it would only be a reaction to his own painful stiffness, to his own bodily expression of fear at the patient's overwhelming despair. When the therapist held back a quick comment and tried to think about how he was feeling, gradually, the paralyzing fear was replaced by overwhelming sadness and a feeling of helplessness. The therapist

remembered another patient's psychotic decompensation and imagined that Beata was probably on the verge of madness. At the same time, the therapist could hear her sobbing, which seemed to be the only consistent experience in the pressure of the patient's chaotic words. He decided to say: "If you can cry, it means that you can feel sadness and despair, you can contact with these feelings and express them, and this is your strength in this very difficult moment." Ms Beata calmed down, her sobs turned into crying. After a few minutes, she wiped her face and began to speak in a calm voice: "I've always felt that I didn't deserve to live. Even when I was a child. And when I started growing up, I felt that all my failures were related to the fact that I shouldn't be alive at all. Everything fits together now. I killed them, I deserve to be punished. I shouldn't be living, they should be living". Later in the session, Beata was able to talk to the therapist about her sadness, fear and guilt.

In the above fragment, the patient was under the pressure of intense emotions from the beginning of the session, to which the psychotic side of her personality responded. The emotional core of excruciating suffering lost its close connection with abstract verbal representations – the concepts of guilt, murder, punishment, blood and death began to disintegrate randomly, as in the psychotic patients described by Robbins [15], and the feeling of suffering began to grow, tending towards infinity [13]. Using his own reflection and examining the somatic dimension of countertransference, the therapist could first tune in to the terrible suffering demanding a direct discharge in action, and then somewhat alleviate this experience and encapsulate it, first for his own use, with abstract representations, for example with a memory of another patient, associated with the emotional core of feelings of sadness and helplessness. In his statement, the therapist tried to use simple language to combine the patient's sensual experience, i.e. crying, with verbal representation, i.e. naming feelings of sadness and despair. By emphasizing the positive dimension of the coherence of crying with the experience of sadness and despair, the therapist tried to strengthen the body-mind relationship, support the patient in surrounding explosive emotion with an abstract representation that could put a barrier to the increasingly driven emotional experience. The patient reacted positively: her expression softened and the intervention triggered a non-psychotic part of the personality, able to lead a more coherent verbal thread based on representations of guilt and punishment.

In the example cited, the attempt to actively contact the patient was probably also important: a direct attempt to establish contact with her at the beginning of the session by asking about her feelings. If the patient experiences an onslaught of intense emotions and is unable to contain them himself, for example with words, the risk of extreme feelings increasing further, in line with their tendency towards infinity. This does not mean, however, that the technique of work based on the ideas presented should be based on constant activity. Moments of reflection and listening to the patient are necessary and inevitable, but the attention devoted to one's own, also sensual, participation in the relationship means that these are not moments of withdrawal, but rather of unimposing presence.

Example 3: Strengthening the vertical body-mind connection

According to Lombardi [13], in the case of some patients referred to as "psychotic", we are dealing with an intense influx of "indisputable unconscious", which disrupts the thinking function and prevents the proper processing of sensory stimuli. Sensory arousal is a raw sensation that cannot be enveloped in thought. Matte Blanco [in: 13] claims that in such circumstances feelings are experienced in a "symmetrical" way: i.e. individual elements merge with each other, some may become a whole, which makes indistinguishable sensations resistant to thinking based on rational logic. In such a situation, the interpretation of the content may turn out to be an ineffective form of establishing contact and communication with the patient immersed in an endlessly spreading state of symmetrical arousal. Moving from a pure experience to feeling sensations and then to thinking about sensations is – according to Matte Blanco's theory – moving from symmetrical (irrational) sensations of the body to asymmetrical (i.e. rational) thoughts about them. According to Lombardi [13], restoring connection with feelings requires paying attention to returning to the body. Taking into account the connection with the body allows to build the ability to feel sensations, and then envelop them in thoughts, i.e. move from the symmetry (illogicality) of the body to the asymmetry (logic) of thinking about oneself and own feelings. The foreground in such work is to support the patient's ability to think about feelings by referring to the body, senses, space and time. Support and strengthening of the perception of sensory experiences helps the patient to connect body with thoughts. Lombardi proposes to postpone the forms of work relating to the relationship with another person, such as interpretations of transference, when the patient is able to feel him/herself well enough.

In the example below, the therapist focused on the description of attempts to establish contact with the patient in the original state of mind based on the idea of symmetrization of sensations and the possibility of their asymmetry with the use of the sensual aspect of the body. It is a description of the first session with a 50-year-old patient, who has suffered from schizophrenia for about 15 years, staying in a psychiatric ward due to the acute recurrence of productive symptoms and a strong, paranoid fear of burglary, which would take place in the apartment next door, as well as in in connection with the inability to eat food and gastric symptoms. The patient had several periods of remission and relapses, culminating in hospitalization.

When Mr. Czesław entered the office, he seemed to be very delicate and fragile, and at the same time heavy and "concrete". He slumped into the chair, sinking into it. His gaze seemed dull and distant, and at the same time filled with fear and closely watching. The therapist felt a tension that provoked two different desires: to collapse with the patient in the chair and another to make contact, though the atmosphere seemed heavy as "concrete": impenetrable, unbearable. After a moment of silence, the therapist started the conversation with a few questions typical of the initial interview, including showing interest in the patient's earlier life. In a confused, scanty and non-chronological way, the patient spoke about his life, including the life from before the disease. Among other things, he said that as a DJ he played in various music clubs. The therapist asked him about his favourite song, the name of which he gave after a while, and the melody of which immediately played in the therapist's mind ("Killing me softly" – performed by Fugees). The therapist shared

this sensory experience with the patient, which sparked his interest and asked the therapist what performance of the song she was hearing. For a moment, the therapist and the patient played the piece together in their minds, almost in their ears. The therapist got the impression that she and the patient were in the same space for a moment, since they both "heard" the same, well-known piece. After a while, the patient straightened up, emerged from the chair, crossed his leg vigorously and looked around the office saying: "This room is nicely decorated. There is a mirror so that you can fix your hairstyle, a sink to take care of hygiene, the flowers are also pretty – what are the flowers? ". The therapist replied that she did not know, did not know them, but that she saw them just like as the patient. In this way, she wanted to emphasize that his observations are correct, that he is using his senses in a proper way. Mr. Czesław went on to describe what he saw. He noticed the statue of an angel standing on the cupboard and commented: "Oh, and there is an angel, and it could be a devil." The therapist's comment referred to sensual perception to enhance the adequate perception of reality and thus the body-mind connection: "Yes, this is an angel. Your eyes can see it well, even if sometimes he may seem like a devil, your eyes can see well today that it is an angel ". It was a very simple description of the reality in which they were together, which the patient perceived correctly, using his senses. The therapist spoke simply, feeling that the excess of words threatened to break contact. The common ground of contact in this case was the sensual, bodily experience of being in the same room, which for the eyes of the patient and the therapist seemed to be similar, tangible, possible to describe using words that mean the same. This allowed to leave the symmetrization of sensations and observations, creating an asymmetrical reality in which the armchair is an armchair (not a sink), and the sink – a sink (not an armchair). The therapist deliberately did not interpret the content spoken by the patient, because she felt that introducing too much verbal abstraction based on showing other meanings, e.g. an angel who can turn into a devil, for example by relating these characters to the patient's inner world, would risk reintroducing the feeling of infinity, lack of boundaries and shapes, re-equating what is external with what is internal and introducing symmetry of these sensations (everything is everything, an angel is a devil). At the end of the session, Mr. Czesław kept his eyes on the therapist for a long time, and she asked him what he was seeing. The patient replied that "he sees a person in a white suit, but underneath, there is a normal person." The therapist commented that "perhaps the patient felt today that they are similar to each other" and asked "if he would like to meet her at the next session". The patient replied "no", which immediately made the therapist aware that the patient did not see her as a person, woman, therapist, and that their connection was not yet a relationship. It is a shape for him, an element of the space that he experienced in a sensual way by engaging the body in it, but in which he did not see her as a person with whom he can establish a relationship. Perhaps the therapist introduced herself prematurely as an essential element of this meeting and thus an element of the horizontal patient-therapist (and not the more fundamental patient-sensory relationship). It was too much, like breaking into his apartment, which he was very afraid of. Therefore, the therapist asked if Mr. Czesław would like to meet next week, at the same time, in the same room, which resulted in a positive reaction from the patient and consent to the next meeting. The following sessions focused on building the mind-body connection. The patient came to the meetings on his own, remembering about the day and time.

The idea of supporting the body-mind connection in patients experiencing the breakdown of relations with the world, with time, with space, and thus with their own sense of existence is complemented by taking into account the autistic dimension of such patients' experiences, about which they write, e.g. Tustin [20] and Mitrani [21]. In this example, the office, space, furniture, and the hour have become something of the so-called autistic shape, into which Mr. Czesław also included a therapist. In this dimension of experience, the words appearing in the space between the therapist and the patient did not serve to convey meanings, but to build a connection. In this register, the therapist was a person in white clothes who made sounds, so she was the so-called "autistic shape" [21], not a partner in a relationship. The patient reacted with fear when the therapist moved closer to the center of the field of view, i.e. closer to the relationship with the patient. The therapist decided that this threatened the patient with an experience of terrifying separateness, so she withdrew and remained on the "perception periphery" [21], i.e. in a visible position enough for the patient to feel safe and at the same time vaguely enough to protect the patient from too much ofunprocessed sensations and unsuspected feelings

Example 4: The indwelling function of the body

An example comes from working with Damian, a 10-year-old boy who was admitted to psychotherapy due to severe anxiety disorders: panic disorder, fear of death and darkness, anxiety about the functioning of his own body and health.

In the process of psychotherapy, the main difficulties were related to the boy's persistent silence, not using the office, lack of play skills, stiffness and repetitiveness in the actions taken. The countertransference was dominated by an acute sense of sterility of relations. Damian brought his own structured board and educational games, and the activity was limited to sitting at the table. The boy, in contact with the therapist, could only endure solid and familiar content brought in by him. The dominant countertransference feelings concerned frustrating stagnation, immobility, and the inability to think and fantasize.

Although the boy had the ability to speak, he did not use this method of communicating with the therapist during the session. Damian's story showed a delay in speech development and its significant distortion, on which the boy worked with a speech therapist. Words and language did not play a communicative function in this relationship, and attempts to communicate at this level disturbed or even blocked contact. The patient reacted with great fear to the classic interpretations of content and transference. He responded to attempts at verbal communication by withdrawing, which at that time was interpreted as a reaction to acute feelings towards experiencing the therapist's separateness. At such moments, Damian would often lie down on the rug in the corner of the room, pick up a block and hit it steadily against the bookcase. He often reacted to verbal activity by purring and making sounds.

In her work with Damian, the therapist decided to use the concept of the body-container, formulated by Pollak [28]. As part of this concept, Pollak proposed a clinical and theoretical combination of Freud's views on the "body ego" with the idea of containment introduced

by Bion, thus creating her own model of practical support for the embodied psyche. She proposed to focus more on the role of the directly, sensually experienced body in developing seedling psychic experiences.

Pollak claims that a therapist who consciously uses the body-container model has a chance to locate, organize and integrate proto-mental functions. The therapist's consciousness can interact on three levels: a) while absorbing raw material of a nature so indefinite and "meaningless" that it does not get recorded in the therapist's mind; b) transforming the physical presence of the therapist into a method of communication with the patient; and c) transforming the therapist's attitude, which in turn affects the way the patient uses the therapist's countertransference [28].

Concentration on mental processes in working with the boy seemed out of place, and the patient's mental structure did not allow for transformation into pictorial and symbolic representations. Due to the use of the model of the primary organization of the psychophysical structure [28], the situations that the therapist experienced as failures became sure signposts to the boy's primary problems. In practice, this required the interpretation of the content to be abandoned in favour of the envelope [17], which was meant to be kept and contained, not to gain insight. The change in the therapeutic attitude resulted in the boy being more active and creative in the office.

In further work, Damian's desire for the possibility of taking advantage of the therapist's activity was revealed. It was not expressed verbally, but was manifested in the attitude and evident expectation of taking up the activity of the proposed play, mainly throwing a ball. Usually he sat on the floor with the ball in his hand, looking at the therapist and making grunts and squeaks. The first single words appeared, but still mainly the gestures with which the patient tried to communicate his needs, which concerned the possibility of using the therapist's hands to build three-dimensional paper objects, e.g. ships, boxes, during subsequent sessions. The objects created by the therapist's hands were explored in a plastic tray filled with water. They were supposed to be able to float above the surface of the water, as well as contain water inside. The patient repeated a situation in which the walls of the box / ship were perforated, its consecutive sinkings and re-rebuildings with the therapist's hands, which most likely was an illustration of his experience of breaking the continuity of sensory experiences, which in Pollack's concept is described as a "skin-sieve" and connects feeling that "the inner world is leaking through perforations to the outside, into a shapeless, boundless, infinite space."

The relation with the object still remained at the original level, but the change in the work formula made it possible to notice the object and the possibility of using its presence at a given moment, mainly at a specific level. The appearance of three-dimensional objects, paper constructions, was associated with the appearance of creativity and more symbolic expressions of Damian's intrinsic activity. Another variant of the game was to colour the water with paints and check how the paper object reacts to colour / dirt. It was a game where more associations and fantasies began to emerge in the therapist's mind, which was previously usually deserted. Colourful water, which eventually turned grey in the course of filling in with subsequent colours, at the same time disturbed fascinated Damian. This was related to the boy's less rigid functioning during meetings and the emergence of greater variety in the "emotional tone" of the atmosphere in the office.

Damian's anxiety about the grey colour directed his interest to a sink with running water. Then there was a series of games involving mixing “coloured” water with clean, diluting and rinsing. The fun eventually evolved into putting more containers in the sink and trying to put them together to allow the water to flow through. Staying with the body-container theory, the boy’s effort can be interpreted as an image of an attempt to build a basic mental system (metaphorized by Pollak as the “frontal axis”), which connects, inter alia, processes such as: processing and organizing sensory perceptions, filling, emptying, digesting, internalizing, ejecting and transforming, and controlling and organizing intentional movements between inside and outside. All these elements were played out in a specific way in the patient’s activity. There are several aspects to the development of the “frontal axis”. The first goal is to detach the “enclosing body” from the experience of fluid sensory arousal [28] and to make the vertebrae sufficiently “constant” in the transference-countertransference relationship. The fixed points on the “frontal axis” connect like “survival beads” and support the “mental extension”. Each point on the axis “contains experiences” that have the potential to create symbols, opening the way from physical to mental, from concrete to abstract. On the example of play involving the senses, it can be seen how Pollak understands the inclusion of the body and sensuality in the development of fundamental psychological experiences.

The use of the model of the primary organization of psychophysical space in the case of the patient described above, proposed by T. Pollak, made it possible to get out of the impasse and clear the communication channel, and to build the experience of the presence of three-dimensional containing and transforming objects, as well as still uncertain connections between various experiences that would constitute Damian's "mental backbone" . For the therapist, conceptualizing the work with Damian, there was also a kind of struggle with combining separate experiences into a whole, because, according to Pollak, fragmentation is the very essence of the experience of the body-container in the case of people with distorted psychophysical space. Connecting fragments of meetings with Damian, giving them continuity, noticing a specific rhythm and directions of movement in the relationship gives hope for building “starting points” that will help the boy and the therapist build a relationship.

Example 5: Analytical third

An example comes from the initial stage of work with a 9-year-old Emil. The following description covers the development of contact with the patient from the first meeting, so the therapist deliberately does not precede him with the introduction of any biography data that she did not have at the time. The intention of this clinical fragment is to draw attention to the possibility – and in some cases even necessity – of using bodily forms of communication to bring into being the so-called “analytical third” that Ogden wrote about [29]. The intersubjective analytical “third” is the subject formed by the mutual unconscious exchange between the analyst and the patient; at the same time, the analyst and the patient are created in the process of the analytical emergence of the third. Perhaps this concept will become more understandable after presenting a fragment of the clinical work.

During the first consultation, Emil was restrained in his gestures and words. The therapist, who works with children, had a natural need to introduce herself. More clearly than usual, she felt she needed to shape the meeting. She described it as an "unusual meeting," which briefly intrigued the boy. His gaze met hers. Then she added: "An unusual and new meeting – because we don't know each other yet. It is true that I had the opportunity to meet your mother a bit, but today you are here personally and I can meet you." Emil smiled slightly and looked down quite quickly. Silence spilled over in the office again. The therapist decided that the emptiness should not take up the boy's space and would not force her into the chair. So she tried to use words that would describe the difficulty of the boy's position: "You may need some time to look around. Get used to this place, look at it, personally check the various things that are here." As she spoke, the therapist gazed at the space around her. She realized that with her own body she was trying to encourage Emil to make a similar movement, even with his head or eyeballs.

The words spoken by the therapist caused a grimace of disbelief and surprise on Emil's face. He quickly scanned the walls and froze again. He sat almost still, lightly rubbing his hands. Then the therapist started to shake. Surprised, she watched the clarity of her own sensations that gradually dominated her attention. After a while, the therapist's legs ceased to be an integral part of her body. They began to change positions restlessly, as if she had no influence on them. She felt an inner compulsion to say something. However, when she brought out the first few words inviting them to play together, she felt as if the office had become even tighter, with less oxygen. The pressure in the throat mixed with the thoughts and the fear of being too insistent. It was difficult for her to recognize whether it was the boy's desire and, at the same time, the fear of leaving some armour, or her own fear and the need to fight for her own existence or survival, as if there was no room for either the patient nor the therapist.

The therapist decided to work with Emil, taking at face value the fact that he does not speak much, but is able to communicate with her through her body, and she can receive this messages. She thought that she might not be able to alleviate the patient's suffering, but she might try to accompany him.

The therapist agreed with Emil's mother that she would meet him once a week. When the boy found out about this at the last consultation, he reacted in a surprising way. He got up from his armchair and walked over to the table on which there were boxes of dough. He had never taken any activity in the office before, apart from sitting in the chair. He began to open the boxes and mix different coloured textures together until he had a green-brown mass. The therapist then thought that Emil might have felt that she was someone who, faced with terrifying and painful mental and physical conditions, was ready to endure with him on his planet.

At the first moment, when the boy crushed the lump, the therapist had the impression that the shape that was forming in his hands resembled a bowl or a shell of Thumbelina walnut. When Emil touched the plastic, he placed his hands as if he was wrapping his hands around it. He squeezed with his thumbs, creating an interior – like a depression in it. The therapist thought that perhaps the patient "shapes the experiences", showing her that the office space and its interior had become a territory that could contain his experiences and his body. She silently followed the movements of the boy's hands that seemed to speak to her.

Working very vigorously all the time, Emil explained that this was the main part of the cave. The boy's voice was unfettered at that moment. The entrance to the cave was spacious. It looked as if it was inviting anyone who would like to come in. Everything in it was visible without much effort. Spacious bedding with a wonderful dog lying on it. The drinking bowl was actually in the doorway. It was a wonderfully idyllic impression that the boy tried to create in front of the therapist, but after a while it turned out to be deceptive. As soon as Emil finished his presentation of the "house" visible to the naked eye, he began to work at the rear of the structure. Asked "what's he up to now?" He said nothing. At the same time, he continued his work. There was a silence, which the therapist understood this time not so much as a refusal to contact or a lack of access, but a message not to rush nor insist but wait. The passion with which the boy was working was a signal for the therapist to remain present and to trust her experiences and associations.

At the same time, the therapist was constantly experiencing difficulties, not only with feeling and thinking, but also with breathing. The dark, earthy colour Emil had obtained from mixing the variously coloured plasters made her feel disappointed (she thought, "it won't be colourful"). She began to feel a growing doubt that the cave was overly open. She linked these associations with the paradoxical feeling of not being able to freely release air from her lungs. This, in turn, caused a pressure of factual content about the boy's life obtained from his mother during the contact preceding the consultations, above all the conflict, constantly escalating between his parents, who broke up shortly after his birth, came back together and parted again in anger.

The therapist realized that she was making intellectual efforts to reduce her own bodily discomfort by recalling the context of Emil's report. All this to be able to get air into the lungs. She could barely bear the state of respiratory discomfort. As she noticed her body struggling and sought refuge in her intellect, she was overwhelmed with sadness.

Then Emil said, "The cave also has a maze of corridors and hidden places that no one can see when entering a cosily looking cavity. There is a dog that comes out when it's dark. Nobody knows he's there.

The therapist decided that Emil showed her what his world looks like. A territory that anyone can invade without notice, and he would remain like a crouching animal in a secret tunnel. Withdrawn from the world that is his place but ultimately cannot be. Emil leaves everything wide open, puts the bowl on the threshold, invites you in. However, these are only appearances, because anybody can ultimately be a potential invader in the boy's survival.

The therapist felt that she had been initiated to understand how Emil was trying to cope with the family home, especially the emotional and physical impulsiveness of one of the parents. She decided that she had also been put to the test of how she would deal with the impulses flowing from her own body in response to what her patient communicated. The boy could test what kind of relationship the therapist would maintain when he was subjected to contradiction and pressure.

The presented fragment is an illustration of the so-called "Analytical third" as the area of the unconscious life of the couple: experiences that arose together in the contact of two subjectivities. According to Ogden's concept [29], the formation of an "analytical third" is based on the therapist's ability to reflect in a specific form, in which the therapist gives space to his own somatic and subjective experiences, personal associations, impressions

and ideas, allowing them to interact with the material contributed by the therapist. patient. It can be said that the interweaving of the content expressed by the boy's play with the content created in the body and in the imagination of the therapists created an "analytical third" – the image of a cave with accompanying sensory experiences, the emotional meaning of which did not belong to the boy or the therapist, but remained the work of intersubjective contact. According to Ogden, in some situations, especially when the patient is lost in his/ her own subjectivity, the creation of space for an "analytical third" must precede attempts at precise verbalization and pointing to the distinctiveness of the owners of individual experiences.

Conclusions

We have presented five clinical examples, drawn from our work with a wide variety of patients and in a variety of contexts. On the basis of the quoted fragments of work with patients, we propose a few general remarks on contemporary, psychoanalytically oriented ways of working with patients who have difficulty using verbal interpretations of the content of statements.

Firstly, in all of the examples cited, the role of the body and non-verbal communication as the primary communication channel is very clear. Regardless of the level of development (children, adolescents, adults), the presented problems or theoretical reference points selected by therapists – it can be said with high conviction that attempts to overcome difficulties with mentalizing and verbalizing one's own emotional states may be based on the direct use of the sensory experiences of both patients, and therapists.

Secondly, it seems that working in conditions of limited mentalization and difficult verbalisation requires therapists to make a special kind of emotional effort: in the presented clinical fragments, therapists struggled with the states of uncertainty and ignorance, when they could use body guidance rather than verbal content, which usually is the breeding ground for intellectual interpretive constructs. In a work that is largely based on verbal communication, the therapist can use direct feedback from the patient, confirming or contradicting the therapist's assumptions, comments and interpretations. In the approach described above, which relies more heavily on non-verbal communication and the emotional atmosphere of contact, the therapist must follow more closely the approximation or distance movement in the relationship on the basis of cues other than words.

Thirdly, therapists trained in psychodynamic / psychoanalytical approaches can find in the cited contemporary concepts of work not only new tools or techniques, but also a much needed sense of security when reaching for interventions other than verbal interpretation of content. Attempts to refer only to intuition, gut feelings or sensory impressions, without theoretical background, threaten to undertake "wild" interventions, not embedded in any structured system of understanding the patient's psyche. Such an approach would be dangerous for both the patient and the therapist – not fully knowing why the interventions are being undertaken, one remains much more open to all forms of playing out uncomfortable feelings in impulsive action. For this reason, we believe that the theoretical background of the described clinical situations was a safe foundation for the undertaken activities, and

we understand the presented work as examples of a technique embedded in the theory, and not a derivative of intuition or gut feelings.

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