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Adam Stanclik[1]

THE BODY IN PSYCHOTHERAPY. THE NATURE AND FUNCTION OF MIND-BODY INTEGRATION IN PSYCHOTHERAPEUTIC WORK BASED ON A CASE STUDY IN THE FIRST YEAR OF PSYCHOTHERAPY

[1] Private Psychotherapy Practice

developmental perspective
mind-body integration
relational crisis

Summary

This article describes the psychotherapeutic work, conducted within a psychodynamic-systemic framework, with a patient experiencing difficulties in communicating her emotional states. In the first year of therapy, the patient complained of deteriorating relationships in her personal and professional life. She was also troubled by a feeling of emptiness, which she believed was responsible for her inability to experience pleasure. I explore the development of the patient's difficulties by combining an understanding of intrapsychic phenomena with an analysis of her interpersonal domain, particularly her family dynamics. Survival was paramount for the patient in childhood, leaving her no opportunity to develop an internal space for self-understanding. She learned to marginalize and camouflage her suffering, which manifested as relational and emotional crises – an unintegrated internal voice she could not hear or accept. Based on the premise that thoughts too difficult to process can cause chaotic experiences, I assisted the patient in creating an internal space for reflection and conscious choice-making. Initially, she struggled to speak about herself and wished to withdraw from therapy. The analysis of transference and countertransference, especially the therapist's somatic countertransference, was crucial for understanding and sustaining the therapeutic process.

Introduction

For many years, I have been collaborating with *Krakowski Ośrodek Psychoterapii i Psychoedukacji* (KOPiP; Kraków Centre for Psychotherapy and Psychoeducation). Together, we prepared a workshop that we conducted as part of the Three Sections Conference 2024, "The body in psychotherapy". The workshop was titled: "The body in the transition room". It was attended by about forty people – psychotherapists from various theoretical orientations. The clinical material presented during the workshop was enriched by the participants' comments, which diversified the understanding of what works in psychotherapy, not only from the perspective of transference, countertransference, and resistance, but also

from the perspective of working with the body and understanding the drive manifesting itself in the psychotherapy process.

In this article, I present a case analysis of a patient (Ms. B.). In my work with her, I tried to utilize theories verified in practice, introducing the most effective therapeutic interventions into the psychotherapy process. Kalita, in his book *Rytmy otchłani. Rozważania o wczesnych stanach umysłu* ("Rhythms of the abyss. Reflections on early states of mind") [1], points to the need to focus on the patient's internal world in order to understand states of internal persecution[1]. In contrast, Lemma, in her book *Ciało w umyśle* ("The Body in the Mind") [2], presents practical indications for addressing transference and "figurative work", which become necessary in the early phase of working with patients[2].

In the case formulation, I referred to works focusing on the mind-body relationship in early developmental stages, as well as on noticing and understanding the psychological aspects of adopting another's perspective, reasoning by analogy, and recognizing intentions. Additionally, I took into account the patient's developmental perspective to understand her difficulty in communicating the need to find a caregiving object in an environment where the body was primarily preoccupied with survival – forced to enclose itself within, thinking about what it experienced.

In my office, I met a person who quickly exhausted the scope of verbal material brought in. She gave the impression that the few sentences she uttered at the beginning of therapy were all she had. She could arrive to attend the therapeutic session, and her activity would end there. She was present with a body that I saw and could try to understand, but not necessarily a body that she herself perceived and understood. The patient had trouble speaking about herself, yet she very strongly signaled the need to be understood by me, seemingly bypassing the necessity of naming her thoughts. She was subordinate to an external motivation, some external entity that visited or left her at key moments in her life, destabilizing her. One time it was a parent who allowed everything, another time a guest invited by her parents into the house, another time a nosy intruder walking through her room, and another time an assailant intruding into her intimate world. Everything, therefore, was to depend on me.

Patient: ...I've already said everything; I don't know what else to say.

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1) "Focusing on internal fantasy worlds, fueled by drive life, helps clinicians understand states of internal persecution and the bizarre solutions protecting against this terrifying torment. The works of contemporary authors inspired by the ideas of Melanie Klein, dedicated to early states of mind, suggest that the schizo-paranoid position [...] provides a foundation for therapists to better understand patients' behavior, and an attitude focused on exploring the process of projective identification – helps find a channel of communication where words are missing" [1].

2) "Psychoanalytic work is characterized by a constant reference to transference, which includes maintaining an analytic attitude rooted in experience [...] In order to understand the patient's state of mind and select the most effective therapeutic intervention [...] we probably all 'use' transference understood in this way; however, we should remain open to various ways of stimulating and supporting patients' curiosity about their minds – especially, though not exclusively, through formulating verbal interpretations of transference [...] Figurative or supportive work may become essential in the early phase of analysis or in psychoanalytic psychotherapy with patients whose pronounced difficulties in representing experiences in the mind prove to be a serious challenge" [2].

Therapist's understanding: Is this resistance? Or perhaps some serious deficit in thought integration – as described in Bion's theory of thinking [3]. Or maybe an introduction to the description of an autistic refuge – as described by Tustin [4] – because some thoughts cannot be thought, as they are too terrifying.

The patient was searching for an object that would think the unthinkable thoughts for her, which would allow her to regain her own history – a continuity of sensations and emotions that do not flood, do not terrify, and do not inhibit development. In mathematics, integration is understood as calculating the sum of individual parts to find the whole. In understanding Ms. B.'s case, I referred to works emphasizing the synchronicity of body and mind and issues related to the therapist's involvement.

Below, I will present selected therapeutic tools that proved most effective in working with Ms. B. This evolved from traditional interpretative forms to those that, through a thorough analysis of the therapist's countertransference, led to the integration of bodily and emotional experiences, providing an opportunity to understand the processes occurring in order to help the patient. I have divided the clinical description into three stages. Each stage will begin with a characteristic, selected fragment of the case presentation, after which I would like to present the therapist's understanding based on the psychodynamic-systemic approach. The former shows how the external, dysfunctional system is internalized by the patient. The transgenerational process shapes her internal world, object relations, and defense mechanisms. The latter allows a view of the family as a system in which behavioral patterns, roles, and traumas are passed down from generation to generation. Based on such an analysis, I would like to present the conclusions that led to the therapeutic interventions.

Both before conducting the workshop and now, before writing the article, I obtained the patient's consent for the presentation of her case. For the patient's sense of security, her personal data have been changed to prevent the identification of her history.

Case description

Stage one. Psychotherapy in the initial stage of working

Ms. B. – an intelligent, attractive, professionally successful 45-year-old economist – sought psychotherapy due to a problematic relationship with her partner, a lack of acceptance of her life, and a feeling of emptiness. The woman is the mother of a 20-year-old daughter – a student – and is involved with a partner five years her junior, the father of a 19-year-old son (the children currently do not live with them). Their relationship has lasted for ten years. The patient described it as: "something has faded". She pointed to a lack of lasting relationships in general, despite a tremendous desire to form a bond with someone. She mentioned a painful loneliness, a feeling of being unnecessary. The patient's partner initially seemed to be the man who needed her. He had problems with his son, and Ms. B. had a good influence on him.

Ms. B. was born into a complete family as the second child – she has a brother ten years older than her, with whom she never had good contact. Currently, they meet sporadically at their parents' house for holidays or family celebrations. The patient described her childhood as "typical". One had to be polite, occupy oneself, and later study and help her mother. The house was always full of guests. Friends came over to her parents' – it was cheerful then. A lot was happening. In Ms. B.'s memories, the relationship with her brother was problematic; the younger sister was mainly a nuisance to him, whom he "chased away or pushed away", treating her badly, as she admits: "he beat me up". The patient's family occupied part of her grandparents' house. It was an apartment where her mother had lived with her parents during her childhood. Ms. B.'s mother once occupied the same room that the patient and her brother later occupied. Other parts of the house were occupied by the families of her mother's siblings. There were many children there – cousins – with whom the patient spent time. In childhood, Ms. B. often stayed overnight at her favorite cousin's – a peer – when a social gathering at her house was not expected to end before nightfall. It was noisy. Children were allowed to do a lot, especially regarding the choice of time and place to sleep – that was attractive. Ms. B. remembered her childhood as carefree – easygoing. "Childhood was great. High school was even better, because friends and classmates could come over, and almost every time something fun happened. Often thanks to my mother, who spent time with us. She organized mini-barbecues with serious topics. There were also games and activities that everyone really liked."

Therapist's understanding

Psychotherapy in the initial stage of working with the patient focused on deciphering the metaphorical and symbolic meanings in her story, in the transgenerational experience of being a daughter and a mother, in which the mother organized her daughter's existence. The patient's family has lived in the same house for decades, which was renovated in various ways. Her mother, as a child, occupied the same room that Ms. B. and her brother later had. However, the patient's ancestors influenced her current life not only with regard to the apartment. The transgenerational message is, after all, the rules that should be followed. It is the beliefs and values passed down to us by previous generations. I asked myself what unconscious message, emerging from the depths, could have contributed to the problems with which the patient came to therapy.

Patient: Childhood was great, high school was even better...

Therapist's understanding: It seemed to me that the patient's idealized presentation of her childhood was significant. I wanted to pause at those moments to reflect on the way the patient presented herself at the beginning of her psychotherapy. The distinction between the functions of idealization processes used for defense and those that occur as necessary developmental stages came to mind.

Laplanche and Pontalis define idealization as follows: "Idealization is a mental process that raises the qualities and values of an object to the level of perfection. Identification with

the idealized object contributes to the formation of the ideal ego and the ego ideal" [5]. Klein, in her 1952 work titled "Some theoretical conclusions regarding the emotional life of the infant", states: "Although in some respects these defenses [splitting and idealization] hinder integration, they are essential for the healthy development of the ego because they repeatedly alleviate the young child's anxieties. This relative and temporary security is achieved mainly by keeping the persecutory object separate from the good object" [6]. In turn, in the work "Mourning and its relation to manic-depressive states", Klein writes: "A shaken belief in good objects most painfully disturbs the process of idealization, which is an indispensable intermediate step in mental development. In the young child, the idealized mother provides security against the retaliatory mother and against all bad objects and therefore represents safety and life itself" [7].

Segal, in her book "Introduction to the work of Melanie Klein", notes: "If the conditions for development are favorable, the child will increasingly feel that his ideal object and his own libidinal impulses are stronger than the bad object and his bad impulses. He will be increasingly ready to identify with the ideal object, and due to physiological and ego development, he will increasingly feel that his ego is becoming stronger and better prepared to defend himself and his ideal object. When the child feels that his ego is strong and has a strong ideal object, he is less afraid of his own bad impulses, and is therefore less inclined to project them outward" [8].

During the first sessions, the patient spoke about her history with difficulty. She mentioned events she usually shared with others, but the sensations associated with them were complicated and distant. The woman seemed startled when she had to connect one with the other.

Patient: Everything was fine. Nothing bad was happening. I don't know why I find it so difficult.

Therapist's understanding: I sensed the patient's need not to be probed; to confirm that she might not know many issues related to her life history.

Lemma quotes Ogden (text published in 1992, "Comments on transference and countertransference in the initial analytic meeting. Psychoanalytic inquiry"), who named "a cautionary tale" what he understood as the interpersonal narrative brought into the first sessions, which is a record of unconscious anxieties aroused by the prospect of developing a relationship with the therapist. She proposes the thesis that: "the unconscious narrative communicated on a sensory level, through the patient's relationship with the physical space and the analyst's body, significantly influences him and is part of the story 'told' by the patient" [2]. For Ms. B., how my office looked was important. She said that "it feels so homey", and the fire burning in the fireplace gave a pleasant warmth. However, it was difficult for her to think about herself, and the most difficult thing was searching for the meaning of what she was talking about. The patient reacted with anxiety to interpretations – references to transference. At this stage of therapy, the most important thing was to maintain this process. What I struggled with was feeling a heaviness, a kind of inertia, and at the same time tension – I couldn't believe the patient. I felt that she wanted me to

perceive her as cheerful and problem-free. After all, she spoke of a carefree, ideal time of childhood: "everything was great". I was also supposed to be "super". I was the ideal therapist for her, the ideal object—I had to be. The analysis of countertransference—the feeling of inertia or disbelief—was not only an insight into the patient's psychodynamic world but also a signal of a systemic pressure for me to adopt a role familiar to her from her family, for example, the role of an ineffective, withdrawn parent. Conscious analysis of these feelings allowed me to avoid repeating the trauma and maintain the framework of a safe therapeutic system. Over time, it became clear to me that the basic early relationships the patient had from the beginning of her life were being reenacted in the office. Primary objects and a child closed in their own world. Parents who were irritated by the daughter's lack of perfection, preoccupied with themselves. The child quickly learned not to bother them. I realized how important it is to create appropriate conditions for conversation in the office, so as not to join the hostile or seducing, with apparent permission, strange figures from the past. When the patient spoke about her world at the beginning, I was close to acknowledging that what she was saying was unimportant. Over time, I could see it differently. An increasingly safe space was created, into which the patient began to bring increasingly different memories of what was happening in her home.

> **Patient:** I knew more about life than my classmates. (...) When others were forming relationships, I was still alone and felt physical pain that I didn't have anyone – like when my dog died.

During the workshop as part of the Three Sections Conference 2024, "The body in psychotherapy", participants were asked to share their own reflections. Stimulated by the content of the presentation, they described what appeared in their bodies and minds. Their statements concerned the darkness, sinister nature, internal constriction, or deep physical pain they were experiencing. Some spoke of a lack of strength to endure their thoughts about what would yet be revealed in the remaining stages of the presentation.

The patient revealed a strong feeling of guilt for "bothering me". I needed changes in the current way of working during sessions. After reading *Rytmy otchłani. Rozważania o wczesnych stanach umysłu* ("Rhythms of the abyss. Reflections on early states of mind") by Lech Kalita, I considered his indications important, in which he referred to Riccardo Lombardi, who spoke about supporting the thinking about feeling sensations [1]. I tried not so much to focus on the patient's anxieties anymore, but rather referred to a simple mirroring of her feelings or mood here and now. Consideration of the function of the woman's idealized story about her childhood also turned out to be important. Ms. B. could feel a strong fear that something was wrong with her, that she was different from everyone else. By not thinking about herself, she distanced herself from the reality she lived in. She could perceive the world around her as hostile, persecutory—full of threats. "She knew more about it than her peers".

Stage two. Space of transition

Ms. B. mentioned that she intensely disliked, even hated, the teenager in herself. She spoke of a crippling loneliness. She deeply craved closeness and friendship, yet at the same time, she was terrified of relationships and commitment. An acquaintance, whom she allowed to kiss her and from whom she felt pleasure, wanted more. She refused. He humiliatingly called her the worst. The saddest thing – as she recalled – was that she thought of herself that way. She hated her body. It had been a problem since elementary school. Ms. B. was "bigger" than everyone else then. Taller than the other girls, she started puberty earlier than her peers. She looked more mature. She recounted a dream:

> **Patient:** I was walking through the city. I was going through small, narrow streets. As I walked, I noticed a blue parrot the size of a German Shepherd dog. A man was with it. He allowed me to take a picture. He was an actor. The parrot kept turning away – I couldn't take a picture. The man then walked up to me and showed me the screen on his iPad, and it showed my apartment. He said I had great books. While saying this, he kept getting closer. I felt he would cross the line any minute – I was afraid! Then I visited him at his house. The parrot was lying outside like a dog – I noticed it had a muzzle on its beak with a chain attached to a nearby excavator. I reacted: "How can you treat animals like that?!". The man said they had recently moved in with his daughter and that this was a transitional period. After those words, a little girl – a scatterbrain – ran up to him and hugged him. Immediately after, a woman appeared – the owner of the house they moved into – and said that if they didn't have money for rent, they could sell the girl, because they could get a good price for her virginity. I screamed, I went into a fury. The father was swimming in the pool at that time... I was screaming – there was no one. When I stopped screaming, the father said that the woman might be right. I started screaming again... and I woke up – terrified.

In her associations to the dream, the patient said: "That's my life. I saw my parents having sex. I saw them having sex with their guests. I saw all those parties... and me with a chain on my beak".

The work on this dream illustrated how the patient's intrapsychic, internal world is inextricably linked to the dynamics of the family system. At the level of psychodynamic understanding, the dream reveals repressed aggression (the muzzled parrot), fear of castration, and loss of voice. Simultaneously, at the level of systemic understanding, the dream figures – the indifferent father, the woman wanting to sell the girl – are representations of roles from her real family. The interpretation of the dream was thus an insight not only into Ms. B.'s unconscious but also into her position and role within a pathological family system.

The transition room, or rather the consequences of living in such a space early in life, became one of the main themes of the patient's psychotherapeutic process. The metaphor of the transition room perfectly captures the pattern of lack of boundaries, privacy, and safety that the patient internalized and reenacts in her psychic life, feeling that she has no safe space of her own. At this stage, I tried to help Ms. B. become aware of these uncon-

scious patterns, understand their origins, and interrupt the cycle of repetition so that she could begin building her relationships on new, healthy principles.

I would like to quote the patient's statement to illustrate the horror that concerned her intrapsychic world – the world of the child she was then:

> **Patient:** It was so terribly cold there, I covered myself up to my ears with the duvet and let out steam from my mouth – that was my game. (...) I really didn't want to know anything about it. Just as I wanted to hide my inner life – to protect it from intrusion, from someone who needed to pee suddenly walking into my world.

Therapist's understanding

This was a difficult time in therapy. Touching childhood memories resulted in the patient experiencing her states very intensely. Ms. B. had never told anyone her story. Before therapy, she didn't remember it, and now she was frightened that such difficult events kept coming back to her. She felt better "without them". Currently, she constantly felt tension because she was talking so much about her parents – especially her mother. She stood at the crossroads of loyalty. She was torn between "invisible loyalty" to the pathological family system and a nascent loyalty in therapy to her own, health-seeking Self. Psychotherapy was gradually becoming the space where her true Self with its needs, anger, and pain, could appear for the first time.

Attention is drawn to the parents' attitude towards their own bodies, described by the patient, which the daughter might have adopted. As Schier writes in her book *Piękne brzydactwo* ("Beautiful ugliness"): "According to Levine and Smolak (2002), in Western cultures, body image combined with general physical appearance is one of the more important components of overall self-worth for adolescents. In girls during adolescence, the relationship between body image, self-worth, and negative emotions is very strong" [9]. The patient often saw her parents intoxicated, not paying attention to what was happening to their inebriated bodies... and yet that was "good fun". From the beginning, she could learn that she should make a good impression, not live in accordance with her own needs and feelings. Observing the intoxicated, unstable bodies of her parents and the violation of her bodily boundaries led to her own body becoming a source of shame, hatred, and problems for her, rather than a safe home. The patient entered relationships in which she reenacted the dynamics of her family home – she had to care for her partners (like her parents), endure their instability and humiliation, while simultaneously feeling unnecessary and lonely.

Becoming aware of her history meant that the patient could no longer maintain her vision of the family with which she started therapy – that basically everything was fine. The woman began to understand what she did not want to know or remember: how she had to suppress her thinking so as not to link the horror of her own existence with the desires of the child who needed safety and peace. The patient's descriptions of her living space were characteristic.

Patient: It was cramped, noisy, like a corridor there, someone was always walking through and looking at what I was doing...

Therapist's Understanding: The patient's body was similar – it was too tight to contain everything. How much anger – and various other unpleasant emotions – was in the space of her childhood. She had no room or peace of her own. She couldn't breathe freely – rhythmically – for healthy development. Her breathing was constantly speeding up or slowing down. Someone "could walk in" at any moment. There was no chance for separation, for isolation in her own world – for learning that such a world exists. Everything was stuck together (the patient glued to every one of her parents' parties). There is no way out. There is an imperative: "remain and survive".

The patient recounted a story from her time in college. One evening after work, she returned to her dorm room to study – she wanted to review material for a colloquium. She found her roommates there, who had organized a party. The triple room was noisy. The group was listening to loud music and inviting her to join the fun. Ms. B. separated herself from everyone with a shelf and a couch, and in those conditions, she reviewed her notes – she studied. This "no-exit" scenario repeated itself constantly, for many years. The patient's life was like a transition room, which perhaps is associated with transience – the fleeting nature of that dramatic period – but for now, left behind terrible consequences. "They come, they walk, they leave, they tread". The patient experienced her enclosure ("a chain on her beak"). There was no bodily-emotional-intellectual space then where she could try to connect these dimensions with each other. I understood the therapeutic relationship at this stage as the patient's persistent back-and-forth, as a path towards the body and then towards intellectuality.

In her psychotherapy, the woman was slowly approaching separational themes, but she still had to understand the self-imposed childhood duty of covering her parents' nudity with her body, especially her mother's. Her body turned out to be too small, insufficient. She wanted to be sobering, to offer help, which was beyond her strength. The patient described external abuse, but she also spoke of self-violence. Schier, in *Piękne brzydactwo* ("Beautiful ugliness"), in the chapter on the development of the bodily Self, writes: "The lack of adequate responses from the caregiver leads to the necessity for the child to seek a point of reference and sources of mirroring externally in the future. Psychosomatic illnesses, as well as providing oneself with intense bodily stimulation or self-harm, become a bridge between the body and the mind" [9]. Ms. B. was mostly alone in her childhood; she wanted to make a good impression to cope with the increasingly difficult-to-contain elements of the surrounding reality in her transition room. As a girl, she tried to cover with her body the terror, despair, and shame. She tried to wrap herself around something that was unwrappable. Due to these efforts, her thoughts became increasingly unspeakable.

Stage three. First attempts at naming her states and assigning meaning to them

To illustrate the new meanings the patient was discovering about her functioning, I will use her own statements. I will present the phrases she was already able to use at this stage to describe her needs regarding seeing and protecting her psychological boundaries.

Patient: I hated my mother. My father was a know-it-all. When I was younger, I was afraid of him, and then he just irritated me. He hit me for disobedience. It was a ritual. I had to come to him, take off my clothes, and he would administer the punishment with a belt. He knew everything best. He had an answer for everything. He knew best what I should think and do. The point was that he shouldn't have any trouble with me, so that no one could accuse him of anything. That's how it was in conflicts with my brother – I was not supposed to bother him... But I wanted someone I could talk to. I could talk later in high school when my friends came over, but they talked to my mother. I could be with them then and talk about life – theoretically. I hated my body. It didn't look good, it was stupid – as my brother said: "moronic and empty". Attempts at conversation were destructive. I started cutting myself. That was my world. I was alive. People – sometimes complete strangers – walked behind my back. Sometimes they felt obliged to talk to me. They complimented my stuffed animals, then my books. I felt that some were uncomfortable and that's why they were talking to me. That was when they were still sober. I remember once – I was 16 – when, at night, when I was already asleep, some vodka-reeking guy stumbled onto me in my bed. I lay there like a log; I was terrified. I couldn't do anything. The worst thing was that I didn't have the strength to push him off. Finally, I ran away, and he left, laughing at me. I couldn't fall asleep until morning. The worst thing was when I told my mother about it, and she then started her thing: "Yes, you think I'm the worst mother". I didn't want her to be the worst. I stopped complaining and hid even more within myself. Maybe I wasn't there? It's possible that I wasn't there. There was a moronic body. Now I think that the emptiness I felt, and now it reminds me of itself – it protected me from madness. I had my emptiness as salvation. Now I think that this emptiness was often filled by my mother, all those people. She was less involved with me. She had no doubt that what was happening was bad, that I was suffering because of what was happening. I was fixing her and I guess I still am, when I visit my parents and I know she's been drinking. I don't say anything. Now I think that somehow connects with how I endure what my partner says to me, what others said before.

In my opinion, the above quotes demonstrate how the patient is increasingly consciously tackling developmental challenges, preparing her to discover her subjectivity and become the person she wanted to be. These are aspects of insight, leading the patient towards working through her agency in the process of separation-individuation. Separation refers to the development of boundaries and differentiation, while individuation concerns the development of the ego, identity, and cognitive abilities that allow one to form an image of the world in the mind and check whether it aligns with what exists in the external world.

In systemic psychotherapy, there is talk of the "identified patient" – a person who manifests symptoms on behalf of the entire sick family. I would like to apply this meta-

phor to understanding Ms. B.'s internal world, where somatization as a process becomes the "identified patient" of the patient's psyche. In the face of trauma that the mind was unable to integrate, it was the body – through self-harm, illnesses, or the feeling of being "moronic" – that began to carry the symptoms of the entire, split internal system. The therapeutic work, therefore, involved the reintegration of this "scapegoat", which the body had become, with the rest of the psyche.

The patient was considering ending her relationship with her partner, in which many bad things had already happened. There was also a lot of good, but the bad that continued to happen was now indelible. She hadn't noticed this before. She saw and heard everything, took part in everything – just like in childhood – but these issues somehow "passed behind her back". Her partner insulted her, but she denied the injury. She was convinced that he did not enjoy being with her, and she couldn't stand her reflection in the mirror, but the only thing she could do was withdraw from contact. She was then told that nothing could be said to her and that it was her fault because she did nothing to make things better – she didn't change as her partner wanted. She heard invectives directed at her, and then he would leave offended. He was silent for many days – she couldn't stand it, she apologized – he would return. The patient asked rhetorically: "What would happen if I didn't apologize, if I endured the silence?".

I thought that partnership was becoming more pronounced in her thinking about sensations; thoughts about herself arising from difficulties in the relationship were appearing more often. Fear and pain still appeared, but the patient no longer pushed away the meanings of these experiences. Her supervisor, who had previously exploited Ms. B. at work, told the woman that she was looking better and better. Ms. B. felt that this was not about her yet. She didn't please people, after all. She often heard unpleasant descriptions from others. She spoke about all this with deliberation. In this way, she was clearly beginning preparations for an attempt to emerge, to separate from the internal object whose good image she had protected throughout her life by identifying with it. Łączyńska and Schier, citing the work of Mahler, Pine, and Bergman (text published in 1975, "The psychological birth of the human infant"), wrote: "The self-image must be separate from the image of the internal object for the person to be able to enter into mature adult relationships" [10]. In this way, the patient was preparing for insight, that is, a deeper and fuller understanding of her problems. A slow process of changing her dominant life narrative was taking place. The woman recounted a dream:

> **Patient:** I dreamed that I wanted to fly to Sri Lanka with my niece, whom I adore. My parents were also at the airport. Before the flight, P. and I went to buy chewing gum. P. said there were two left. One was "goodness", and she couldn't remember the other. I said I wanted goodness, and when I reached for my wallet, it turned out I didn't have it – I forgot to take my wallet and passport from home. I decided not to tell P. anything and transported myself home for the documents. When I returned to the airport, the plane was gone. I wasn't too bothered. I left the airport and walked as if on the Great Wall of China. Then I went down the stairs to another plane to fly to my family, but it turned out my backpack was missing. I found it moments later, but

> again, the things inside weren't mine – some old rags. I was scared, I regretted not flying with my parents and P., but then the thought came: "I have my passport – I kept telling myself – look at this as an opportunity". But simultaneously, the thought appeared that they would now perish: "You were supposed to fly and you didn't – such a coincidence. You came back for your passport, and that saved you from disaster".

In her commentary on the dream, the patient said that now she could truly choose her flight. She was freed from the conviction that someone would intrude again and force an unwanted, unauthorized action. She no longer had to travel with the ballast of "old rags". She was now able to leave her "too heavy baggage" behind when it turned out to be so. For now, she had not yet boarded any plane, but she began to understand her silence from the beginning of therapy, her difficulties in talking about herself, and her guilt as an expression of fear of the collapse of her parents' image. The dream of escaping the plane they were flying on was a symbolic reflection of this conflict. Saving herself was linked to the fear of destroying her parents and her bond with them. This translated into my understanding of the patient's resistance. Her initial idealization of the past and her sense of guilt ("bothering the therapist") were a manifestation of a deep internal conflict that she was not yet able to resolve.

Therapist's understanding

I reinforced the synchronicity of the patient's body and mind. I interpreted her behaviors or statements when she spoke about her sensations and tried to understand them herself. The woman increasingly mentioned her body. She spoke poignantly about self-harm, which she needed as intense auto-stimulation when she could not cope with loneliness or violence from her loved ones. Memories of her internal emptiness were very important to her. Perhaps this was related to the parents' lack of attunement to the child. McDougall states in her book: "They were preoccupied with themselves, which may have been the basis for a kind of lack forming in the patient's psyche" [11]. The lack of adequate reactions from Ms. B.'s mother and father may have led her to seek a bridge between body and mind; numerous bouts of tonsillitis and hospitalizations for unclear reasons in childhood, as well as self-harm in adolescence, became a reflection of this. Living in bad conditions could cause a slide into an existence stripped of meaning, where horror outweighed any vitality. The therapist's reactions to the patient's behavior in the office proved important. She would freeze, become motionless. When I said that I noticed her state, it was as if she woke up. It was crucial that these interventions were not associated by the patient with someone walking through her room, with a desire to accost her. Over time, Ms. B. began to react positively. Her disappearance and withdrawal were significantly reduced, and the mentioned interventions activated those parts of the patient's personality that favored naming the experienced emotions (sensations) and connecting them with the possibility of reflective thinking about them. I was constantly exposed to unconscious attempts to pull me into roles from the patient's old, dysfunctional system. The analysis

of transference, countertransference, and resistance allowed the psychotherapy process to be maintained as a collaborative effort toward change. From a systemic perspective, these were reformulations of the family history that shattered the pathological myth of an ideal childhood. From a psychodynamic perspective, it was the process of creating a coherent narrative about herself, which allowed for the integration of split-off parts of the Self and the transformation of traumatic chaos into a history understandable to the patient. This is how the first year of therapy passed.

Later, we tried to talk about the patient's intentional, planned involvement in her own affairs and those of her loved ones. Schier, citing Stanley Greenspan (text published in 2000, "The development of the mind: The emotional foundation of intelligence"), writes: "As early as around the fourth month of life, the child begins to form the first experience of producing an effect through their own action, allowing them to provoke expected behaviors from the caregiver. The pleasure of agency creates the foundation for the development of competence". [...] "Without some degree of ecstatic delight in the child by at least one adult who adores them, the child may never know the powerful intoxication of human closeness, never fully surrender to the magnetic pull of human relationships, never see other people as complete human beings capable of feeling what 'it' feels" [9].

Conclusions

The transgenerational transmission of trauma and relational patterns is a clear bridge connecting the systemic and psychodynamic approaches that were illustrated in the presented case description. The integration of both approaches lies in understanding how the dysfunctional family system (systemic perspective) influenced the formation of the patient's internal psychic world (psychodynamic perspective). Trauma is a process, which is evident in Ms. B.'s case. Her mother repeated her own experiences, creating an environment that shaped her daughter's psychic apparatus.

The key metaphor of the transition room for this case was analyzed on two levels. On the systemic level, it illustrates the pathologically permeable boundaries within the patient's family. On the psychodynamic level, the lack of external boundaries translated into difficulties in building ego boundaries, manifesting as somatization, a feeling of being violated, and an inability to protect her own internal world.

I tried to consider the patient's symptoms (emptiness, relationship problems) in two ways. Systemically, her withdrawal and problem-free facade served to maintain the dysfunctional family homeostasis. Psychodynamically, this same emptiness was a powerful defense mechanism, protecting against disintegration in the face of traumatic experiences.

My actions as a therapist were the realization of an integrated psychodynamic-systemic way of thinking. Among the most crucial interventions, as I understand it, were those that, at the beginning of our work with Ms. B., involved actively enduring the silence and my own countertransferential discomfort. These interventions had a dual purpose. Psychodynamically, I created a "container" (following Bion's concept) for the patient's unbearable, unthought feelings. Simultaneously, systemically, I modeled a new, safe relational system.

In this system, silence is accepted, presence does not have to be invasive, and the object does not flee from difficult emotions into chaotic actions.

Other important therapeutic interventions were those in which I succeeded in mirroring the patient's bodily states "here and now" ("I see your body freezing now"). These were a bridge connecting both approaches. Psychodynamically, they helped build connections between the body and the mind, repairing the traumatic split. Systemically, such mirroring was a direct challenge to the old family rule, which stated that the patient's body and its needs were unimportant and should not be a nuisance. For the first time, her somatic state was seen, named, and treated as an important form of communication within the relational system.

I would like to return once more to some issues and, in a few points, show the significance of this year of work in the context of the role of the body and the limited communication capabilities, which were the basis for understanding the difficulties in the patient's life. Inspired by the work of Young [12], who talks about the meaning and scope of contemporary body psychotherapy, I present the role the body can play in the psychotherapy process in a few points:

- The person's body is a source of information about their state, both in the context of visible body language and the created emotional atmosphere.
- The body is a place for containing emotions and memories, in line with the assumption that memories are stored somatically.
- The body can be a starting point for change in the therapeutic process, "helping" to bypass intellectual resistance to treatment and neutralize the power of transference projections.
- The patient's body can be the source of the psychotherapist's somatic countertransferential feelings. It is worth adding: feelings that should be thoroughly analyzed in the supervision process.

Below, I relate these points to Ms. B.'s psychotherapy.

Firstly, **the patient's body was a source of information about her, both in the context of visible body language and the emotional atmosphere she created**. Ms. B., who did not betray her anxieties and was highly functional socially and professionally, could not talk about herself or her suffering at the beginning of psychotherapy – she marginalized it. Work with the patient at this stage was based on the direct use of sensory experiences of both the patient and the therapist.

Secondly, **the patient's body was a place for containing emotions and memories, in line with the assumption that memories are stored somatically**. The patient found a space in the therapeutic consulting room that was the beginning of the possibility of recalling and holding difficult, terrifying memories. The horror of the primary moments, which manifested on the body level through stopping, freezing, and dying down, was being reenacted. In the "home warmth of the office," the patient showed her way of functioning before words, images, and concepts appeared regarding her behaviors that inhibited her potential for creating satisfying relationships. For now, the possibility of building them was exceptionally unstable and uncertain. My work then constituted a special kind of emotional

effort related to uncertainty and not knowing, because I undertook it solely based on the clues flowing from the patient's physicality. As it seemed to me then, they were insufficient for interpretation due to the lack of verbal communication. I tried to synthesize snippets of information and adjust, thus linking the phenomenon of the patient's subjectively felt suffering with the impossibility of articulating what it consisted of. This brought positive results.

Thirdly, **the patient's body became a starting point for change in the psychotherapy process, "helping" to bypass intellectual resistance to treatment and neutralize the power of transference projections**. Imagining and understanding the horror that the patient had dealt with, which systematically emerged during psychotherapy, allowed for the understanding of the desired but unattainable state of the "ideal" object. Working through this developmental need and a better understanding of it as a defense against reality allowed for the reduction of strong anxieties related to the desire to withdraw or freeze. The patient wanted to quit when the memories could not be withdrawn, when they accumulated, and new ones kept coming back. Only the realization of the role that the patient's fears played in her life allowed for the removal of the primary terror to which she had been excessively exposed as a child.

Fourthly, **the patient's body was the source of the psychotherapist's somatic countertransferential feelings**. During therapy, the patient showed what her world looked like – a transitional territory that anyone could invade without warning. It was a world that did not belong solely to her. She had to remain vigilant, constantly ready to help others or fight others – with no place to rest. Her story produced strong bodily sensations in me as the therapist. It was difficult for me to listen to her without tension. There were moments when I realized that I was not breathing, as if I wanted to wait out some very difficult situation, or I was impatient with the fact that I could not change my difficult position and had to endure it. My emergence from these difficult feelings and thoughts paved the way for the patient to do the same. The initial non-acceptance of her story as significant, disbelief in her, and the feeling of disappointment resulting in a strong need to fall asleep during the session, necessitated a thorough analysis of the meanings of individual feelings or thoughts in the supervision process. This enabled the linking of new information from the patient's subsequent stories with their sense and meanings for her. We managed to avoid premature termination of therapy and subsequently continued it, leading to a palpable improvement in the patient's life.

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E-mail address: adamstanclik@gmail.com