American Journal of Dance Therapy
1981, Vol. 4, No. 2, 21-32

The Emerging Self: Psychoanalytic Concepts of Self Development and Their Implications for Dance Therapy

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The birth of the human infant, which is quite miraculous in itself, is just the beginning of yet another wonder, the psychological birth of the child from a physiologically dependent infant to a unique and separate person. This paper is devoted to discussing some psychoanalytic concepts of early development and their implications for theory and practice in dance therapy. The first part of the paper discusses the sequential progression of stages of development as demarcated by Mahler and others as a theoretical basis for dance therapy. The second portion of the paper examines spatial organization and its relationship to these developmental stages.

Sequential Progression of Stages of Development

The first step in development is the adjustment to the birth process, itself. The neonate must now function as a separate physiological unit. The infant must now breathe independently, utilize his or her own digestive system, and adjust to gravity and changes in light and temperature for the first time. The concern at this time is predominantly physiological homeostasis (Mahler, 1975).

Although Spitz (1965) referred to this as the objectless stage of development, characterized by no differentiation between internal and external stimuli and no inner organization, the more recent research of Bower (1977) suggested that the infant is a complex organism at birth with the perceptual ability to localize sounds and locate objects visually. The current research also indicates that the infant is a social being capable of displaying interactional synchrony almost immediately after birth (Condon and Sander, 1974). Interactional synchrony is a highly complex behavior characteristic of human communication. Thus, it appears that the human infant has the potential to relate and learn at a very early age, and that the infant interacts with the mother not merely for need gratification, as once thought, but for the pure pleasure of the interaction. The research of Carpenter (1975) indicated that by 2 weeks

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Presented at the Fourteenth Annual Conference of the American Dance Therapy Association, Philadelphia, Pennsylvania, October, 1979.

old the infant is able to identify the face and voice of the mother and will demonstrate anxiety if the face and voice do not match. Thus, at a very early age, some form of object recognition and attachment has formed.

Spitz (1965) hypothesized that there exists from birth a *coenesthetic organization* (which we loosely call intuition) which allows the infant to assimilate experiences. He described the coenesthetic organization as follows:

> Here, sensing is extensive, primarily visceral, centered in the autonomic nervous system and manifests itself in the form of emotion. (p. 44)

This visceral sensing is connected to the infant's peripheral boundary through the oral cavity and the inner ear. Thus, the sensual experience of feeding and the changes in position as the mother lifts and holds the child become connected to the infant's inner experiences. The infant's inner visceral experiences will provide the core for the basic sense of self, and the peripheral stimulation provides the basis for later boundary demarcation. The hand movements of the nursing infant which are at first random, soon become coordinated with the infant's sucking during breastfeeding. This coordination of hand movements and sucking leads to the development of the rudimentary body ego (Spitz, 1965). As the infant matures, increased muscular activity and coordination will lead to the further development of ego functions.

Symbiosis

The tactile, kinesthetic, auditory, and visual sensations of the first weeks of life permit the infant to become familiar with his or her future symbiotic partner. Here, the infant is completely dependent and fused with the mothering figure. There is, as yet, no self/other differentiation. In this boundless space between mother and infant, one's basic trust in oneself and others unfolds. The *holding mother* in Winnicott's (1958) sense defines the inner and outer world for her child. Her empathic, non-intrusive holding will confirm the infant's sense of inner goodness and self-worth. Basic feelings of emptiness and lack of trust probably stem from the "earliest psychosomatic insecurities in the arms of the 'non-emphatic holding mother'" (Deri, 1978, p. 49).

The *primary maternal preoccupation* (Winnicott, 1958) of the mother, that is, her deep intuitive involvement with her infant, allows her to utilize her coenesthetic organization and, thereby, be emphatically "in-tune" with her infant. Her empathic, loving care allows her to provide the right thing at the right time, thereby allowing the infant to develop the sense that he or she is creating that which is needed. Winnicott refers to this as the *"primary illusion"* (Winnicott, 1958). The

mother's attunement allows the child to believe that the world coincides with the infant's needs and that he or she has the basic capacity to create. Because the mother is non-intrusive in her nurturing, the infant develops the illusion of self-sufficiency. The mother's empathic responsiveness becomes a permanent part of the child's psyche and a basis for the cohesive sense of self (Kohut, 1977). This remains throughout life as a basic feeling of self-worth and a belief in the ability to care for oneself and later to love and care for another. Conversely, if the mother's nurturance is based on her needs, it will be experienced as intrusive and the infant will not have the opportunity to maintain the illusion of self-sufficiency, and the object incorporated into the psyche will be experienced as alien.

Communication during these early stages of development is primarily affective. "The coenesthetic system responds to non-verbal, non-directed, expressive signals" (Spitz, 1965, p. 134). The mother's conscious and unconscious feelings are communicated to the infant and shape his or her perceptions of self and the world. In the arms of the holding mother the infant may experience a world which is basically warm, rich, and loving or a place which is cold, empty, and hostile. A child in distress experiences a dissolution of ego. The mother's touch, her secure holding, can restore a sense of intactness to the child. Since the child experiences him or herself reflected in the face and shaped in the arms of the mother, how the mother views the child will profoundly effect his or her identity. If the mother is not able to reflect accurately the child's affective states, the child will not be able to develop a reliable sense of self.

Michael, a patient the author worked with for two years, suffered from what may be termed an "unsustaining" sense of self. He was never able to develop a reliable sense of self due to dificiencies in the early mirroring process during the symbiotic phase. There are many indications in the transference of an almost completely non-responsive, non-empathic maternal introject.

> Michael sought therapy due to severe panic states and "feelings of unreality." Michael had a long history of losses in his early life. The eldest of two boys, his brother was born shortly before Michael's first birthday. His parents were divorced when Micahel was four, afterwhich he rarely saw his father.
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> When Michael first entered therapy he was in a state of severe panic, yet there were no external manifestations of this inner turmoil. He entered the office the first time like a young boy without a care in the world. Never once, as he described

the events and feelings which precipitated his crisis, did he "loose his cool." His head was held high, slightly askance. His eyes were distant and often as he talked he had an affable but rather empty smile on his face. He reminded me of a plaster-cast; he didn't have the three dimensionality of a sculpture. Michael's physicality was rather reflective of his inner world, an empty shell; a place where there was form without substance. Most of his feelings and memories were split-off and repressed. His emptiness and fears were rigidly iced-over. He didn't know what to do the first session and thought perhaps he could learn some "dance routines" to enable him to "move more gracefully and less like a robot."

Due to the extent of Michael's depersonalization and his facility for imitating external structures, I avoided working with dance steps, exercises, or stylized movements. My initial work consisted of mirroring those small, spontaneous gestures expressive of Michael's internal reality, thereby, helping to provide the empathic response needed as the cornerstone for a consistent and reliable sense of self. Michael is now developing a sense of the possibility for communication and connectedness from having another in phase with him for the first time.[1]

In working with patients like Michael, it is necessary for the therapist to utilize his or her own coenesthetic organization in order to be viscerally present with the patient. The therapist's affective presence will help to create the "transitional space" (Winnicott, 1971) necessary for the work of therapy. In this space, the psyche of the patient and therapist can play, meaning they can join in the spontaneous affective exchanges which were so lacking in the early maternal environment.

As previously stated, the mother's ability to accurately reflect the affective states of the child is the foundation for the formation of a reliable sense of self. The internalization of the tactile, visual, and affective image of the mother provides a core of inner organization on which later abstract thinking is based. This coherent integration of the physical, visual, and emotional allows the child to develop three dimensional consistency which gives life and meaning to ideas. All subsequent thoughts are sustained by the full and constant image of the mother.

The following case vignette[2] illustrates how dance therapy can be utilized with a patient who experiences severe

[1]This case was discussed previously by Avstreih and Brown (1980).

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inner depletion and for whom the world is a rather flat and lifeless place. During her initial consultation, Marcia complained that she tended to be immobile and uncomfortable with her body. She said, "I want to be able to run and jump and move around like other people." While we were talking, I noticed a general giving in to gravity in her body and a tendency toward quick, self-related, gestural movement.

After the first few weeks of working together, two important aspects of Marcia's dynamics became evident: she was hypercathected to her body which led to a great deal of somatization and she felt an overwhelming sense of emptiness and isolation. She found the room we worked in (a medium sized dance studio) uncomfortable because of its lack of stimuli and mentioned that she always had the television or radio on at home because she would feel lost without the noise. As sessions proceeded, Marcia asked for more and more structure. She wanted me to give her exercises and I kept feeling she wanted to change the therapeutic work into a teacher/pupil relationship.

During one session after talking for ten minutes or so, I encouraged Marcia to move around the room. As usual her movements were forced, stiff, and unrelated. The movement came from her thinking and not from experiencing and feeling. I chose at this point to move with Marcia. Her deep sense of isolation and emptiness, her lack of awareness of inner cues, and her push for structure led me to believe that she needed a primary role model. I felt she had lacked the primary educative experience which exists in the mother/child dyad. I began to use my body as a mirror to serve as a bridge enabling her to rediscover her body parts and gain a sense of mastery over them. I structured a play-like situation where Marcia and I would alternate initiating and joining each other in movements. This was not merely imitation, but psychic play which allowed us to form an affective bond. I felt it was particularly important for us to share in this way, for it was just this type of "feeding" that Marcia had lacked. At one point during the session Marcia said, "My body must be curved now because you are doing what I'm doing and your body is curved."

This is a clear example of how the child, or in this case, the adult, begins to develop a stable body image through reflective interaction with the mother/therapist. Here we see the origins of a reliable sense of

self. The child initially organizes reality through the reflection of the mother. Marcia needed to experience a reliable and harmonious object to give life to her very empty and lonely world.

Differentiation

Initially, the mother herself is of intense interest to the child. The child in the differentiation subphase of the separation process will actively explore the mother's body. During breastfeeding, the child will explore her face, her mouth, and her hair. However, soon the world beyond the mother beckons the developing child. The further maturation of the child's musculature fosters independence. The crawling child can actively pursue the outside world. It is of no coincidence that eighth month stranger anxiety tends to coincide with crawling for most children. Crawling is a physical verification of separateness. As Spitz (1965) pointed out, stranger anxiety seems to be a reaction stemming from the realization of the loss of the mother, not merely a fear of the unknown. The research of Bower (1977) further elucidated this point. By this time in the child's life, he or she has developed a highly intricate and specific communication pattern with the mother. There is speculation that when the specific, expected response of the mother is not forthcoming because someone else is in her place, the child experiences a void which increases the awareness of aloneness.

Practicing

Mahler (1975) characterized the next phase, the practicing period, as a "love affair with the world." Upright locomotion catapults the child toward separation. If the symbiosis has been satisfying, the child leaves the mother for a time and embraces his or her newly found mastery and the world it provides. Needless to say, when patients begin to regain a freedom of expression in movement, they can reexperience this very same feeling.

In the following case, the working through of the early symbiotic rage allowed Maria to progress to the practicing period and reexperience her "love affair with the world" which had been severely curtailed. The therapist's availability and support during this period allowed Maria to liberate libidinal energies necessary for motoric and cognitive development.

> Maria was 3½ years old when she was referred to a Community Mental Health Center by her day care center. She was a pale, awkward child with very tense, jerkey movements due to her hyperextended fingers. She had little strength in her

extremities and exhibited quite flaccid muscle tone in her arms and legs.

Maria was referred for treatment for numerous reasons. She had severe tantrums at the day care center, particularly when corrected in any manner. She would recoil from touch and had poor language and motor skills. For example, she could not pedal a tricycle and spoke in two and three word sentences. She would often scratch and bite other children or stick her finger in their eyes, manifesting a lack of boundaries. She was very fearful of separations and would run after her mother when left at the center. Yet, she was inappropriately affectionate to adults in school and on the street.

Maria's early years were marked with significant losses. Mrs. T. had been married only a few months when she became pregnant with Maria. There was a great deal of difficulty in the marriage at this time with frequent fights and threats of separation. The delivery of Maria was normal, but Mrs. T. described herself as "too exhausted" to care for her. Maria's father, who was quite depressed at the time, and a neighbor's child were the main caretakers for Maria during the first 2 years of life.

For Maria, loss was piled upon loss. Her mother was hospitalized twice when Maria was 2 years old, and her father began a series of hospitalizations for severe depression. He had been hospitalized five times by the time Maria entered treatment. She was never allowed to visit him during these times.

When Maria first started treatment, she would not come into the room without her mother. Eventually, she would allow her mother to wait in the hall if the door remained opened. I saw before me a terrified child who often acted in a pseudo-adult fashion.

Maria's mother considered Maria to be a terrible eater. In the day care center, Maria would threaten to gag if asked to try any food other than cookies. For the first 6 months of treatment, Maria pretended to force feed me. She would stuff me with food while taking nothing for herself. At first, she would ignore my complaints, refusals, and crying. Eventually, she acknowledged me and responded at times with scolding and at times with soothing. It seems that by acting out the good and the bad mother, she was able to become a child again and her aggression emerged.

At this point, we began to move together more actively. She liked to march around the room and beat a drum. She loved to jump down stairs with me. This focusing of strength allowed Maria to express her aggression without flooding, which helped her gain a sense of self definition. Her aggression found outlets in "weebo" the bop toy and hand puppets. She would attack me with the wolf puppet, the aggression initially overflowing to her mouth which would bite in unison with the puppet. As her aggression was expressed and channeled, she gained a sense of strength and confidence. The breakthrough came when she could pedal her tricycle. At this point, she had enough sense of consolidation and control to be receptive to other input and she began to develop her cognitive, language, and social skills. The sense of mastery that came from her increased muscular activity and coordination provided the foundation for these later cognitive skills.

Rapproachment

At approximately 15 months of age, the rapproachment phase sets in. The child's growing awareness of separateness focuses attention back on the mother again. The world, which was the child's oyster just a few months ago, now also represents a space away from mother. The task of this new phase, which perhaps remains a task throughout life, is to mediate between the need to be close to mother and the need to have distance and independence. Also during this stage of development, the child must integrate the good and bad object representation of the mother. In order for this integration to take place, the mother must be libidinally available for the child's need for dependence as well as the child's need for self-assertion. A lack of this synthesized internalization will seriously affect reality testing and further object relations. If this subphase has been navigated properly, the child is well on his way to object constancy and has the libidinal energy available for further ego development.

Spatial Organization and Its Relationship to Separation and Individuation

Regarding dance therapy with patients in terms of their degree of separation-individuation and the issues involved, it is important to consider three aspects of the therapist's movement responses: (1) What is the optimal distance? How near? How far? (2) To what degree can the

therapist's movement be the same as the patient's without it being experienced as impingement or engulfment? (3) What is the proper amount of contrast needed in the therapist's movement without it being experienced as abandonment?

Dance therapists must be aware of the use of space as an epxression of inner and outer reality and as a reflection of the separation-individuation process. According to Bergman (1978), initially the infant has no sense of space for there is no space between the infant's needs and the mother's responses. During the symbiotic period, the child's developing ego allows him or her the first experiences of space. The child sees and hears the mother come and go; she picks the child up and puts the child down. The child begins to sense a space in between. Kestenberg (1978) stated that the coordinated breathing of the mother and child helps to demarcate body boundaries and is perhaps the precursor to later separation. "Both mother and child feel closeness during inhalation and the slight separation during exhalation" (Kestenberg & Weinstein, 1978, p. 84).

> The following case vignette illustrates how working with breathing may be used in dance therapy for insight and reparation. Bonnie entered dance therapy because she felt blocked and isolated from her feelings. She said that she felt as if she were dead most of the time. Her chest felt particularly frozen and I could see that her breathing was severely constricted with little flow of energy in her upper torso. She touched her chest as if she were touching a foreign object, with no molding or shaping of her hand to her chest. Because she was not able to provide any self-nurturance in her own touch, I asked if she would feel comfortable if I put my hand on her chest while she relaxed and concentrated on her breathing. She lay with her eyes closed, quietly breathing. I sat next to her with my hand gently on her chest. Although we stayed that way for only a few minutes, it felt timeless and very full. When Bonnie opened her eyes and sat up she said, "I don't think anyone has ever paid that much attention to me in my whole life." She was beginning to clarify for herself the extreme deprivation she had suffered in childhood and to experience in our therapeutic relationship the possibility for caring relatedness with others.

During the differentiation subphase, the child extends his or her awareness of space. The child will push against the mother's body to have a fuller view of her and the world around her. By pushing and creating a greater space between the child's body and mother's body,

the child is able to more clearly delineate his or her own body boundaries. Yet, the child remains rooted and separate at the same time and begins to use the developing musculature and sensory apparatus in the service of separation.

The child in the practicing period invests energies in the world outside of mother. As previously stated, the child has a "love affair with the world" and is inebriated with his or her own ability to move.

In the rapproachment phase the child is indecisive, leaving mother only to return, moving toward and moving away.

As Bergman (1978) so aptly said:

> At the completion of the separation-individuation process, the child emerges as a separate small individual surrounded by space which both separates and unites him with his mother, a mother who now exists not only on the outside but also as an inner presence that regulates the sense of well-being and safety and enables the child to gradually exchange the omnipotence of the mother-infant unit for a growing sense of his autonomy and competence. If the process fails, the space that both separates and unites is not available, and the individual is threatened by engulfment or unbearable isolation. (p. 148-149)

In the following case,[3] the intrusiveness of the early environment did not allow Jeanette to develop a sense of well-being and safety. Instead, she needed to constantly ward off engulfment.

> Jeanette entered therapy because she had suffered from asthma practically her whole life. During the first few months of treatment she worked on breathing and rageful feelings surrounding early oral experiences of scheduled feeding and the premature introduction of solids. Specific body sensations and asssociations emerged around feeding, particularly around her mouth, her throat, and her stomach. She described becoming aware of a reluctance to use her teeth and found she tended to eat using her tongue and upper palate predominantly, thus avoiding chewing. To this, she associated an inner emptiness and a wish to drink in her environment. She began to experience a tightening in her throat and a rigidity of her stomach. She felt her stomach to be an empty vessel surrounded by a thick, steel wall. Despite the yearning for nourishment from the outside, and despite a tendency toward compulsive eating, her rage and withholding were reflected in the muscular tension of her throat and stomach. While she had overtly submitted to the forced feeding, the

[3]This case was discussed previously by Avstreih and Brown (1979).

"No!" was trapped deep within her and part of the task of therapy was to liberate that assertion.

In her exploration of movements to enable her to loosen her throat and stomach muscles, she began spontaneously to make the sound "Mmmm" with her movements. She then stopped a moment, repeated the sound, and said with surprise, "I don't know if I'm saying 'Mom' or 'ummm,' and I'm not sure if it's inside or outside." In this session, Jeanette was able to reach that very primitive space and bring it to awareness. She was now ready to work through some of her rage and break down the "protective" wall which separated her from people and kept her starving inside.

She initially needed to put me in a corner facing the wall to feel safe enough to move. After gaining a sense of control by externalizing her need to guard against intrusiveness, she was gradually able to free her own motility. My non-intrusive presence eventually allowed her to move toward and finally with me.

Each person is surrounded by space which does not belong to them and yet does not belong to another. It is this potential space for a relationship which Winnicott (1971) called the *transitional space*. In his words:

> It is useful then to think of a third area of human living, one neither inside the individual nor outside in the world of shared reality. This intermediate living can be thought of as occupying a potential space, negating the idea of space and separation between the baby and the mother. (p. 110)

In this space a bridge can be built to both connect and separate the inner with the outer and the self with the object.

For Michael, mentioned earlier, the spaces in between are a "no-man's land" from which he feels at times he may never return. When we first started to work together, he would carry a notebook with his name and address in it as he traveled on the train to my office so in case he died en route, the person who found him would know his identity. For Michael to experience a deep attachment is profoundly frightening and the separations are just as terrifying. By being affectively available and reflective, I helped to create that transitional space. My reflective containment was intended to allow Michael to incorporate a reliable, empathic object from which he may safely venture forth into the world.

In closing, this article encourages an increased understanding of the separation-individuation process so that dance therapists will enter into

movement dialogue with their patients with a richer understanding of the patients' needs.

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