

**EXPRESSIVE ANALYSIS:**  
**TWO PEOPLE PLAYING TOGETHER**

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*“Psychotherapy has to do with two people playing together”* (Winnicott, 1971. P. 38)

Like other schools of thought, expressive analysis is first and foremost a manner of thinking about the analytic process and of what transpires in the room between therapist and patient. This definition involves the understanding that the therapeutic process itself is a creative process, which consists of building blocks like those of any creative process, as well as relating to the therapeutic space as a Winnicottian transitional space, "play space".

Expressive analysis is an approach that is aware of the relationship between creation and play, the unconscious and the analytic process. It is based on the assumption that even when the therapist and the patient do not specifically engage in "real" play or artwork, they always “play” and move in the intermediate area between internal and external reality, between fantasy-play and reality, and between primary and secondary processes.

Professor Arthur Robbins, the founder of the Institute for Expressive Analysis, defines expressive analysis as an eclectic analytic approach that invites the patient to make use of various creative modalities, whether verbal or non-verbal, based on the empiric understanding that any kind of play in transitional space bears effect upon the brain; and conversely, that any action that activates these parts of the brain is responsible for the alteration of the human psyche (Robbins, 2007, Personal communication). In this chapter I will attempt to situate the expressive perspective

within the analytic field, while refining its definition and presenting relevant clinical examples.

Freud gave a comprehensive description of the primary process in his seminal work "The Interpretation of Dreams" (1930). His work and description of the primary process in dreams opened a new understanding to the creative process, and as I will mention later, to the Winnicottian creative analytic process of play and to "talking as dreaming" (Ogden, 2007).

Winnicott (1971) begins his discussion of transitional phenomena by explaining about the piece of cloth or the Teddy bear that the infant uses as a transitional object. This object connects internal reality with external reality - the subjective and that which is perceived objectively - the infant's oral eroticism and real object relations. The transitional object belongs to the child and comprises part of his "body", yet it does not belong to him and is identified as part of external reality. This, then, is the beginning of symbolization, whereby the specific object represents the mother or part of her, and is therefore capable of soothing the infant.

The idea of the transitional space, then, presents a psychic dimension that relates simultaneously to an inner reality and an outer reality, with no contradiction between them, a dimension that connects these two worlds, but also consists of a new world in itself. This is the space in which play is possible. This space is also the space within which analysis works. Winnicott claims that psychotherapy is carried out in the overlap between two play spaces, that of the therapist and that of the patient. In this area of overlap, meaningful moments of meeting exist that have the potential for creating change.

Infant research findings support the centrality of the co-construction and mutual influence between parent and infant and between therapist and patient. Beebe and

Lachman (2002) found that the infant is engaged in highly complex interpersonal interactions from the very first hours of his or her life. These interactions are mutual. The infant is not only influenced by the mother, but also influences and stirs her primal attachments. Beebe and Lachman's use of the concept of co-construction also describes the way interactive and self-regulation processes influence each other and affect each other's success (Beebe & Lachman 2002). Karlen Lyons-Ruth (1999), Boston Change Process Study Group (1998) CPSG & Lyons-Ruth (2001), and Daniel Stern (1998), all present findings that support the understanding that primary dyadic relations are co-created. These findings back a notion of change that is not related to words or to interpretation, but to a shared implicit relationship between therapist and patient, to the intersubjective meeting in a here-and-now occurrence, and the emotional affect that the relationship itself brings about.

Infant research yields results indicating repetitive patterns of symbolic and pre-symbolic interactions, which affect the representations of internal working models and suggest that the moment such a meeting takes place is also the beginning of a possibility for change. In this sense, expressive analysis, like relational psychoanalysis and self psychology, perceives the therapist-patient joint creation within the therapeutic relationship as more significant than objective interpretations and observations. Sander's concept of a "moment of meeting" (1977), that was later developed by Stern and "The Boston Change Process Study Group" (1998), denotes a moment when two states of consciousness are matched, such that the way that one is known by oneself is matched by the way one is known by the other. This is a new coherence in the child's experience of inner and outer.

From an expressive perspective, in analysis the transitional space necessarily constricts anywhere there is anxiety and threat. The inability to play is often a form of

resistance, sometimes an expression of the fear of change that accompanies the very hope for such change. Such constriction is expressed in difficulty using imagery and symbols, associating as well as presenting dreams, and is marked by a reduction to concreteness. Some patients come to therapy with a limited “play space”. These are considered "non-analytic" patients, concrete patients, who find it difficult to come in contact with realms of fantasy and to use symbolism. Progress with these patients entails creating such a space and initiating the ability to play. Other patients, that we define as more analytic, also enter phases in which the space is constricted; when this happens it is a meaningful indication of the therapeutic transpirations – whether between therapist and patient, in the transference material, or within the resistance associated with the hope for change.

Sophie, a 38 year old patient, a successful businesswoman, deals with the painful fact that she is not married, and with the notion that the few relationships that she has had have been failures. She speaks of being unable to grasp how this happens, since her parents are “such a perfect couple”. Despairingly, she asks again and again, "Will something change? Will I get married? Will I have children? Is there hope?" I realize that in very specific situations in the session, when we touch authentic feelings, she stops and states, "Oh, that's terrible, how hopeless. There, nothing helps." This is the moment when the play space constricts, and Sophie becomes very concrete. I ask her about the despair. "I want to be in a certain place, and I'll never get there," she says. I ask about this feeling, which I already know has been accompanying her for years – the wish to be there, and the knowledge that it will not happen. I ask about the earliest memory of this feeling. "I was 15, I had my first boyfriend," she says, "He was older than me. I wanted him to love me, I wanted to be like the grown up girls, his age. I was desperate. I knew I would never get there,

because I was a little girl." We talk about this feeling that she will be unable to compete with girls his age, wanting to be a woman while still feeling like a child, never becoming the woman she wished to be, married with children. I lead her back to the image of the ideal, admirable woman whom she speaks about so often, her mother. The woman who knows restraint, who contains everyone, listens, and knows everything. "She's God," Sophie says, "She's the paragon of femininity, and she is so wonderful that she will always protect me." This is the woman that Sophie will never be able to be. This is the woman she is forbidden to compete with, in relation to whom she can only take a rear position, protected by her mother's body, but also hidden by it. She doesn't have her own female body. Very gradually, we begin talking about the disappointment. Every time we draw near her mother's image, or when hope is raised concerning an imminent relationship, great fright and despair crop up. She then becomes concrete, informing me that nothing has changed and it never will, and how horrible that is. Every time an insight is gained she has to stop and say, "So of what use is this?" Indeed, she is not allowed to make use of the insight, as she must not compete with God. It is a sin. In these moments in therapy there is no hope. Space constricts and there is no third. The third can exist in the transitional space, and here the transitional space shrinks. I understand that in case the mother is God, that is, if she is the object, as well as the food that the object feeds the baby, then there is no transitional space. The transitional third can exist when there is mother, food, and baby, not when the mother and the food are undifferentiated. In case there is no such differentiation, the baby cannot play with the food, expel and take in, suck, or spit, because by doing so she risks losing the object. The baby cannot allow herself to play because the mother-God might withhold her food. This is a situation in which there are external and internal realities that do not coexist. The baby's illusion that she can

control the food does not exist. Developmentally, a point arrives when mother and food are differentiated; the mother is then the feeder, but not the food - even if the food is her breast, they are not one. The child can then play with the food without the risk of losing the mother and play with the mother without the risk of losing the food. This is the third that can exist in the transitional space. In Sophie's case, the limited play space is linked to the anxiety of creating the oedipal triangle. This triangle must not exist so as not to undermine the mother's status. When such a threat arises in therapy, the space constricts automatically and implodes to concreteness, devoid of room for imagination or the sharing of dreams. Therapy then "stalls" and despair sets in. Sophie, incognizant of Mitchell's words (1993), speaks of the hope and the dread, of the dread in the hope for change. We become aware that every time there is hope for change there is despair aimed at constricting hope and removing the threat of change.

Everything that is said about child play is valid for adult play as well, writes Winnicott (1971), while the main difference between the two lies in the adult's ability to speak and in the verbally communicated substance, usually accompanied by an ability to listen to it and to assess it. Nilman and Heiman (2005) discuss verbal intensity, and word use in general, as potentially forming a barrier that denies authentic entry into the psyche, thus serving as resistance. They discuss patients who have difficulty letting go of words even for a moment, who either feel a compulsion to speak in order to fill something, as a part of anxiety surrounding being empty and the need for control, or who experience difficulty in leaving room for someone else's words, because the object cannot be trusted. Verbal intensity can serve as self regulation, as an auto-erotic act when the object is experienced as dangerous, as a creation of a word-curtain that is a mode of defending against life, an action aimed at

wrapping the psyche in a kind of "second skin" (Bick, 1968); or due to a need for symbiosis and the fear of being dropped and abandoned alone in silence (Nilman & Heiman, 2005). In all cases, there is no "transitional third", but a person who avoids-fears playing.

Balint (1968) claims that expression in "adult language" forces the patient to speak in oedipal terms, at the level in which the child has already acquired language. But pre-oedipal, preverbal regression in therapy, that many of us and our patients gain from, includes abstract emotion such as usually does not carry words. Words often have difficulty reaching this type of emotion, claims Balint. To illustrate this we can make use of a work that Guy, an artist patient, brought to therapy. At a certain point in therapy Guy showed me a series of pictures in which he photographed his room, always from the same place, the same angle. The world changes and he maintains stationary in the corner of the room. The sun rises and sets, the ashtray fills and empties, and he stays in the same place. The photograph transmits a strong emotion that Guy has no words to describe. We talk about the perspective of the baby who cannot move. He sees the dynamic world around him and is in a state of helplessness and dependence. Guy says, "The baby wants to die." This series of photos presents the wordless story of Guy as baby, who all through his life has wanted to die, and who has made many suicide attempts throughout his history. During the session he is aware that now, again, he feels like that same baby, and the pain overwhelms him. He wants to shout but remains mute, wants to flee, but cannot. We feel the baby that is waiting to be approached, to be recognized, but experiences himself as one of the objects in the photo, outside the frame, possibly closed up in some room, lying alone. He has a fantasy of being part of the picture, being seen, and the act of photography itself is his way of being present, being invited to the places he is not invited to, like

the sense that he has never been invited into this life. As a photographer he is indeed still situated outside the picture, but he has power and control and cannot be disregarded. We talk about the neglected preverbal baby, a good baby, who does not cry, quietly waiting; there are sunrise, sunset, sunrise, the world goes on as usual while he waits there and dies. We are dealing, then, with a preverbal experience, that for Guy is the experience of the baby/photographer who sees, but is invisible.

In experiences from more verbal points in life, Winnicott (1971) claims that the choice of words and the manner in which they are transmitted are a type of play. Each person's unique use of words, humor, and intonation are his private mode of play. Through play the patient touches upon what Bollas (1987) terms "the unthought known", and a patient who is exceedingly fearful of arriving there will refuse to "play", remaining unable to be creative. Analysis, according to Winnicott, is a creative play of communication with the self and with the other. He considers analysis as a sophisticated play phenomenon that is suited for adults in the 20<sup>th</sup> century. And here we are, already in the 21<sup>st</sup> century, in which we might say that people are drawing farther and farther from direct "child" play, creating "safe" cyber communication. In analysis, we feel the fear of authentic play alongside the hunger for play, the wish to hide, but also the fear of not being found. All of these are part of the play process, and as mentioned, resistance, according to this conception, is expressed as an unconscious attempt to constrict the transitional space so as to prevent a real meeting with self and other.

The question of "together" and "alone" arises time and again. Is creation a joint moment? In what parts of the psyche does creation exist, and can it exist between two people? Or, as defined by Winnicott, does play transpire inside or outside? Mine and yours? Analysts in many different schools have been trying to answer these questions.

According to Balint (1968), what he terms as the "zone of creation" is an area in which no external object is present. The subject is there with himself, and his main concern is to create something from within himself. To Balint this is also the reason why we have little knowledge of the creative process, since in the zone of creation no external object is present, the subject is present there all alone, and therefore transference relations cannot develop at all. Balint's zone of creation precedes the dyadic relation between two people, not to mention the oedipal relationship of three. This is a stage where, rather than objects, there are "unorganized" and "unwhole" "proto-objects" (Balint, 1968). Only after the work of inner creation has been completed can the "creative products" communicate with an object; this is the stage characterized by exclusive and special object relations between two people, which Balint calls "the basic fault". What Balint names the zone of creation is to be differentiated, then, from Winnicott's transitional space. While Balint refers to an entirely inner space, Winnicott helps us define a space that is both inside and outside. On the one hand, this space exists in fantasy, while it also maintains contact through a real act with the external world. Play is not simply to think or to wish, it's a real action. "*Playing is doing*" (Winnicott, 1971 P. 41). In analysis this real act is the analytic couple's here-and-now play. Creation, according to Winnicott, is transitional rather than internal. I believe that the zone of creation described by Balint is the primary, preverbal unconscious process that developmentally exists before the moment of play in which actual creation is born. The primal stage that Balint describes precedes the transitional creation and involves two people's proper development from stage to stage, accruing an ability to use the object in a Winnicottian (1956) sense. This stage permits the healthy transition to symbolization and to the creation of the transitional space between imagination and reality, between

inside and outside. As described below, this is a transitional stage in which the object, too, is constantly and simultaneously internal and external.

While the transitional space is indeed a developmental stage that the infant achieves within healthy development, and each creation is achieved within healthy creative process, it is also a person's state of mind at any age. As we know, developmental phases are states that the adult person revisits over and over again. One of the examples is the Kleinian schizoid-paranoid position, a state of mind that the person returns to at different moments in life – to the good and bad breasts and to the inability to contain ambivalence. During creation a connection is established with the contents of inner reality, to be transformed into something in the external world. This is a to-and-fro process, in and out - out and in. The process of analysis is like this, too. Transitional space permits the child to play, allows the adult to play with ideas, to replace one thing (Teddy bear, blanket) for another (the soothing mother). This is the space that facilitates the moment in therapy when something is born into the space between therapist and patient; the authentic moment when inner reality becomes something in outer reality; an image, a word, a story, a facial expression.

Winnicott states that psychotherapy exists in the overlap between two play spaces, indicating that counter to traditional conception of one-person psychology, a psychology of two people playing together transpires in the room. Expressive analysis is a perspective that engages in dialogue with object relations theories and self psychology, and has an especially close affinity to the relational perspective. As implied by the definition of transitional space, the object is comprised of the external and internal objects that continuously coexist for two people in parallel. The therapist and the patient who succeed in playing with each other usher into the room their separate transitional spaces simultaneously; which, as mentioned, include for each an

internal reality, an external reality, and a third, joint space. I grasp the meeting of two people, two psychologies, that creates a third joint space, similarly. The relational third exists in transitional space, and like it, it is not only a developmental phase, but rather a state of mind. As regards technique, the focus is on the here-and-now, the therapist-patient relationship, transference and countertransference, with interpretations no longer at the center of the therapeutic process, but becoming a part of the play process that occurs between two people, shared implicit moments between therapist and patient.

"In therapy, patients and therapists alike are engaged in finding the artists within themselves..." writes Robbins (1987) "Do you know what kind of an artist you are?" Bion (1978) asks the therapist, adding that each therapist must ask himself this question in order to locate the creative place from which to apply the special attentiveness required for listening to the unconscious dialogue that the patient brings to the session. The expressive analyst must be acquainted with his own play space, as well as with his own creative process, as he unconsciously invites the patient to visit this space. Some would claim that every good analysis enables an entry into play space, and that all aware therapists assist patients to connect with it." I believe this space can only be created if the therapist himself acknowledges it and the therapeutic process as a creative process, which, akin to dreams, opens the "royal road" to the patient's unconscious. "He (the analyst) is participant in the road's construction and, we hope, in the paving of its potholes" (Bromberg, 2006, p.43). In so writing, Bromberg pinpoints the role that the therapist's unconscious has in this creation. If the patient reaches unfamiliar spaces, the therapist will probably not recognize them and will unconsciously bar entry to them. The therapist can unconsciously invite the patient to the analytic play space only when he himself can play and is acquainted with this

space inside him. The expressive therapist permits the patient to bring the creation created outside the room or to create it in the room concretely or metaphorically. The therapist treats the creation like a dream or a fantasy. And although concrete creation does not necessarily have to be brought into the room, it constantly exists there with “talking as dreaming” (Ogden, 2007) and “talking as playing”. Transitional space, according to Ogden, supplies the patient with the ability to give birth to the analytic subject that did not exist before (Ogden, 1992). The analytic play that Aron (1992) describes includes the use of both the therapist's and the patient's imagination and creativity, the ability to reorganize, the ability to reframe, and creative work with interpretations serving as playful raw materials. Bion (1978) claims that we don't work in a scientific laboratory, but rather in a studio - a studio in which the therapist's artistic vision sharpens to discern the global experience presented by the patient.

Expressive analysis is an approach centering on observing the psyche that uses the same tools with which we observe primary creative processes, and it is associated with the comparison drawn by Freud between the similar processes of dreaming and creation. Thus, for me, the therapeutic setting, which is the therapeutic contract drawn between the therapist and the patient, also defines an expressive psychological idea according to which what happens within the framework will be perceived differently than what happens outside of it; the rules of thought of external reality do not hold for reality within the room, which is a transitional reality between internal and external reality. As a patient said, "Therapy is a dream and dream laws apply to it, everything is possible in it, it's real yet unreal, there don't have to be logic or logical connections during the session, and when I leave I feel like I have to return to reality, like I've awoken." The rules of play, then, are that everything is both real and unreal, and that we have the liberty to "play" with ideas, to write, to erase, to hide,

to be discovered, to love, to hate, and all of these simultaneously, without being considered a contradiction. A patient conveyed to me that therapy is a dream that he often forgets the minute he leaves the room. Bromberg (2006) speaks of working with dreams and reminds us that historically, many therapists did not believe that the patient can enter what Freud termed "another world" (in the sense of reliving a dream that he dreamt) during the session; therefore, they entered the dreaming part without losing the patient's waking part. If we consider this claim within the context of the analytic process and the therapeutic session, I would agree that the patient is "dreaming" while simultaneously holding on to waking parts of reality, even if he does not always express them and although he does not always need to be assisted by them. With the aid of the therapist, the patient can make space for the "dreamer" based on the understanding that the one who is "awake" is present even if unfelt, and that this will assist the patient to reach primary contents and inaccessible parts of the self. There are people who can enter "dream reality" during the session with greater ease, and others that find it more difficult, but most patients have entries and exits, "awakening" and "falling asleep". Bromberg writes: "In potential space, each party allows himself to experience the other's waking reality as if it were his own dream" (Bromberg, 2006, p. 40). The analytic process according to Bromberg combines an interconnection between the multiple realities of both persons. In this sense, it is a meeting of two people constantly immersed in both inner and outer reality, real and fantastic at the same time.

In this sense, creative blocks and blocks in therapy stem from the same roots. Maya is a 30 year old patient, who talks in therapy about her creative blocks that disturb her very much in her work. Maya defines them as a fear to create in the presence of people; in her work she is surrounded by people, creators themselves, and

one must be creative. We understand that in therapy this emerges as her being unable to "create" next to me or play with me. She feels un-spontaneous, that she must constantly stay on guard, and she cannot allow herself to play. She usually comes to work and to therapy with fabulous ideas that she has created at home alone. Maya can share them, but cannot expand on them or feel them. She talks about her ongoing awareness of others' presence, my breaths, my facial expressions, and of the difficulty reaching a space in which she has "inner freedom". We gather from her history that she must "restrain" herself lest she destroy the other, just as she has "killed" her father physically, and her mother emotionally, during childhood. Confusion between inner and outer worlds set in surrounding her father's death, together with fantasies ascribing what had happened to her being a bad, stupid girl. Her mother, who had presumably sunken into a deep depression, stopped speaking to Maya, and so she ceased to exist, too. Maya had thus lost both of her parents at once. When her father died she lost her whole world. She tells me that the childhood period preceding the death was characterized by a stupid child's spontaneity: "I used to sing and dance and play, I was terrible." Now she cannot do any of these, and they are experienced as dangerous. In play there is a kind of freedom that she cannot allow herself. If she creates near me she might harm me, kill me, again being the bad, stupid girl who annihilated everyone. In order to come back to life Maya must retrieve the child she got rid of, along with the qualities this girl had had. Slowly, as she experiences me surviving and herself as less destructive, as she gains awareness of this child's feelings and the subjective experiences she had had without grasping what they were, I sense a play space opening between us, initially marked mainly by humor, and gradually permitting more use of imagination and the lessening of concrete talk.

Expressive analysis provides us with a way of thinking about the therapeutic process, a way to understand ourselves and our patients and facilitate their ability to play with us and to use the room in any creative way that they choose.

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