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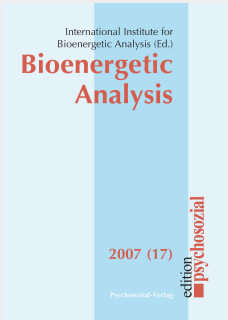


Bioenergetic Analysis
17. Volume, No. 1, 2007, Page 105–133
Psychosozial-Verlag
DOI: 10.30820/0743-4804-2007-17-105

Bibliographic information of Die Deutsche Nationalbibliothek (The German Library)
The Deutsche Nationalbibliothek lists this publication in the Deutsche Nationalbibliografie; detailed bibliographic data are available at http://dnb.d-nb.de.

2007 Psychosozial-Verlag GmbH & Co. KG, Gießen, Germany
info@psychosozial-verlag.de
www.psychosozial-verlag.de

Cover image: Theo van Doesburg: *Heroische Bewegung (Heroic Movement)*, 1916
Draft design: Atelier Warminski, Büdingen

https://doi.org/10.30820/0743-4804-2007-17
ISBN (PDF-E-Book) 978-3-8379-6887-3
ISBN (Print) 978–3–89806–704–1
ISSN (Online) 2747-8882 · ISSN (Print) 0743-4804

Embodied Comprehension: Treatment of Psychosomatic Disorders in Bioenergetic Analysis[1]

Jörg Clauer

Summary

Bioenergetic Analysis should prove to be the method of choice in the treatment of psychosomatic diseases. Patients with psychosomatic dissociation need an embodied dialogue with the parent-body of the therapist, i.e. non-verbal somatosensory awareness and attachment as well as verbal dialogue. For the basic construction of a new embodied self the three **Ss** are needed: Slowness, Safety and Support. In this way the process of therapy supports bodily self-awareness and agency, and a change in the implicit relational knowledge of patient and therapist is co-created. Inevitably, the therapist shares the dissociation of the patient and attunement is disrupted again. By acknowledging his »faults« the therapist regains his self-regulation and is thus available for the regulation of the patient's somatosensory states and emotions. The new implicit knowledge leads to changes in the »mental organizing principles«. This is shown by an extended case history of ulcerative colitis. Finally exercises and techniques helpful in the work with psychosomatic as well as traumatized patients are described. In this context triangulation is a useful concept.

Key words: Psychosomatic dissociation, basic creation of an embod-

1 Slightly changed and extended version of a lecture and workshop held at the international conference for Bioenergetic Analysis in Cape Cod, Mass. 5/2005. The extension concerns the work of Beebe & Lachmann 2004, Benjamin 2005, Schore 2005 and Stern 2005, which meanwhile have been published.

ied self, self-efficacy or agency, parent-body, implicit intersubjective knowledge, triangulation, balance disc, rope, teething ring

Introduction

As Lowen noted, a core belief of Bioenergetic Analysis is that there is a *functional identity of body and psyche – and the body doesn't lie! According to this, we, bioenergetic analysts should be* the experts for the treatment of »early disorders« and, in particular, psychosomatic diseases! But there are surprisingly few articles and books to be found in the area of bioenergetic literature where psychosomatic diseases and their treatments are explicitly described (see Büntig 1996, Mahr 1991, Svasta 1984). Ehrensperger (1991) made an interesting attempt to describe a theoretical concept for the bioenergetic view on psychosomatic diseases. Lowen & Pierrakos (1970) and Lowen (1985, 1986, 1991) wrote articles on cancer, migraine, Morbus Crohn and all of them demonstrate his great intuitive diagnostic abilities, but like Ehrensperger he described only a few therapeutic methods and no statements concerning the relational dimension in long-term courses of treatment.

Due to their faulty bonds in early relationships patients with ulcerative colitis or Morbus-Crohn have a weak self-awareness and body-core-self. Lowen (1986) regarded these diseases as a dramatic exhaustion of body and mind. The patients deny the exhaustion and struggle to continue functioning as usual, to conform and to impress (with an ideal image of themselves). For that reason a relief of strain and a corresponding regeneration are often difficult to achieve. According to Keleman (1985) they are energetically »collapsed structures«. Self psychology describes the psychosomatic fragmentation (or better dissociation, according to Schore 2005), in which one's body and mind are felt to have irrevocably separated, as a variety of self-loss experience (Orange et al.1997). Neurobiology explains Lowen's experience today: »In the case of relational trauma-induced dissociation, under conditions of massive default in metabolic energy production for basic brain/mind/body function, there is not sufficient energy to con-

struct the biological state that sustains cohesion of self function and thereby subjectivity«. There are: »specifically, functional deficits that reflect structural defects of cortical-subcortical circuits of the right brain, the locus of the corporeal-emotional self« (Schore 2005,P.421).

This work describes a psycho-somatic, long-lasting and often difficult stimulation of the energy and growth of the self. With my patient the bodily emotional attunement (empathy as a right brain resonance) was a necessary basis. The key is the use and perception of the embodied countertransference (see Clauer 2003b, Downing 1996, Heinrich 1999, Lewis 2005). This enables the patient to experience and administer his self in contact with the therapist's »parent-body« in a new way. From understanding the world in a monitoring-intellectual (explicit) way the patient grew into comprehending the world from a secure anchoring in the body-self.

It is not easy for the therapist to maintain an overview without developing the illusion of being in control of the process. The attunement (like in the mother-child dyad) is a mutual developmental process where both partners have a stake (co-creation). Like intersubjective/relational psychoanalysis (Benjamin 2005 and Ferenczi 1933) I emphasize the point that this process and the attunement are going to be inevitably disrupted and breached again. If these interruptions aren't ignored or denied they contain the great opportunity for a curative reorganization. It's vital that the therapist opens up to the distraughtness from the perspective of the patient. In doing so, he shares the dissociation of the patient and serves the implicit and explicit relational knowledge and the growth of the self.

Commented Case History

The Patient at the Door

My patient (»Suzan«) came into my office with a seasonally dependant depression. She had phobic anxieties of gatherings, fear of contact and sexual indifference, although she was feeling safe and sound in her

marriage. She was on the brink of finishing her systemic science studies, which were accompanied by work problems and self-doubts. Like other relatives in her father's line she suffered from an ulcerative colitis. With her first boyfriend at the age of 16 she developed weeping spasms triggered by tenderness, but both were strongly attached to each other for many years. With the second one at the age of 24, however, she immediately and for the first time in her life felt safe and sound. When he was killed in an accident a month later her shock was so much the worse. Since there were no stabilizing and sympathetic relationships she got frozen. She was in the midst of her final examinations in applied economics and continued working without bothering or being able to mourn. In the following the first colitis crises appeared as well as a first major depressive episode.

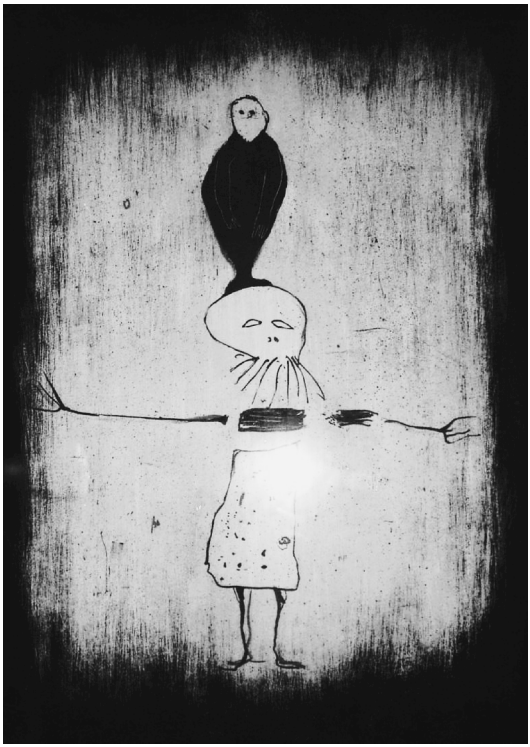
The History of her Life

The patient's mother was a nurse. The door to her parent's house had always been wide open to all people – even strangers – in need. During holidays the parents also took care of an older foster child who was known to assault children of her age. Instead of protecting her, the catholic parents made a massive demand on her to take care of others.

For many years the grandfather, who was suffering from Alzheimer's disease was being nursed. Sickness of the children was seen as a personal offence to her mother. On the other hand she is still claiming distinctive attention to her needs or care from the patient. Suzan described her as being emotionally demanding and easily offended. Each attempt at autonomy was answered with a threat of loss. A framework of a positive, mutual relationship and the mother's useful response especially for the protest of Suzan were missing.[2]

2 See Schore 2005 S.417: »…at the level of psychic survival helplessness constitutes the first basic danger. This helplessness is a component of the survival strategy of conservation withdrawal, the early appearing primitive organismic defense against the growth-inhibiting effects of maternal over- or understimulation.«

Before starting her therapy with me she had had inpatient- and outpatient treatment, which according to her had both been helpful. Her statement »I've never been able to set any limits or to get angry« sounded as if it would be our motto for the therapy. Physically her thin extremities with flat and narrow feet attracted my attention. This was in line with the global impression of a flaccid-schizoid structure (Ben Shapiro, personal communication). According to DSM-IV beside a depression and colitis the diagnosis was a developmental disorder with depressive-anancastic narcissistic character traits and an alexithymia.



At the end of her therapy Suzan brought this picture. We investigated its meaning in the same way we did with her dreams. She found that it expressed her state of self-perception at the beginning of therapy.

In a World of Psychosomatic Dissociation

Suzan was a brilliant systemic scientist, able to understand many different things – but could hardly find her way to implement herself in her body and in this world. She never trusted her body and was almost proud, when she told me about switching it on stand-by (psychosomatic dissociation). Her self-portrait at the beginning of therapy consisted of a head only. Her self-confidence was totally dependant on her performance. She only had few memories of her childhood or grieving school days. During her therapy she started to lament having no memory. However, the more she felt at home in her body, the more memories appeared.

The Balance Disc as a Step towards Healing Dissociation

At the beginning of our therapeutic work I immediately invited her to use the balance disc.[3] The experience of using the balance disc provoked uncertainness for Suzan. And the following exercise – to stand on the floor breathing into it and to imagine a tree and its rooting – made her scared of profound dolefulness (a black hole she didn't want to talk about). She might have felt a lack of being anchored in her body-self and our relationship. She experienced this lack as emptiness and nothingness. Nevertheless we could examine the context of her experience, namely her relationship to the therapist. This led her to

3 This encourages »grounding« in a playful way and at the same time enhances the integration of the most important proprioceptive body perception combined with equilibrium sense and visual perception (the »subjective anatomy«, Uexkuell et al. 1997). This work introduces a change of perspectives too. It is an indirect way to change »cephalic shock« (s. Lewis 1984, 1986). The holding of the patient's head in a lying position combined with a massage of the neck and the skull was only possible at a later stage of therapy. Lying means in therapy situations to entrust oneself to the therapist. The patient has to have confidence in the relationship as well as in her body-self. Otherwise, mobilized fear leads to aggressive or passive self-protection. Suzan was so afraid of lying in the room that she resisted working in this way.

being able to grasp me as a support. – [When she grasped me, her tree (her self) experienced a support like with a plant stake and then could start rooting.] – Only then Suzan started liking this exercise and she was able to include it in her daily life.

Other offers for using physical work like for example »Do-In«[4], a comprehensive method to encourage body perception, the inner structure of the skeleton and »grounding« via a kind of self-massage were never accepted by Suzan even on repeating the request. Her self-perception and grounding developed more by touching a rope on the floor with the sole of the feet or balancing on the rope at my hand (like children do at the hand of their father). Strengthening exercises for the ankle joints or the arc and the elephant again made Suzan panic. In the first two years the following subjects were emphasized: Exam nerves, difficulties in delimitation and self-assertion, feelings of isolation, loss of the self and of existential threat (particularly during her illness episodes).

Dialogue with the Therapist's »*Parent-Body*« promotes Self-Consciousness

The investigation and growth of the true self and its boundaries a patient can only explore – physically and mentally – in a relationship perceived as sufficiently secure. To help Suzan with this I invited her to push with her hands or other body parts against a wall or later against me. Her panic showed us an increasing aversion of Suzan to getting involved in such exercises! Not pushing against a limitation but feeling herself in contact with me encouraged in Suzan the necessary perception of her bodily self! It took a long time and patience until she was able to perceive and develop out of herself personal limits and impulses originating in an inside movement. Only then could she begin to explore who and how she was and what she could effectuate. Before that I had been a threatening person for her (like her mother or

4 »Do-In« is a Japanese massage which supports body-perception, grounding and feeling oneself into the inner structure of the skeleton.

her classmates) whom she had to watch in order to protect herself.[5] This generally applies to patients with psychosomatic disorders.

The Development of Aversive/Aggressive Emotions – Stabilizing Affect Regulation

Suzan now started to sense that she had suppressed her disappointment (and rage) at family reunions regularly. During the first two years my supporting presence and continuous willingness was necessary: to regulate emerging tensions of colitis crises as well as depressive decompensations due to family conflicts. During colitis crises I often worked with techniques from Body Enlightenment (Clauer 1997, Clauer&Heinrich 1999). I put my hand on her abdomen and guided her to imagine a warm healing solar energy in her belly. It reminds of the work Lowen (1986) did with a woman with Crohns' disease. The calming body contact together with the symbolization creates an effective healing atmosphere, as it does in children too. This alleviated the symptoms. Often it was difficult for me to maintain confidence in the therapy process and in the development of Suzan. These self-functions have been exactly those she did not possess adequately.

Moberg has given us scientific proof that touch stimulates via the hormon Oxytocin the calm and connection system, which is the opposite of the fight and flight system. In this way pleasant touch and warmth especially at the front side of the body activate the parasympathetic system, growth, healing and social learning. – The touch at the belly together with warmth as well as the stimulation of the breastbone seem to effectively use this process.

5 Regarding development from a psychological view, one can say that a lack of acceptance, empathy and communication in early years can lead to a perception of the other subject as an obstacle, a feared judge or an exploiting object (malignant object representation) (Benjamin 2005).

Embodied Countertransference of Aggression

When she was severely depressed, we often sat back to back also. In doing so I got painful tensions in the area of my midriff. Since I often sit back to back with my patients, I can determine that these tensions emerged in the contact with Suzan, representing an embodied countertransference reaction. She herself was not aware of aggressive tensions and emotions. Thus she had a high expectation with regard to my regular presence. As a matter of course she kept her job-related appointments, wishes and obligations and interrupted and cancelled the therapy for this. I sensed in her one-sided engagement her aggression[6] as my perspective. She was so adapted to a relationship like this, that she could not realize it.

Co-Creation of Aggression

During times of my vacations Suzan felt defenseless and abandoned. One time she was in a really bad condition, mentally and physically, suffering from a colitis crisis. She asked for an additional appointment before starting my vacation leave. I recognized her misery and felt responsible and obliged not to abandon her like this (the same way she felt towards her mother). At that time I was very exhausted and had no further resources in my time schedule. Nevertheless I fixed an appointment with her outside of my normal office hours – *and forgot to attend this appointment!* I felt very bad about the way I got tangled up. After my vacation I was expectant in anticipating her reaction. But she only reported that it had been »displeasing« for her. Even when I insisted it wasn't possible to talk it over with her. It was depressing to feel that she could perceive and bring up neither her disappointment nor her anger on this matter. I was aware that we had co-created a situation similar to

6 Put into self-psychologist's terminology, she needed me and used me here as a self-object (Kohut 1971, Milch 2001). The need of a self-object which emerged during therapy could be seen as one of her basic principles of self-organization (Stern et al, 1998).

her childhood experiences. Approximately one year later, on the occasion of a new vacation of mine, the mutual trust was so much further developed that as I approached her on that back-dated matter, I found out from Suzan how dramatic this event had been to her. She had even contemplated the possibility of abandoning the therapy.

Acknowledgement Creates an »Open Space« for Change

Beside my exhaustion there was a complementary countertransference reaction: Her mother continuously asked too much of herself and others. (Suzan had learned to deny her wishes and boundaries and felt she couldn't abandon her mother). Like her I asked too much of myself and did not show my limitations clearly (see Heinrich 2001). – My dissociation in this crucial »Now moment« of therapy caused a real abandonment of Suzan.[7] – The later acknowledgement of my »fault« and limits became an important experience for her and opened a door for new possibilities within our relationship. A »now-moment« which had passed unused for a »moment of meeting«, had returned here and had thus not got lost (see Stern et al. 1998, Stern 2005).

Further Unfolding the Self and Aggression in the Therapeutic Relationship

After having broached the issue of this incident again and furthermore having acknowledged her disappointment and anger[8] we worked back to back more frequently. While sitting back to back she could look out of the window. During this session she reported on her experience at the choir, the way it was offensive, invidious and painful when the choir director ignored her, for example. She was

7 This reminds to the comments of Schore (2005): »…the caregivers' entrance into a dissociative state represents the real-time manifestation of neglect. Such a context of an emotionally unavailable, dissociating mother and a disorganized infant … is totally devoid of mutually regulating interactions. Rather, both mother and infant,

very unforgiving for such incidents and cold-shoulders this person – he's literally »dead«. Not a big surprise, in this session once again I felt pain in my back. I carefully started studying her physical experience, instead of giving an interpretation about the anger – as one might suggest. She didn't feel her back, but described a kind of protective armor or »wall« in the breast region or at the front side of the body. Due to my further enquiry on this matter she recognized that her attention wasn't focused at all on her body but outside in fantasies – she was dissociated from her physical experience. During the session we slowly advanced her apperception of her back. She was able to perceive more and more, that in the area where I felt pain she had a diffuse aching and at the same time perception[9] of non-contact. As a result she started pushing against my back. Until then such pushing against resistance provoked panic in her. *After she felt accepted within her self with the help of my acknowledgement, she could follow her impulses less frightened*. Lying later on the floor, with her feet against the wall she started subsequently pressing her head and shoulders against my hands. In order to be able to push me away she was obliged to perceive her own aggressive, powerful impulses. Her mother had taken possession of her, violating her boundaries. Suzan now could use my *parent body* (take possession of me) in order to restore her-self following her proper impulses. She finished this session with the request to sit at the wall and for the first time I had to sit next to her on her right side instead of in front of her. She didn't need to anxiously control me any longer. She found her subjective anatomy (Uexküll et al. 1997), her body self after a phase of dissociation and depersonalization.

although in physical proximity, are simultaneously autoregulating their stress, in a very primitive manner, in parallel but nonintersecting dissociative states.«

8 The therapist did not need to dissociate any longer in contact with the patient's dissociative experiences. If the therapist accepts his own weakness and mistakes, he will gain back his self-regulation and he will be available to the patient's regulation of feelings (compare Benjamin 2005, Resneck-Sannes 2002).

9 Suzan's feeling of abandonment which were provoked by me resembled not only her feelings in the past when she felt abandoned by her mother but also when she lost her beloved boyfriend by an accident. She could only cope with her lack of human contact by dissociative numbness and continuous functioning.

As in a playful dance she unfolded her self perception and self expression within the embodied relational dialogue. Her thereby strengthened self-confidence permitted it to have me as being »the other one« next to her. This is an example of the *co-construction (co-creation is more appropriate, as I see it)* of a new way of *being-together-with-the-other* (Beebe & Lachmann 2004). There was communication and no longer this silent void, this vacuum, this *black hole of nothingness*. Instead of a dissociated context of a One-Person-Psychology now there was an intersubjective field within the context of a *Two-Person Psychology* (cf. Schore 2005, p.415).

The Developing Body-Self and New Implicit Relational Knowledge Leads to Changes in the Mental Organizing-Principles

In order to encourage self perception and in particular agency, I now asked Suzan at the beginning of each session to decide about her preferred way of working. Often she asked me to hold her head while she was lying on the mattress. I always invited her to find her own tone. This took a long time until a cautious, soft tone emerged from deep inside her (although she sang in a choir in her spare-time). At the same time she started recognizing a tension which began in the neck area turning downwards and affecting the back and even the small of the back. In the further progression she learned to recognize this tension as being associated with aggression. One session within the shelter of the subject to subject experience in a particularly intensive way she experienced grief and feelings of abandonment and a panic of the sorrow of emptiness (being not recognized and getting no resonance). She had to painfully experience abandonment more than once in her lifetime (The end of the therapy had already been picked up as an issue at this stage). This time Suzan stayed in contact with herself and did not lose her own tone. Her self perception was now evidently encouraged in such a way that she reported the following during the next session:

> »After the session I was on my way to my work at university by bike when for the first time in my life a clear and uninhibited furiousness about my mother assaulted me.« She described this process in a clearly structured fashion – it persisted exactly one block by bike. Her grief and anger were now directed at her mother since she was the original cause of her pain. (This is to be seen as a determining sign of mental and physical health according to psychologist and emotion researcher Traue 2005). According to Stern (2005) in this »Present-Moment« the implicit relational knowing that she had experienced before in the context of the therapeutic intersubjective field rises into explicit consciousness.

Now she felt how much she had missed, how much she had been deprived and how much disappointment and anger existed towards her parents. She reported that during these minutes her inner relationship with her parents had changed. The feelings towards her parents, of being careful, being not allowed to offend them and the obligation to show respect had subsequently disappeared. Her overall inner structure of thinking and experience had changed with the perception of her real emotions, she said. She described that with the tempered or suppressed grief and anger all her energy was lost in the past. Now it seemed to be more complete and whole. This process of change continued and was comprehensible at the increasingly clear delimitations towards her family.

Dreams as a Feedback Loop

Suzan often brought visions and dreams into the therapy. With the benefit of hindsight these visions appear like a continuous reflecting and feedback on her part about her relationship and its experience towards me. In the beginning the feeling of existential threat and persecution predominated her visions. So she dreamt that she would be killed by injections in the hospital. With increasing security the threatening parts in her visions weakened. Later two men appeared (her husband and her therapist) who entered new worlds together with her, for instance diving through a water swirl into a canyon. This canyon now for the first time wasn't bottomless but had a visible

basement (obviously she had an increasing grounding in and perception of her bodily-self). When she was hanging above the precipice she was able to rescue herself (increasing agency). These dream pictures mirrored again how her self-perception changed after I had acknowledged her justified anger against me.

In the beginning of her therapy she handled the world in a monitoring and controlling way (as a systemic science student). At the end of the therapy after she had developed a familiar security in the physical and emotional contact with me, she dreamed about a world she could touch and comprehend. There were bridges over a canyon to a new world, which was animated with aggressive pictures and trees[10] and seemed attractive to her. The access to the bridges was blocked by edible materials (her digestive tract played a major role in her access to aggression). At the same time there was a high place from where she was able to see both worlds. – Her desire to connect both and our repeated struggling for access to her feared aggressive affects and pictures (or inner object worlds) were captured in this dream. It also showed that she would be able to continue her struggle for integration of her partial selves independently after therapy. An appointment at the doctor's confirmed this: To the amazement of the gastroenterologist the colitis-changes were not any longer detectible at a post-examining colonoscopy. Depressive decompensations didn't occur during the last winter season. On the basis of a relationship with my »parent body« as well as the mutual searching of unfolding her original self, the movement finally emanated vital processes of growth.

10 Aggressive pictures (resulting from the relationship with me) and the tree (resulting from the experience with the balance disc) probably stand for the therapy, which she perceived as her second life.

Some Thoughts about Psychosomatic Disorders

Answers to Cartesian Dissociation

Western civilization's way of thinking and especially the thought of western medicine have been influenced by a body-soul dichotomy since Descartes. In its history psychoanalysis excluded psychotherapeutic pioneers like e. g. Reich and Ferenczi. It shows how deeply rooted this split is. Instead, the monadic and Cartesian viewpoint of the abstinence principle, the metaphor of mirroring and the principle of neutrality showed the more distant approach of Freud. His initial attempts to develop a physical/ energetic point of view weren't again taken up by him later: I quote from Freud's (1927) basic work »The ›ego‹ and the ›id‹«: The ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body, also as we have seen above, representing the superficies of the mental apparatus.« This description by Freud will seem almost visionary if we look at today's trends of research and thinking!

The Neurobiological and Developmental Psychology of Dissociation

Neurobiological research (e.g. Schore 2005) shows that human attachment behavior / the developing self system is located non-symbolized in the early maturing emotion-processing *right brain hemisphere* and the limbic system. This corresponds to the emerging and body-core-self phases according to Stern (1985). In the first 3 months of life the baby develops his own organismic perspective as referential standard for the following journey into the world of intersubjectivity. »The right hemisphere is dominant in human infants and for the first three years of life … more so than the left, forms extensive connections with the emotion processing limbic system and the autonomous nervous system (ANS) which regulates the functions of every organ

in the body« (Schore 2005). As implicit memory those early corporeal-emotional experiences of relationship and bonding decide our lifelong abilities of resonance (empathy and embodied countertransference) that is a subconscious communication of one person's right hemisphere to the other person's right hemisphere. These »organizing principles« of our self are gradually mentalized during our development. These »mental projections« (as Freud said) or rather »explicit knowledge« are of secondary nature, but nonetheless an immensely important highest level in the self-development-pyramid.

A baby possesses abilities for the necessity of human attachments as a human inheritance. The matrix of this intersubjective relatedness, cocreated by the baby and the caregiver, is a primary motivational system according to Stern (2005). However, the mother helps the infant with her empathy to adjust its state of excitation and its physical balance. The ripening of the complex brain structures depends on this adjustment. – »Recent neurobiological studies in developmental traumatology indicate that the infants' psychobiological response to trauma is comprised of two separate response patterns, hyperarousal and dissociation. – … this state of fear-terror is mediated by sympathetic hyperarousal, – … a longer lasting traumatic reaction is seen in dissociation, in which the child disengages from stimuli in the external world and attends to an »internal« world. – … in the case of relational trauma-induced dissociation…a »depleted« self characterizes an organismic state of dysregulated parasympathetic hypoarousal, dissociation, and excessive energy conservation, subjectively experienced as an implosion of the self, wherein there is not enough energy in the brain/mind/body system to form interconnections responsible for coherence. This would be clinically manifest as an anaclitic depression …« (Schore 2005). It is easy to find Suzan with her psychosomatic symptoms and Lowens' intuitive view in these descriptions, as well as the value of Moberg's (2003) research.

How Distance-Culture Gives Way to Dissociation

Two issues in Suzan's therapy have not been mentioned yet. As other babies, she grew up in baby carriages, playpens and similar carriers, distant from her primary caregivers.[11] I called this »western distance culture« (Clauer 1997, 2003a). In addition, rules like right-hand-writing were taught to her very strictly, as it was usual in Germany for a long time. Suzan like other patients of mine experienced this (pedagogic) disciplining as »brainwashing«. The further development of the right hemisphere is thus hampered and the development of the left hemisphere is emphasized. Above all, the combination of the left and right hemispheres' modes of assimilation can be hampered. Dissociation should be a shifting from the right to the left hemisphere (see Benjamin 2005). So I conclude that the experiences mentioned above promote the tendency for psychosomatic dissociation. Dominance of secondary over primary process and the importance of symbolization have been emphasized for a long time in psychoanalysis, an approach which has its limitations in the treatment of such problems. This assumption of mine is confirmed by Schore (2005): »Note that the system that underlies *psychotherapeutic change is in the nonverbal right* as opposed to the verbal left hemisphere«, – and Stern (2005): »The basic assumption is that *change is based on lived experience*. In and of itself, verbally understanding, explaining, or narrating something is not sufficient to bring about change« (underline by author).

Ehrensperger (1991) stressed that psychosomatic patients' subdominant right brain-hemisphere and their emotional expressions are underdeveloped. If the right hemisphere is activated, the hypothalamus stimulates the production of T-lymphocytes and the immune-defense. In Bioenergetic Analysis integration processes of the left and right brain-hemispheres are facilitated e. g. by training on the balance disc. Tests with golfers and basketball players have shown that those who trained on the disc hit the hole or the basket better (Klöpsch 2005). For many patients it is helpful to knock on their breastbone with the fingers and thus stimulate it, combining this exercise with a

11 Also patients »grow up« physically distant in a psychoanalytical therapy.

sentence like »me first«. It stimulates the feeling of self-confidence and boundaries (and the immune defense too? The thymus is directly situated behind the breastbone (cf. Moberg 2003)). A perception of one's own body and its boundaries and the ability to say »no« without loosing contact strengthens the body-self with a consolidation of the ego-functions.

The Embodied Dialogue and Acknowledgement of the Perspective of the Patient Heals Dissociation

In the same way as babies and caregivers form a dialogic or intersubjective system of relationship, this happens later in each relationship, especially in that one between patient and therapist[12]: They co-create a relational framework in which the »organizing principles« reveal themselves and are maintained and transformed (physically, emotionally and mentally). Psychosomatic patients, like Suzan, suffering from an insecure sense of self, need to develop their basic self functions (such as self-awareness and self-efficacy). In contrast to the predominant verbal dialogue of relational / intersubjective psychoanalysis (Mitchell 2000, Orange et. al 1997) this happened here in a bodily and verbal dialogue[13] (Clauer 2003b, Downing 1996, Heisterkamp 1993). I call

12 Buber (2002) talked about this dialogue principle: »There is no pure »ego«, but there is the »ego« of the etymon »ego-you« and the »ego« of the root »ego-it«. […] Who says »you«, has no »it«, has nothing. But he / she stands in a relationship«. Buber here mentions the fundamental essence of the human being's »ego-you« relationship. Dissociation also is a »standing-no-longer in the etymon »ego-you«. I would say: Who is being separated from the »ego-you«, also dissociates from his body. Who is dissociated from his / her own body, is also dissociated from the »ego-you« root.

13 I found corresponding viewpoints in Resneck-Sannes 2002 and Stern 2005: »Present moments involving intersubjective meetings are based on people with embodied minds who act and react physically as well as mentally. The phenomenological approach … assumes that the mind is always embodied in and made possible by the sensorimotor activity of the person, that is interwoven with and cocreated by the physical environment that immediately surrounds it, and that it

this: »embodied dialogue«.[14] There is no dialogue which is not also physical – but there are dialogues without symbolization or words (see Krause 1983). The therapist's »parent-body« is the primary instrument for the psychobiological attunement and with acknowledgement of the perspective of the patient a basic grounding for therapy.

Moments of Meeting, Attunement Disruption and Repair: A Core of Psychotherapy

Moments of Meeting

Sensory-affective and motor-affective experiences – more than verbal therapy alone – offered to Suzan opportunities for feeling her-self and safety within the relationship. If repeated, such physical and emotional relational experiences perceived as secure will slowly instigate changes in the neuronal organization of the right brain and the limbic system, in previous metastable patterns of self-organization. Then the patient does not share the perspective familiar to the therapist. A disruption of attunement and empathy can be the consequence. Missing my appointment with Suzan was a prominent and well documented example only of many smaller and bigger breaks that occurred in the therapy-process. In a state like this the therapist feels lost and not in contact with himself and the patient. In doing so he shares the feelings and emotional state of the patient: a dissociated context of painful silent void, a black hole of nothingness. It is hard to bear for the thera-

is constituted by way of its interactions with other minds.« – »Neurobiologically speaking, this prereflective experience of intersubjective openness can be seen as emerging from mechanisms such as mirror neurons, adaptive oscillators, and other similar processes likely to be found soon.«

14 This phrase contains the contemporary thinking of Lakoff & Johnson (1999): »Philosophy in the flesh. The embodied mind and its challenge to western thought.« In their philosophical and linguistic examinations they tackle the question of how human experience and language is organized along physical-sensorial patterns.

pist as it is for the patient. Stern (2005) calls this a »*now moment*«: »These are moments of *kairos*. They test the therapist and the therapy. They set the stage for a crisis that needs some kind of resolution. The resolution occurs in a different special »present moment« called a »*moment of meeting*«.« Those moments cannot be planned. In my model they happen within a relationship like an earthquake after a continental drift.[15] In a positive case implicit knowledge is newly organized in a healing way and leads to a change in the way of »being together with the other one«. Within the »open space« that follows the »now-moment« the »mental organizing principles« of the self can change too (they must not for a change of being; see Stern et al. 1998, Stern 2005, Mitchell 2000). It seems, Klopstech (2002) tried a similar integration for Bioenergetic Analysis when she calls the simultaneity of a bodily, emotional and cognitive insight an »energetic insight«. Suzan described such a change in her explicit knowledge in the story about her experiences on the way to university, having a new feeling of boundaries in regard to her parents and finally being able to express anger towards them. My acknowledgement of her perspective hence was a moment of meeting and supported her self development.

Disruption and Repair

My assumption is that the rhythm of disruptions and repair in relational attunement make up a core part of development and psychotherapy. It seems such blunders belong unavoidably to an ongoing therapy. Instead of disclaiming these events for reasons such as abashment or urge for perfection they represent a big chance – when taken into consideration on handling the ongoing therapy. If one has too much fear of being fallible, there is a danger of concealing mistakes or getting rigid by compulsively trying to avoid them (compare Beebe & Lachmann 2004, Orange et al. 1997, Stern 2005). According to Ferenczi (1933) »it is unavoidable that the analyst impairs the patient and thus, the patient notices that and reacts towards it. The analysts' repetitions and participation are inevitable. There can be made a distinction between the analyst and the original offender due to the analysts'

willingness to accept what has been denied so far. He is willing to take responsibility for his difficulties to tolerate the feelings that emerge in the intersubjective relationship with the patient« (Benjamin 2005).[15]

Finally Suzan felt at home in her body, she was grounded in herself. With this new implicit and explicit relational knowledge she was able to comprehend the world. For this process I use the term »basic creation of an embodied self«.[16] Bioenergetic Therapy of psychosomatic patients then could be named: *Resomatizing therapy of right-hemispherical deficits*.[17]

Exercises and Tools in the Treatment of Psychosomatic Patients

The Context of Intersubjectivity

I always evaluate the effectiveness of bioenergetic exercises in individual therapy within the context of the therapeutic relationship. I consider the conflict between the energetic and the relational perspective in Bioenergetics as based on Descartes' viewpoint. It sounds to me as if to ask the question, if I better live with my right or my left brain? And it is far beyond Reich's insight, that body and soul are two embodiments of our life. I disagree with Klopstech (2000), who refers to M. Stark. She made a distinction in Bioenergetics between: one-, one-and-half- and two person-psychology. I believe that Stark tries to

15 As in psychoanalysis, this process assumes that the therapist is able to adopt responsibility for unavoidable moments of his own dissociation (his conflicts and problems in handling and bearing painful aspects of his own personality) in dialogues with his patient and does so.

16 I refer to Guy Tonella's personal suggestion.

17 (according to Schore (2005): »… Krystal terms desomatisation. Impairments of these right-brain functions preclude an adaptive capacity to evaluate external-social and internal-physiological signals of safety and danger.« And stressed by Stern (2005): »With an emphasis on implicit experience rather than explicit content, therapeutic aims shift more to the deepening and enriching of experience and less to the understanding of its meaning.«

save in this way the old monadic-psychoanalytic and Cartesian viewpoint as a possible perspective. I emphasize in this article: *All I do and talk with the patient is part of our relationship and has a dimension of intersubjectivity:* We co-create the process of therapy (cf. Beebe & Lachmann 2004, Stern 2005). Thus only the intersubjective perspective of a two-person-psychology in the context of an energetic understanding meets the challenges of treating psychosomatic dissociation.[18]

The Triadic Perspective

In addition to the dyadic the triadic perspective seems to be important in Bioenergetic Analysis, in particular when we discuss the use of exercises and tools. The research of Fivaz-Depeursinge & Carboz-Warnery (1999) showed that triadic experiences are important for the baby already in the first year of life (and maybe earlier according to Klitzing). Thus they are part of our implicit knowledge. Klitzing (2002) refers to Brickman: »… the triadic experience is an essential factor that helps the self to develop in a psychic space.« He emphasizes: »… under early stressful conditions the triads break into a two-plus-one-relationship and such *dissociation and disintegration* processes can become predominant under conditions of early emotional stress and trauma.« He defines triangulation: as a »process that places the perception of objects (including other persons) in a world of a three-dimensional space« (translation and underline by the author). *My thesis is: By utilizing tools and exercises Bioenergetic Analysis can support the growth and development of the self in the same way and on the background of triangulation in early childhood.* This is a perspective of intersubjectivity too.

18 To support my perspective I refer to Stern (2005): »Perhaps the two most important clinical consequences of intersubjectivity´s being a major motivational system are: (1) that it affirms the idea that the therapeutic relationship is essentially a two-person, cocreated phenomena …(148)« – »… when self-identity is threatened and dipping into the intersubjective matrix is needed to prevent self-dissolution or fragmentation (p.111).« – »The idea of a one-person psychology or of purely intrapsychic phenomena are no longer tenable in this light. The center of gravity has shifted from the intrapsychic to the intersubjective« (p.77).

I would like to point out that I do as many exercises as possible together with the patient (especially with people with early trauma and deficiencies). The dynamics of the relationship then comes into focus more easily and is different. For instance clients don't feel so much under observation. I assume that in doing so, the development of the self (especially agency and self perception), empathy and intersubjectivity is supported by activating mirror neurons – like imitation in early childhood does. This work of bodily support and moving together emphasizes the embodied dialogue. In addition, the development of explicit relational knowledge (verbal attunement) is important to stimulate the integration of the right and left brain. Now I describe additional tools and exercises for the treatment of traumatized and psychosomatic patients.

The Possibilities of the Rope

Treatment of Cephalic Shock

My therapeutic approach in treating tensions of the skull base and the jaw is influenced by Bob Lewis' work (1984, 1986). The importance of the balance disc I have already described above. The rope offers a further opportunity to work on the skull when my fingers and hands get tired. I use a rope like those used in gymnastic halls for climbing, approximately 3,3 cm in diameter. The client lies on the mattress (often after kicking) and puts the rope under his or her neck. I stand behind the client and pull the rope up so that my arms are hanging and the head of the client is a few centimeters above the mattress. Now I invite the client to do the work by pulling the rope down with his head. I can support the process by shifting the rope from the left side to the right side, up and down. This gives a gentle rolling impulse to the head of the client. He can either work with the jaw or with his voice, or he can use the teething ring. An integration of the eyes is important, so I ask the client to open them and look at me. This is a reference to the significance of the relational context, which means an

essential extension and to energize/intensify one's work. The client can control fits of fear by controlling the rope with his hands. The whole exercise can soften the neck and the jaw and stimulates the energy flow in the whole body.

Grounding with the Rope

We lay the rope down on the floor and step on it. First we try to grasp the rope with our toes like monkeys grasp branches (or monkey babies hold on to their mothers' skin). You also can imagine holding a branch (or another person) tight with your toes, using the words »I will get you!« (And you won't be able to get me). After this, you can integrate rolling the toes on the floor to stimulate them more. Next, we go with the arch of our feet over the rope, slowly back and forth. At places where it hurts we use our voice and can stay a little longer. The support for the arch of our feet is like going barefoot in the sand.

In our phylogenetic inheritance, the first and most important grounding was the ape's hold of its mother's skin. This hold can be compared with the feet grounding on the rope. Most people feel their feet more stable on the ground afterwards and more supported – like a mother supports her baby under the neck, the back and the head. I further support the client in developing more confidence and grounding in his or her own body and in our therapeutic relationship by inviting him / her to balance on the rope and walk along on the rope at my hand – (like little children do on a wall at their father's hand). Patients may have fits of fear during this exercise and they may hold their breath like in shock. By and by they get more playful and often they start to enjoy this exercise and get relaxed.

Instead of the rope I also use a stick (like most of you have in your breathing stool) to work with the sole and arch of the feet. With the stick this work goes deeper and is more painful. My experience is that the stick is especially useful for working with traumatized people. When I work with them on their trauma experiences and flash-backs I use the stick to help them stay in contact with their feet, body and

»grounding«. The patients then stay in contact with the present reality and don't dissociate so often.

The Benefit of the Teething Ring

With patients who grind their teeth at night or who have tinnitus you find severe tensions in the masseter muscle. When dentists suggest a teething splint, I propose using the *teething-ring*, which is a rubber ring with a diameter of 9 to 10 centimeters that you can buy for dogs in a pet store. The patient carefully bites on it with his molar teeth (never with his incisors!), moves the jaw to and fro and at the same time he can make sounds. [If you are used to horseback riding you know that your horse will drop the neck, curves the back and will release and gain more integration and coordination in its movements when it starts chewing on the bridle]. Again I'm interested in the way the patient deals with this exercise, his physical reactions and feelings which arise towards me. The kind of relationship and its level of development vary significantly. In addition it can be helpful to kick or to work with the rope in the back of the neck / skull as described above. While the patient is working with the teething-ring the therapist can massage the masseter muscle.

Apart from this, any work using the teething-ring in a standing position is very intense and challenging. The patient bites on it with his molar teeth and takes a well grounded position. The therapist holds the ring with one hand, also standing in a well grounded position. Then the client begins to pull back his head, to shake his head to and fro and by doing so he can make growling sounds. At the same time it is important to open up the eyes and to look at each other. The whole exercise reminds one of a playing dog that pulls at a stick which its master is holding firmly in his hand. This is an effective exercise for raising a grounded feeling of anger, competition or joyful play within a relationship. It can lead to an energy flow through the whole body. An impulse to bite and to destroy can be perceived in a safe and playful way and it can be integrated in therapy without harming the partners. When patients work with the ring and kick, lying on a mattress

they often experience feelings of resistance, self-assertion and defiance. One can also integrate sentences like »I will never give it to you!« or »I will never do that for you!« Many people like the exercises with the teething-ring more than those with a towel.

Conclusion

Treatment of psychosomatic patients has to deal with their dissociation. It is usually a time-taking process and is based upon embodied countertransference. The therapist's »parent-body« is the primary instrument for psychobiological attunement and growth of the patient's self. Then it is vital that the therapist opens up to the distraughtness from the perspective of the patient. In doing so, he will share the dissociation of the patient. A deconstruction of the different perspectives of patient and therapist and the acknowledgement of the therapists' »faults« and the perspective of the patient repairs the disruptions. This restores the emotional regulation within the dyad, heals the dissociation and serves the implicit and explicit relational knowledge and the growth of the self. The attunement in the relationship leads to bioenergetic interventions, they are not the outcome of an elaborated diagnostic perspective. Thus a two-person-psychology (or triangulation) meets the challenges of the therapy of psychosomatic dissociation. The energetic work in Bioenergetic Analysis, the healing of dissociation and development of the self are possible in the context of intersubjectivity only.

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