Angela Klopstech

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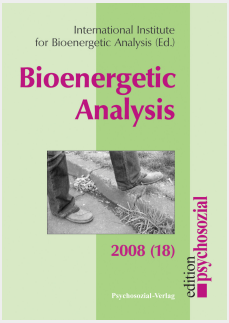

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Bioenergetic Analysis and Contemporary Psychotherapy: Further Considerations

Dialoging with Other Modalities and the Neurosciences[1]

Angela Klopstech

Summary

This article attempts to make a case for the integration of neuroscience research and theory into the field of Bioenergetic Analysis, and body psychotherapy in general. It is argued that such an integration might lead to a better dialogue between body psychotherapies and more traditional schools of therapy.

After discussing basic neuroscience terms a basic bioenergetic concept, "energetic charge", is reviewed in the light of neuropsychological models; in this context the concept of a "window of tolerance" comes into play.

Then, illuminated by the description of two concrete therapy situations, the author demonstrates how body oriented interventions might have an influence on brain activity. This, it is argued, points to the necessity of more focus on the body in traditional psychotherapy, as well as to the necessity of integrating appropriate body oriented interventions into the repertoire of traditional psychotherapy. In this context, a propositon for 'multi-lingual' understanding and language, bioenergetic, neuropsychological and relational, is made, in order to ease our communication with other modalities.

Keywords: neuroscience, limbic system, optimal arousal level, mirror neurons, body-oriented interventions

1 Keynote speech delivered at the biannual Conference of the International Institute for Bioenergetic Analysis in Seville, Spain, May 2007

I. INTRODUCTION

There is considerable buoyancy in the broader therapy world surrounding Bioenergetic Analysis and we can be sailing on this full sea. Exciting developments in modalities such as EMDR, trauma therapy, and positive psychology, and in the arenas of the neuroscience, emotion theories and infant research are creating waves. And at the same time, the familiar waters of psychoanalysis and Jungian analysis are undergoing dramatic changes that have not adequately been explored by us.

Some years ago, I wrote "it is obvious that Bioenergetic Analysis can neither remain solely within the limitations of its original energy concepts, nor can it afford to lose its roots and become lost in the recent relational and process oriented approaches. In part, its viability will require that it expands its conceptual framework and cast a curious eye on the research from contemporary neuroscience. A continual reevaluation of old and integration of new concepts is necessary for surviving and thriving" (Klopstech 2005a, p. 101). While I still maintain strongly that we not lose our own center and become an eclectic mishmash, it seems to me that we have emerged from our splendid isolation and are more fully attempting to enter the mainstream with its attendant opportunities and dangers. We are expanding our conceptual frame, we are reevaluating our key concepts, and, particularly, we are casting a curious eye toward infant research and the neurosciences. This paper will explore some of the exciting and challenging possibilities for linkage.[2]

First, an overview of some potential linkages with other therapeutic modalities at present will be provided. This will be brief and buzzword-like, so that developments or connections familiar to the reader may be detected, but mainly so that new buzzwords or better 'buzzconcepts' of interest may be discovered and followed up on. Two separate prisms will be used for this purpose: a.) just naming the therapeutic modality – e.g. psychoanalysis – and listing some dialoguing efforts by topic and authors, and b.) defining core issues and concepts that are being re-thought by us, as well as by other modalities.

Second, I will delve more deeply into an area that I am passionate about, and that is the impact of neuroscience research on Bioenergetic Analysis and the broader world of psychotherapy.

2 It is part of a series of papers and presentations in which I deal with the broader topic of exploring and defining the place of Bioenergetic Analysis in the contemporary psychotherapy world (Klopstech 2000a, 2000c, 2000d, 2004a, 2004b, 2005a, 2000b)

II. LINKAGES WITH OTHER THERAPEUTIC MODALITIES AT PRESENT

a.) Bioenergetic Analysis in Dialogue with Neighboring Psychotherapies

Bioenergetic Analysis and Psychoanalysis:

Enlarging the Therapeutic Frame (Heisterkamp 1993; Geißler 1995, 2002; Hoffmann-Axthelm 1996; Klopstech 2000a, 2000c; Moser 2001; Koemeda 2002)

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Relationality, Intersubjectivity and Mutuality (Aaron and Anderson 1998; Heinrich 1999;
Cornell, 2000, Lewis 2004, 2005)

Relationality, Modes of Therapeutic Action (Stark 1999; Carle, L. 2000, Hilton, B. 2000; Klopstech 2000d)

Gender and Sexuality revisited (Cornell in press; Klopstech 2004b; Hoffmann-Axthelm 2007)

Bioenergetic Analysis and Jungian Analysis:

Jung and Reich (Conger 1988)

Archtypes, mythical figures and their embodiment (Collier and Goodrich Dunn; Klopstech 2000b)

Bioenergetic Analysis and Trauma Therapies, EMDR

(Berceli 1999; Eckberg 2000; Lewis 2000; Resneck-Sannes 2002; Maley 2006)

Bioenergetic Analysis and the broader world of Body Psychotherapy:

(Analytical Body Psychotherapy, European Association for Body Psychotherapy, United States Association for Body Psychotherapy)

b.) Core Concepts which are Being Re-Thought by Other Modalities as well as by Us

- ➢ *passion, libido and sexuality* (Psychoanalysis),
- ➢ *contemporary models of self: multiple, evolving selves?* (neurosciences, infant research, some schools of psychoanalysis),
- ➢ *the multifactorial, frustratingly elusive definition of emotions* (emotion theories, neuroscience, positive psychology, EMDR)
- ➢ *human development between the poles of person/body in relation to itself and in relation to others* (theories of emotion, neuroscience, infant research, relational psychoanalysis)
- ➢ *autonomous and dyadic self regulation* (neuroscience, infant research, relational psychoanalysis)
- ➢ *unconscious-which unconscious?* (Psychoanalysis, neuroscience)
- ➢ *body-based theories of the mind and plasticity of the brain* (infant research, neuroscience)

III. INTEGRATING NEUROSCIENCE

In a relatively new interdisciplinary endeavor where "the best of modern science [converges] with the healing art of psychotherapy" (Siegel in Schore, 2003a, Preamble), data from neurobiology and neuropsychology are applied to understand and describe the origin and development of the self. What emerges from this convergence and meeting of the various fields of neuroscience, infant research and psychotherapy theories is a complex, dynamic and holistic (brain-mind-emotion-body) view of the human being and of human interaction, a view that is clinically applicable and, at times, experimentally testable. This new knowledge and scientifically based understanding is of particular importance for us as bioenergetic therapists because it relates to the interplay of body, mind, emotion and interpersonal relations, which is at the heart of our therapeutic enterprise. It is called interpersonal or affective neuroscience and emphasizes the basic role that brain bodily phenomena play in the process of change. At the same time, there is no coherent or good conceptualization of the place of the actual physical body, and it is here that neuroscience can meet Bioenergetic Analysis. My presentation is an attempt at some bridging between

the neurosciences and Bioenergetic Analysis, This integration can allow us to rethink what we do bioenergetically in neuroscience terms; it can enable us to speak neuroscience language as a second language (or third if you think of relational language as our second language). And because this second language is fast becoming the common language for various schools of psychotherapy, we may actually begin to understand each other and talk to one another in a dialogue fashion, rather than in collective monologues. As a consequence, I argue, we as Bioenergetic therapists will become more eloquent in getting across to our therapy neighbors what we have to offer.

A number of cognitive therapies, trauma therapies and some psychoanalytic schools have done a better job than us in bridging their theories and understanding of therapeutic process to neuroscience. Particularly relational psychoanalysis, which I consider a close professional neighbor, has responded to neurobiological research and studies of mother/infant interaction with a rigorous rethinking of its understandings of human development and the psychoanalytic process. One outcome among others is a changed notion of the dynamics within the therapeutic dyad (Boston process of change group, Tronick et al. 1998, Schore 2003a, 2005). But relational psychoanalysis has failed to adequately update their conceptualization of the body and bodily phenomena, and there is again an absence of any nuanced conceptualization of the place of the body. It is here that Bioenergetic Analysis meets both Psychoanalysis and Neuroscience. Only recently, have we, as Bioenergetic therapists, begun to consider the implications of neuroscience to our field with a series of articles and speeches (e.g. Klopstech 2005a, 2000b, Koemeda 2004, Koemeda & Steinmann 2003, Lewis 2004, Resneck-Sannes 2003a, 2003b) and some private communication between the authors. I will be referring to their work later in my paper.

I believe that integrating neuroscience into Bioenergetics should be much more than paying lipservice by bowing in its direction. This area needs to be part of our curriculum and our everyday practice. Why would this be important? Verbal methods and symbolic processing have always been, and still are, the goldstandard for how to conduct therapy. It is at this crucial point that neuroscience provides a breakthrough for what matters in psychotherapy, and that is that VERBAL PROCESSES ALONE ARE NOT ENOUGH ANY MORE! This notion is gaining increasing momentum in the general psychotherapy arena, and neuroscience is establishing it as a fact,

not an assumption, not a question. For the first time from outside of body psychotherapy, the body is treated as an active and necessary protagonist for understanding development and process in psychotherapy, rather than being considered helpful at best and not essential at worst. Because of neuroscience research, contemporary psychotherapy shows increasing interest in nonverbal interpersonal communication and in nonverbal processing, i.e. dealing with emotion, all of which is definitely our area of expertise. This presents for us an opportunity that we cannot forego, a chance we would be foolish to miss and a challenge that we need to meet.

Now, what do I actually mean when I say 'integrating'? Integrating means fully absorbing neuroscience research and models into Bioenergetic theory and practice *and* making good use of it in a way that dialogue becomes possible with neuroscience and the larger psychotherapy community. But real dialogue and 'crossfertilization' depends on both sides having something to offer. I think it is ironic that we have real goodies to offer, i.e. a profound understanding of the role of the body in human development and interaction, but nobody except us really knows this; partly because of our arcane language, partly because of our ideosyncratic albeit useful concepts, partly because of their adherence to an obsolete touch taboo, and partly because of their essentially limitating the body to the face and facial expression.

So, this paper wants to contribute to establishing a common language, with re-evaluating some of our basic concepts in the light of this language, and with demonstrating the value of body-to body-interaction for the broader psychotherapy world. Bob Lewis (2005) and Helen Resneck-Sannes (2005) gave presentations at the last convention in Brazil in a similar vein, and I hope they started a tradition which I am now continuing.

Let's look at:

1) *What neuroscience offers us:* A re-evaluation of our foundational concepts and a common language that makes us contemporary and able to link with mainstream psychotherapy.
2) *What we offer to the neurosciences and the broader psychotherapy world:* Bodily interventions can have an impact on re-organizing processes of the brain. It thus becomes sensible for these modalities to integrate appropriate body oriented interventions into their repertoire.

Before I can address these issues more fully, I will provide a Brief Overview of Relevant Neuroscience Terms, Data and Models (brief, because of spatial constraints and my neuroscience understanding that if it were too long I exponentially increase the probability of losing my readers. Also, this is meant to be a motivational paper, i. e. motivating readers to want to learn this language; not actually learning it here and now.)

Comprehensive summaries of neuroscience data and their application to psychotherapy (in the English speaking world) are provided in several voluminous books by Damasio (1994, 1999), Schore (1994, 2003a, 2003b) and Siegel (1999). Their writings are fascinating, complicated and here is my condensed and very, very simplified version.

Although the brain functions as an integrated whole, it is comprised of different systems. So, consider two ways of understanding brain structure and function, an lower-upper view and a right-left view: There is a lower area: the limbic system, the so called 'emotional brain' that is involved in the perception and regulation of emotions and bodily states. This is also the place where our early interaction experiences are stored. They are stored not as explicit, conscious knowledge, but as 'implicit knowledge', i. e. preconscious knowledge that is not verbal, but with the potential of becoming conscious and verbalized. And there is an upper area, on top of and surrounding the lower area limbic system. This is the neo-cortex, with its different parts, that are involved in reflection, reasoning, associating, planning etc.

Now that we have done the upper-lower, let's go left-right. The left hemisphere primarily communicates with the pre-frontal cortex and the right hemisphere primarily communicates with the limbic system. The right brain has been linked to the implicit, i. e.unconscious and preconscious processing of bodily information that is embedded in emotional conversation and interaction; it is also linked to such crucial nonverbal and verbal therapeutic agents as attention and empathy. As Bioenergetic Analysts, we are working a lot with the right hemisphere and the limbic system.

Schore (2003a, 2003b) has developed a concept of 'dual-hemisphere regulation', i. e. both right-brain and left-brain self regulation, that provides one possible, and for our purposes very useful, organizing frame. He distinguishes between two different forms of regulations, the conscious, voluntary and verbal control of emotional states of the left brain and a nonverbal regulation of the right-brain. The more conscious and explicit "top-down" process (from

higher cortical areas to subcortical limbic areas) of mainly the left hemisphere (LeDoux 1996, p. 172) is familiar to us as the concept of 'self- control' or 'we change the way we feel by changing the way we think'. It is at the core of cognitive psychology and cognitive psychotherapy. Of more recent vintage is the research on the regulation function of the right brain which is is a "bottom-up" process, involving the reception and expression of emotions. This process is relevant for the nonverbal or preverbal, body-to-body communication between therapist and patient, which is the essence of our ways of working. Together both sides of the brain share in the task of processing information and regulating emotion, but with different functions and different patterns of cortical-limbic connections, top-down and left and bottom-up and right. Schore's regulation theory suggests that implicit mechanisms lie at the core of major change processes and that the right brain, (the limbic system and the orbito-frontal cortex), plays a dominant role in psychodynamically oriented psychotherapy. 'Implicit mechanisms' basically means, that therapist and patient are involved in dealing with emotions and emotional memory that they are only partially aware of, often bringing them to consciousness via what is now frequently referred to as 'right-brain' and/or 'limbic' attunement.

Equally important, but easier to grasp is Schore's understanding of the interactional nature of self regulation. He distinguishes between an interactive, person-to-person and a non-interactive intraperson mode, and he emphasizes that good therapy and a well functioning therapy dyad involve flexible and sensible use of both modes.

Now that we have some frame for brain functioning and how it is conceptualized in interpersonal neuropsychology, let's go back to

What Neuroscience Offers Us

What might the actual application and integration of neurobiological and neuropsychological findings into the therapeutic domain look like, and which kind of new language could be used? The concept I have chosen here for purposes of illustration is *energetic charge level*. It is basic to our work and for some controversial.

High charge, low charge: Historically, the therapeutic value of high arousal and intense feelings has been at the heart of our therapy model, initially

unquestioned, then heatedly debated, at times thrown overboard, but ever-present even when avoided. There has always been a dichotomy between low charge/energy and high charge/energy work: when, how much, with whom and so on. This therapy issue has not only divided *us* at times, but also has kept us apart from the mainstream which tended and tends to frown upon the concepts of arousal/charge/excitement as legitimate elements of therapy. Their accompanying Cassandra-cry was overstimulation and re-traumatization and we responded to it with either defending or posturing (depending on our character), claiming to be able to touch our patients more 'deeply' i.e. profoundly. The good news: it turns out that both sides are right some of the time, so let's take a closer look.

Neuroscience findings and models (Greenberg 2002, Siegel 1999, Traue 1998, 2005, Hüther 2005, Schiepek 2003) show the value and even necessity for some arousal level for neural restructuring in the limbic brain to occur. When you look at the relevant literature, the magic words are 'optimal stress', 'neuroendocrine stress reaction', 'high emotional arousal', 'window of tolerance'. And some scientists/practitioners are dealing with the implications of these findings for the therapy process, i.e. defining the specific conditions under which heightened arousal can have a therapeutic effect. I will be combining Greenberg's and Siegel's models to provide insight into the neurophysiological underpinnings of the clinical debate regarding charge level.

Greenberg believes that intensity, expression and reflection are major agents of change. With regard to therapeutic interventions, Greenberg reviews research that provides evidence for the close connection between emotional arousal, depth of experience, emotional focus and therapy outcome. What is relevant for us here is that Greenberg finds that " high emotional arousal plus high reflection on emotional experience distinguish good and poor outcome cases, but that arousal and expression of emotion *alone* may be inadequate in promoting change" (Greenberg, 2002, p. 13). On the basis of these findings he concludes that emotional arousal needs to be combined with meaning construction and reflection, i.e. with a process of metabolizing and integrating high intensity experiences for it to be clinically useful. This is what we used to call 'working through'.

The therapeutic model developed by Siegel does not deal with the 'qualitative' factor of arousal/intensity/charge, but rather with the 'quantitative' one. Siegel does not focus on arousal as a therapeutic agent per se, but he asks 'how

much is too much/not enough/for whom and when'. Relating to the literature and data from neurobiology and trauma theory he defines a 'window of tolerance' as the optimal frame for arousal in order to process emotionally loaded material: "one's thinking or behavior can become disrupted if arousal moves beyond the boundaries of the window of tolerance" (Siegel, 1999, p. 254). The window of tolerance connotes a dynamic quality that involves the movement of affective or energetically charged material from limbic structures to the upper right and/or left brain so that expression can occur, either implicit, e. g. with a gesture or a vocal uttering, or conscious, linguistic and narrative. Windows of tolerance will differ among people. "For some persons this window may be quite narrow, for others a wide range of emotion may both be tolerable and available to consciousness. How open the individual window is for a specific person at a specific time depends on his/her inner circumstances and the social context, and it is different at different times" (Siegel, 1999, p. 254).

Siegel's concept emphasizes the individuality and variability of arousal levels with regard to their therapeutic usefulness. This becomes a guideline for therapeutic action: therapy only works well when it takes place within the window of tolerance, therapists only work well when they stimulate or calm down, attuning to this specific patient in this specific situational context. The interpersonal context, the dyadic regulation is of immense importance. Resneck-Sannes (2005, p. 38) refers to this as the 'therapeutic window' and describes in detail how bioenergetic therapists can actually work within this window.

Greenberg's and Siegel's positions have been at the center of our clinical practice and our theoretical discussions forever. We have had polarized debates about the merits of high charge versus low charge, mobilizing and soothing techniques, with defined camps of hardliners where only 'energizing blocks' and 'breaking through resistence' counted, or soft Bioenergetics where mobilizing and raising energy levels in itself was already considered bad therapy. The neuroscience that I have briefly summarized provides enough evidence for what most of us, I hope, intuitively have been paying attention to and actually practiced: how much charge is too much/not enough/for which patient and at which point in the therapy process; in summary: what does 'charge' mean for how one does relate to *this* patient in *this* context. Compared to therapists that rely on verbal and interactional explorations, our knowledge of bodyreading and character, and our expansive repertoire of indirect and direct body interventions gives us a huge advantage in the arena of regulation within the

therapeutic window. We know both how to create low and high arousal and how to work with it, e.g. how to ground arousal. In this context"grounding a patient" means nothing more than bringing the patient into his/her window of tolerance.

What we have been missing so far is a language, that translates our concepts (in this instance, charge and grounding) and our ways of working into a language understood, accepted and used in the contemporary broader therapy world (arousal, window of tolerance). We have been hampered by the fact that 'energy' and 'charge' remained mushy concepts. For a variety of reasons beyond the scope of thispaper, I do not propose abandoning these notions, but I believe it is necessary to integrate terms and concepts such as arousal, implicit/explicit knowledge, limbic system, regulation theory, dyadic regulation, window of tolerance and so on, into our bioenergetic language and tool kit.

Because of spatial constraints I have provided only this one example of integrating neuroscience thinking. In the example, I briefly touch on our concept of grounding, which deserves a fuller re-evaluation in neuroscience terms. This will be explored in a subsequent paper. Another good candidate for re-evaluation and integration of neuroscience ideas is our concept of catharsis; it is right in the the middle of a debate about the advantages and merits of high charge/low charge as agents of change. Cathartic experiences, if proccessed well, can be good examples for neurological restructuring: there is the high arousal (Greenberg), there is the combination of arousal with expression, meaning and reflection (again Greenberg), there is the emergence of changed emotional information from lower, limbic structures to upper brain structures (Schore), together with the right brain-left brain processing (Schore again) and there is the therapeutic window (Siegel).[3]

Let's turn now to an essential contribution which we can offer to both affective neuroscience and the broader therapy world. The contribution consists of the knowledge of

3 I have explored the concept of catharsis and its re-thinking in neuroscience terms in earlier publications (Klopstech 2004a, 2005a).

How Bodily Interventions May Influence the Re-Organization of the Brain

First, small segments from two therapy sessions will be presented and subsequently compared and contrasted using bioenergetic as well as neuroscience language and perspective. These segments are cursory and moment-focused. They have the character of snapshots, embedded in and enriched with some background information. I call them clinical moments. Bear with me, there is a reason why I present two clinical moments in a row.

Clinical Moment 1:
The following situation takes place after about half a year of weekly therapy. The patient is a young woman, Athena, in her early twenties, an art student, who grew up in Italy and in New York City, in a household suffused by art. Her father is French and her mother American, and the parents divorced when she was twelve years old. She entered therapy because, after having lived in Italy during her high school years, she wanted very much to live and work in New York, but felt increasingly 'confused' about this enterprise unable to concentrate on her work here or develop a circle of friends, and yearning back for Italy. Up to this point, we had generally worked with a mixture of talk and autonomous and interactive grounding techniques, starting with some verbal interaction in my office chairs and moving into some physical work from there. The story of her un- and uprooted life began to unfold for us and she realizes that it is about creating her own roots now, here in New York, in school, with her friends and with me.

This session is starting differently. My patient does not sit down in her chair immediately, as usual; she rather stops, standing next to it, tentatively, looking around. I walk over to her, look around with her and ask, also tentatively: "You are looking for something…?" Her gaze turns to the floor, and she says that she would rather like to sit there, which she then does. At the same moment, before she even utters her words, I "know" what she has in mind, a barrage of images from the last sessions is flooding my mind: I become aware how uncomfortable and stiff, like squeezed in, she appeared as soon as she sat down in her chair. I obviously noticed all this before, but it had not reached the threshold of consciousness to use actively in therapy. I feel a palpable sense of relief in mind and body about Athena's action/solution and I let her know.

She smiles, approvingly, as I sit down, half next to her and half across from her. Her body seems not only to let down on the office floor, but also seems to take up more space in my office, now that she is not confined to a chair. As she is talking, her legs extend as if by chance in my direction. I lean my body forward, her toes reach my feet and come to rest there.

For many of the following sessions we start with a similar position, both of us on the floor, her toes somehow up against my body. As we sit this way, she shares more and more about what is happening inside her when we are in this position. It makes her feel "at home" and her words flow with more ease. It is easier to be "with me" rather than across from me" which made her feel separate, though the actual distance between the upper parts of our bodies was approximately the same as when we were sitting on our chairs, face to face. Now, sitting on the floor, we have the bodily bridge of 'her-toes-to-my-body' to reduce distance and amplify connection. At times I just listen, responding with my body, leaning toward her or away, shifting with her, picking up the slightest change in her feet/toes movement to stay connected, letting my body be shaped according to hers. At other times I respond not only with my body, but also with words and we get engaged verbally. She reports that she is actively finding and creating her space, physically and emotionally, not only in my office but in her larger life in New York, creating friendships and becoming involved in art projects with other students. Memories emerge for her about sitting at the family dining table: how she had to stay in her place, her hands on the table not daring to change her position, not daring to speak up to her overbearing father. For a number of sessions the contact with our feet, somehow, remains important in the therapy. It also appears important that she can move her hands freely: "My hands belong totally to me, they are my tools" (she is an artist, painting, sculpting, sewing, soldering).

Clinical Moment 2:

The following cathartic situation occurs after three months of therapy. The patient is a forty year old woman, Sarah. She entered therapy with me because of a lifelong history of not liking her body, and because of recent marital strife. She had been in body psychotherapy before, so bodywork is familiar to her and the first three months of therapy consisted of a mix of verbal interaction with physical interventions. At this point in therapy, we are both aware that a big part of her life involves fighting, starting with her family of origin in

South America and continuing here in the US where she started out as an immigrant without a green card, rising to become a well regarded physician. Sarah's fighting mentality is manifested in a hard muscled body with the strong jaw of a warrior. Her overdeveloped calves and thighs insure that nobody will push her over!

She feels understood and accepted in the relationship with me, and so, three months into the therapy, I decide to offer her an intervention, deliberately not telling her beforehand my reasons for this specific choice of intervention so as not to influence her reaction, I tell her that I want to carry her on my hands and explain the technique: I will lie down on the floor, on my belly with my arms extended forward and my palms turned upward, resting on the ground. She will walk slowly onto my hands so that the soles of her feet will actually rest on my hands. My patient is okay with the notion of exploring her feelings and reactions in this setting without, to begin with, explicitly knowing why we are doing this admittedly strange enterprise together. We agree to talk afterwards about my underlying assumptions.

The basis for this intervention comes from my understanding of her history, i.e. there was a severe lack of parental support in her family life, paired with the simultaneous burden of having to care for younger siblings and having to make it in the world. Going back to the literal root of the word 'support', which means 'to carry from below', I offer the physical experience of 'supporting' her body and weight from below and hope that her body gets the message that support is something that exists and can be literally experienced.

Sarah's immediate reaction is surprise, disbelief and the concern that she will be too heavy, followed by an apprehensive, affirmative nod of her head. I can feel in my hands how she is letting down more and more, giving me more of her weight, relying on me to support her. She tells me how relieving this feels to her. Then I hear a deep sigh and she breaks into a strong sobbing that shakes her whole body … but she remains on my hands … crying for a long time. What comes to her mind when the sobbing abates is something she has not realized before: how much she criticizes and bosses her husband around with sentences like "Why didn't you do …?". She is horrified. I say to her "demands harden and wishes soften". She is quiet … I ask her to slowly leave my hands and to move back onto her feet. She experiences the ground as softer than before, with more give. I ask: "The way you would like to be?"

The next session Sarah tells me that during the past week she made a point

of asking her husband rather than demanding and that she felt less exhausted than usual. "Also" she says half embarrassed, half fascinated "sex was much better".

Compare and contrast, using a multi-frame approach[4]

The two clinical moments are not atypical for clinical work in body psychotherapy and they share essential similarities. Of course we can look at them through our familiar lenses, psychodynamically, bioenergetically, relationally, but for our current purposes, they also lend themselves well to a neuropsychological understanding. I will switch back and forth between the different lenses to demonstrate how enriching multicentered language and understanding can be. My specific reference will be to the new language we are trying to grasp, neuropsychological language.

Both clinical moments can be viewed as corrective experiences that attempt to create new neurological connections involving right-brain-to-right-brain-then-left-brain sequences, both involve flexible self-regulation, i.e. autonomous, within-my-patient regulation and dyadic, between-her-and-me regulation. And in both situations my patients remained within their windows of tolerance, though the arousal levels were quite different, and shaped the course of the therapy differently. Our bioenergetic language would emphasize the essential role of physical contact for change, the specific interventions that I made, e.g. body-to-body, the role character assessment and body reading played and so forth. A relational view might for example focus on the specificity of the relationship, e.g. Sarah's and my interaction around her concerns of being "too much", or Athena's and my converging attemps to make my office a new good " home" for her, as transitional space for making New York a good home.

Now, more specifically, in both clinical moments the communication between my patients and myself take place using verbal language and also body language. It is a conversation with words and a conversation with gestures, literally with "hands and feet". This conversation can, on one hand,

4 Some reflections in this particular chapter are an updated and expanded version of a similar line of thinking in an earlier publication (Klopstech, 2005b, p. 100–103)

be understood as an attempt to "talk" to the patient's limbic system which does not understand verbal language but seems to understand the emotional content of language and the language of the body. But it can also be seen as a communication between two limbic systems via a body-to-body interaction: it is about "listening with my limbic system" via my body "It is the body of the therapist that is the primary instrument for psychobiological attunement" (Lewis 2003, p. 59) and it is about "talking to the patient's limbic system" also via my body. Both moments work with flexible self-regulation, i.e. a mix of autonomous regulation where the patient uses inner resources without help from the therapist, and interactive regulation, back and forth, between patient and therapist. The new experience does not necessarily have to become verbalized or even conscious -a new buzzword for this is 'right-brain-to-right-brain-then-left-brain sequence'- in order to have a regulating effect on thoughts, behavior, feelings. Instead, it may play itself out below the threshold of awareness -buzzword again- 'right-brain-to right-brain'.

In our bioenergetic language, energetic changes are complex entities made up of more or less conscious microelements, ranging from a subtle change in the quality of the eye contact or the quality of touch, to obvious changes in breathing patterns, emotional states and thought processes, and to changes in verbal expressions. Athena's body movements, her head nod, the extension of her feet, repeated in every session provide a good example for the complexity. The connection via our feet and legs, for example, was silently acknowledged but never a word was exchanged about the significance, a typical limbic or right-brain-to right-brain communication. And remember Sarah, emotionally experiencing, relishing the support of her body through my body, right-brain-to right-brain communication, and then her verbalized insight about being overcritical and bossy with her husband, i.e. now the upper left brain comes into play. As you could hear, I used what I call ' brain pinball language' to illustrate the translatability of neuroscience language into bioenergetic clinical event language.

With its direct bodily interventions and explorations Bioenergetic Analysis possesses an excellent, and expansive repertoire of techniques, which, when embedded in an appropriate relational field ('old' psychodynamic language: transference and countertransference) *can* become the carriers of both relationship and communication between limbic systems. How much repetition of essentially the same experience, interactional and intrapersonal, or how

much variation within one experience pattern is necessary for the weakening or overwriting of an old neurological connection and the creation of a new one? We don't know and the answer is left to the belief system, assessment or intuition of the therapist. As an aside, I do not believe that all physical or physical relational work leads to neural restructuring. The subset that seems more likely to lead to reorganization of limbic structures consists of those interventions and explorations that trigger important, perhaps traumatic biographical material. If, in additon to the ontogenetic, i.e. biographical information, phylogenetic material in deeper subcortical areas is also touched upon, it may increase the chances of reorganization. This issue will be adressed in a subsequent paper.

The two clinical moments also differ in important ways. The first one deals with a spontaneous "enactment" between Athena and myself. I understand "enactment" as a co-created constellation, i.e. a "production" created jointly by therapist and patient, often in the non-verbal arena, where it is not clear-cut who reacts to whom, who instigated an action and whose actions are a mere consequence of the other's actions. The second one, on the other hand, is based on a hypothesis-guided action by me and results in a cathartic experience for my patient Sarah. My intervention is based on a conglomerate of different pieces of background information: verbal input from Sarah, both about her life history and current situation, my reading of her body, comparing notes with her about how she knows her body, and my assessment of the relational field, i.e. the momentary and underlying transference-countertransference situation.

Also, the arousal levels in the clinical moments are different. The first is not cathartic and the therapeutic agent seems to be a repetitive low charge dyadic regulation with small variations in each session, easily within Athena's window of tolerance. The arousal level is nevertheless high enough for Athena for change to take place, she becomes increasingly grounded in her actions in life, i.e. in reality. There is an 'energetic insight', but the insight is on my, the therapist's side.[5]

5 By 'energetic insight' I mean the cognitive insight that goes together with the actual physical and emotional experience of a shift inside. The crucial component here is the almost-simultaneity of thought/feeling/body sensation. The simultaneous emergence and togetherness makes for the depth of experience and the experience of a shift inside (Klopstech 2005d, p. 60).

My implicit knowledge of how uncomfortable Athena was in her chair all of a sudden crystallized into explicit knowledge, and became the trigger event for subsequent action i.e. seating myself with her on the floor. This specific moment, the change of positioning from chairs to the floor (but also the process as a whole) is an example of the way 'mirror neurons' function as a neural basis for empathy. The initial constellation, moving to the floor together, and moving my legs towards her toes suggests that my mirror neurons 'anticipate' my patient's movement intention.

The recent discovery of mirror neurons is helping neuroscientists to explain a backlog of enigmas. Mirror neurons are labelled this way, because they re-create the experience of others within ourselves, allowing us to put ourselves into the shoes of another person, and thus experience empathy. Mirror neurons are located in the premotor cortex, the area that plans movements, and they are connected to the limbic system, the brain's emotional region; thus, when my mirror neurons fire in reaction to my patient, it triggers empathic emotions -or limbic resonance- in me. If some physical movement is involved in the other, mirror neurons may be responsible not only for perceiving action, but also for understanding the movement, behavior intentions and emotions of the other. In a sense, we do not just see somebody's action, but also start to feel the actions as sensations in ourselves as if we are the actors. I believe that mirror neuron phenomena have wide applicability, and present a real breakthrough in the connection between neuroscience and the psychotherapy process.

The second situation, on the other hand, describes a cathartic experience for the patient, induced by my hypothesis-guided intervention. I consciously wanted to provide a bodily-emotional and potentially intense corrective experience. This did result in a high aroual situation of physical and interpersonal intensity, where the intensity or high arousal was mobilized by a specific physical technique with its specific meaning in a specific relational moment. It paved the way for catharsis and two insights and a new experience. One insight occurred right away in the therapy session (I am too bossy with my husband). The other occured outside of therapy, as a low charge integration process (her realization that sex was much better). The new experience was the better sex, possibly coming from a limbic restructuring, and her realization of this as an insight. This process was not characterized by repetition but rather by initial high arousal within Sarah's window of tolerance and an instantaneous change in meaning. This was followed by dyadic regulation

and then integration into everyday life. In traditional Bioenergetic language this whole process would be called a breakdown (or removal of an energetic block) followed by a breakthrough.

IV. CONSEQUENCES FOR CLINICAL PRACTICE: CAN BODY-ORIENTED INTERVENTIONS AND EXPLORATIONS PLAY A ROLE FOR NEIGHBORING PSYCHOTHERAPIES?

I used the clinical presentations to illustrate both 'multilevel' understanding and ways of bringing therapy process into different languages: bioenergetic, psychodynamic, relational, neuropsychological. The committment and desire to do these forms of translations has implications for our relationship with neighboring schools. Mainly because of neuroscience they are becoming attentive to non-verbal communication involving the body (and not just the face). *They* are talking about it, are interested in it, but *we* do not speak their language. The cost to us is that we are not integrated into the broader world, the cost to them is that they don't have a wide array of tools and approaches that potentially can reach lower brain structures. But they are not body psychotherapists so what can they sensibly take from us and usefully metabolize? This is an important question and my current view is mainly based on the way I work, and some training that I provide to non-body oriented practitioners. For a preliminary and general answer we can draw some conclusions from the clinical moments and their discussion while a fuller elaboration requires a speech or an article in its own right.

I consider verbal-physical fields of meaning, and particularly body metaphors, like those experimented with in the clinical moments, as providing an essential contact boundary between Bioenergetic Analysis and our psychotherapy neighbours. Of course, an intervention like the patient standing on my hands to provide literal support and human grounding, will likely remain in the sole repertoire of Bioenergetic Analysis. But a change of the setting, spontaneous or deliberate, such as sitting on the floor or standing up, could

be integrated into the clinical practice of verbal therapists, at least of those who want to include the body more in their practice and/or are experimenting with ways of reaching their patients subcortical structures. Then there are also the more familiar and socially accepted forms of touch, like 'taking-by the hand' or 'a hand-in the-back-or-on-the-shoulder', that could be differently explored. And finally, bodily interaction, *without direct physical contact*, may open up new doors. Again, taking body metaphors literally provides an easy way in. Think, for example, of a phrase like " I want my own space", a phrase therapists hear quite often. Literally exploring closeness, distance and positioning between patient and therapist, far and close, front-side-behind, in the full field of vision or from the corner of an eye, is a potential physical interaction without even breaking the touch taboo. An example of a different kind is the therapist simply adapting to the breathing rhythm of the patient, creating a physical attunement and a sense of togetherness, without body contact or explanatory words.

These examples can be understood and taught using traditional bioenergetic language and neuropsychological language aswell as relational language. If we become 'mulit-lingual', and if we can switch back and forth, or even be multicentered in our thinking and speaking, then we can *show* that we provide a necessary conceptualization of the the place of the actual physical body for neuroscience, and for non-body oriented therapy modalities.

V. FINAL REMARKS

So, you can see, that I am interested in and excited by what the broader therapy world is up to. But, after all, what has getting involved really done for me?

1) It has helped me maintain a vitality and freshness in my work, which is no small matter when there is therapy burnout around.
2) I can have a meaningful conversation with non-bioenergetic therapists, and at times I actually do.
3) I can't tell you that they are actually interested in what I do specifically. That has not happened yet, and believe me, I have tried. But I am sure this will change with therapists' growing interest in the body and the body's role in the therapeutic encounter, an interest essentially sparked by neuroscience.

4) I am now at the point where I myself am multi-centered when I work with patients. Both the Bioenergetic frame and the frames I have spoken about, neuroscience and relational, are in my conscious (explicit) mind and, from the way things pop up for me, they seem to be in my preconscious (implicit) mind also. I maintain that having this multiplicity of frames has made me a more effective therapist.

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