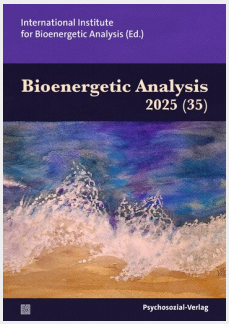
Guy Tonella

Book Review of: G. Perlman (Ed.). (2023). Restoring a Somato-Psychic Unity or Getting the Head to Really Sit on One's Shoulders



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Book Reviews

G. Perlman (Ed.). (2023). *Restoring a Somato-Psychic Unity or Getting the Head to Really Sit on One's Shoulders. The Collected Essays of Robert A. Lewis, MD.* 504 pages, Paperback, ISBN 9781304900173

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We needed this book: Robert Lewis's theoretical and clinical contributions considerably enriched the earlier models of Reich and Lowen, founder of Bioenergetic Analysis. Bob defines his orientation as a "relational somato-psychic" approach (other IIBA bioenergetic analysts have, of course, also worked in this direction, often sharing together).

Bob Lewis, a clinician artist

What a pleasure to present this review of *The Collected Essays of Robert Lewis*. His writings are poetic and metaphorical, drawing equally on psychological, neuro-scientific, literary and mythological sources. I was about to omit one of his most sensitive inspirations: his own history as a infant, a child and then as an adult, from which he draws his intuition, his sensitivity, his humanity and his understanding of the wounds and pains experienced by his patients with whom he was able then to resonate.

Perhaps it would be simpler to say that he's an artist, a clinical artist practicing the art of psychotherapy, a "wounded healer" taking care of "another wounded

person" (the patient) as he says so many times in his papers. "So, I Bob Lewis, try to be aware of what the patient is showing me in his gesture/facial expression/vocal timber/eye gaze, etc., and let these messages guide what I do and how I do it."

His essays depict the evolution and integration of Reichian/Lowenian body therapy with Self Psychology, Object Relations and attachment theories, and particularly with the work of Winnicott. He incorporates the importance of early relational trauma, attachment theory and neurobiological data to expand our understanding of human growth and health, and the impediments to these processes.

Opening a new perspective in Bioenergetic Analysis

I personally remember, after my Freudian personal/didactic Psychoanalytic process in France, discovering Reich, then Lowen and Bioenergetic Analysis. I was thrilled by these perspectives. So, I decided to go to New York to begin bioenergetic analysis with A. Lowen. It was in 1979 I met Bob Lewis and had sessions with him.

I can say that first with Al Lowen, I travelled from my feet to my head, passing of course through my pelvis, then secondly with Bob Lewis, I went from my head to my feet passing again but differently through my pelvis. Above all, I discovered that the head was not to be considered apart from the body, but rather as a part of the body. Bob writes that too often bioenergetic therapists encourage their patients to get out of their head and get into their body. He encouraged us to help our patients to connect the body and the head as one unit.

Thus, his major criticism of the classical Lowenian approach to bioenergetic analysis concerns its focus on the body – without the head – (breathing, muscular tensions, sexuality, grounding) rather than on the relationship, the attachment paradigm and its implications for relationship (Lewis, 2007[1]). "Finally, Freud, Reich and Lowen were so focused on oedipal sexuality, on "the left brain" that some of the preverbal issues "from the right brain" were relatively neglected." (Lewis, 2010[2])

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1 Lewis, R., 2007, Bioenergetics in search of a secure self, *Journal of the IIBA*.

2 Lewis, R., 2010, *Freud, Reich, Lowen: An Historical Overview---Looking Back to Where We Have Come From, Towards a Better Understanding of Where We Are Now, Journal of the IIBA*.

So what are the specific theoretical and clinical fundamental contributions of Robert Lewis? Without doubt, his most original and fundamental approach concerns "Cephalic Shock" as an alternative understanding to the Reichian/Lowenian model of mind/body dissociation. He discusses this issue in many of the articles in this book, both directly and indirectly, with numerous clinical vignettes illustrating the art of the empathic therapist he is.

Definition of "Cephalic Shock"

"Cephalic Shock" (Lewis, 1981[3]) or "Cephalic Freeze Immobility Response" (Lewis, 2021[4]) reflects a process by which body-mind dissociation is structured in the infant's body. It happens when, in the first months of life, the infant, in response to the frequent experience of a "borderline" (sometimes schizoid or schizophrenic) mother who holds *(holding)* and handles *(handling)* him in a non-empathetic way, experiences this failure of maternal empathy and registers this dissonance. With only his immature nervous system to rely on, the infant must find a way *to resist*, *avoid collapse* and *maintain his cohesion* by himself. He has to fight gravity prematurely and dissonant maternal care generates a chronic state of imbalance or shock. He will begin to fight against a profound anxiety of falling, fear of fragmenting, disorientation and head-body dissociation. He will begin to think prematurely, trying to understand his deep feeling of insecurity. And he will never have complete peace of mind for the rest of his life, which initiates the *never-at-peace mind syndrome*.

"Cephalic Shock" and "False Self"

Cephalic Shock is at the origin of the development of a False Self (Winnicott's "False Self"). When the intellectual function is prematurely activated by perception and thought, it becomes the center of the Self, dissociated from psychosomatic existence. This Self, cut off from its energetic and sensory-emotional foundations, develops as a False Self, located in the head, is the origin of a distort-

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3 Lewis, R., 1981, The psychosomatic basis of premature Ego development, *Energy and Character*.

4 Lewis, R., 1984, 'Cephalic Shock' as a Somatic Link to the 'False Self' Personality, *Comprehensive Psychotherapy*.

ed way of using knowledge. In this sense, Cephalic Shock is a form of False Self, involving the head as a physical part of the body (Lewis, 1984[5]).

What does 'Cephalic Shock' look like in the adult patient?

He cannot stop thinking, he never or rarely experiences peace of mind and he lives in his head: the Cephalic Shock is guarded by an ever-vigilant 'left-brain'. (Lewis, 1998[6])

The patient has a frozen or shock-like appearance: the head, neck and shoulders are as one unit. The facial expression is mask-like with no play of expression; the eyes look vacant, glazed or terrified. The head looks like a fortress sitting on top of a more vulnerable, alive looking torso and limbs. There are, however, an infinite number of other possible signs. In all cases, these are dissonances of bodily expression betraying, at an underlying level, the dissociation of body and mind.

How does Bob Lewis work?

Bob Lewis asks the patient to lie on the mattress on his back. He gently supports the patient's neck with his hands, and he observes the degree to which a subtle movement with each breath in and out is transmitted through the neck, physically unifying the head with the rest of the body: 'Cephalic Shock' allows less or more movement depending on the severity of the early trauma.

He has already begun to assess the degree to which the patient can let the therapist support the weight of his head. Typically, the patient caught in the cephalic attitude of self-holding will lift his own head automatically. He still is unable to give over more than a small fraction of the weight of his head and this only with difficulty.

"When I hold my patient's head firmly between my hands, he is stunned that I am actually supporting his head in a predictable, reliable manner. But and he

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5 Lewis, R., 1986, Getting the Head to Really Sit on One's Shoulders: A First Step in Grounding the False Self, *Journal of the IIBA*.

6 Lewis, R., 1998, The Trauma of 'Cephalic Shock': Case Study in Which a Portuguese Man-O-War Faces the Jaws of Death and Thereby Reclaims Its Bodily Self, *Journal of the IIBA*.

is very afraid that it is much too heavy for me". (Lewis, 1981[7]) The patient will comment: "It felt like I could lose my head, go crazy."

Over the months, he is able to explore his fear of insanity, his underlying not knowing and un-integration. Throughout this process Bob Lewis is offering, in the quality of contact in his hands, his eyes, voice, his body an invitation to give over to him some of the holding of the false, caretaker self, and to relax the muscles of the skull, face, jaw, and the shoulder girdle.

Bob Lewis adds: "The experience of having one's head supported or rocked to the point of dizziness may be gratifying or terrifying; the more important point is that it may be part of a process which allows repair of trauma for which there are no words or images."

Working with Cephalic Shock involves gradually releasing emotions sequestered since childhood (terror, rage, grief, despair, shame ...), as well as exploring his fear of madness: 1) Acknowledge that his own body has been ejected from his consciousness, which has always been engaged in an abnormal effort to care for and support himself, 2) Acknowledge that deep down, a sense of physical existence is missing, 3) Understand that he can discover bodily sensations that seem elementary to us and that in this he is not crazy.

It is understood that this therapeutic process needs much empathy from the therapist.

Empathy (2005[8])

Empathy consists in "the projection of one's own personality into the personality of another in order to understand the person better; ability to share in another's emotions, thoughts or feelings" (*Webster's New World College Dictionary*, 2001, quoted by Bob Lewis, 2005[9]).

Bob Lewis adds: "Being empathic is still very much a clinical art and the right brain is the mediator of empathy."

Empathy is complex. The behavioral anatomy data of facial expression, gaze behavior, vocal rhythm, coordination, and body posture is more immediately relevant. So we need to distinguish between explicit and implicit empathic communication.

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7 Lewis, R., 1981, The psychosomatic basis of premature Ego development, *Energy and Character*.

8 Lewis, R., 2005, Anatomy of empathy, *Journal of the IIBA*.

9 Lewis, R., 2005, Anatomy of empathy, *Journal of the IIBA*.

The first two years of our lives are lived on a largely implicit level. Procedural memory includes non-symbolically encoded action sequences which guide behavior while explicit memory is intentional recall of symbolically organized information and events.

How do we receive these implicit and explicit messages empathically?

Neurobiology can help our understanding. Empathy involves the right limbic and orbitofrontal cortical areas of the brain, and a right-brain to right-brain conversation. The right orbitofrontal cortex, anterior congulate and amygdala, helped by mirror neurons (Lewis, 2008[10]) are directly involved in evaluating facial expressions, direction of eye gaze and other nonverbal behaviors that reveal what is going on in another person. The attuned, intuitive therapist is learning the moment-to-moment rhythmic structures of the patient and is relatively flexibly and fluidly modifying his own behavior to fit that structure. We're talking about 'synchronization': timing and rhythm are powerful organizers of communication and are associated with interpersonal attraction and empathy. Finally, "Our limbic systems silently cast a suffusing light on each other- and I am told (by my intuition) what to do." (Lewis, 2005[11])

Intersubjective relationship

We communicate intersubjectively, on a core bodily level. The elements of this non-verbal dialogue include our level of arousal and energy, motor activity, the size of our pupils, the tone and pitch of our voices and lots more.

"In summary, when you have no words for your feeling, for what happened to you, for what is missing in you, we listen to the inner resonance – of your inchoate secrets – as it lives in your body. We help you to sense and amplify this inner resonance until its movement comes close enough to the surface of your being to enter your consciousness. But we also listen carefully to your words, and we are touched by them when they come from a depth of your being. We invite you to embrace your true self." (Lewis, 2001[12])

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10 Lewis, R., 2008, The clinical theory of Lowen, his mentor Reich, and the possibly all of us in the field, as seen from a personal perspective, *UABBP Journal*.

11 Lewis, R., 2011, Broken and Veiled in Shame: Revealed by the Body's Implicit Light, *Journal of the IIBA*.

12 Lewis, R., 2001, The body frozen in transference: early traumatization and the body-psychotherapeutic relationship, *Conference presented at the Park Klinik, Bad Tothenfelde, Germany.*

Projective identification (2004[13])

Projective identification can be defined "as a ubiquitous mode of reciprocal communication occurring throughout life between infants and caregivers, lovers and, last but not least, between therapists and patients". Its healthy use allows the infant to project valued parts of the self into the mother as "conversations between limbic systems [...] as preverbal, bodily-based dialogue."

However "when the dyadic conversations involve significant dysregulation and mis-attunement, a defensive use of projective identification becomes imprinted into the maturing limbic system". We find that unconscious use within the therapeutic relationship.

The therapist's body, "as with the empathic mother who matches her infant's internal state, is the primary instrument for psychobiological attunement". Now, how do we allow the sensory-motor, chaotic, diffuse traumatic experience of the patient to invade our body, so that we can help them to better tolerate it? How do we not, Schore asks, defensively shift out of the right brain state into a left dominant state, thereby cutting off our empathic connection to our own and therefore to the patient's pain?

Schore shows, comments Bob Lewis, that we are well equipped neurobiologically to bring the body's messages (specifically, the autonomic nervous system and limbic mediated sensory-motor experiences) to the spoken word. The right orbitofrontal cortex, sitting at the 'hierarchical apex of the limbic system and acting as the "senior executive of the emotional brain", brings with it the therapeutic use of projective identification.

Disorganized and chaotic somatic components of dysregulated biologically 'primitive emotions' are often involved in projective identification, like raw arousal, excitement, elation, mutilating rage, terror, disgust, shame and hopeless despair.

How to treat these projective identifications?

Indeed, what needs to be communicated can be un-mentalized or experienced in the raw, what Bion (1983) calls 'beta particles'. They cannot be thought about and can only be communicated by projective identification and not by words. "My own bodily state, claims Bob Lewis, my way of being present with the patient, is 'holding' his unconscious, somato-sensory or otherwise un-integrated material ... and thereby helping the patient to better contain and integrate unspeakable things, involves actually physically touching the patient". He adds: "Parents intu-

13 Lewis, R., 2004, Projective identification revisited: listening with the limbic system, *Journal of the IIBA*.

itively hold and physically help to contain and organize their children when they are overwhelmed with excitement and emotion.

Touching in body psychotherapy

Touching the patient's body is a theme dear to Bob's heart. He returns to it in many of his papers: "When we touch a patient, we affect his energy level, we literally give him our energy. We may also directly affect his deep belief that he is untouchable. This, in turn, releases profound energy within him. The quality and timing of the touch become part of the relationship – part of a complex dialogue." (Lewis, 2001[14])

In an extremely powerful clinical vignette, Bob Lewis shows us his unique, unconventional way of working: "Ben invited me to lie next to him on the bed. He felt 'close ... like we were two monkeys'. He called it a 'baboon mode.' This mode felt like the bedrock of the therapeutic process for close to two years meeting twice weekly. Typically, I sat with my side pressed up against Ben's torso, as he lay on his back on the bed. We might speak, I might work on an area of his body with my hands, but what we "did" emerged out of the constant, firm, warm contact of our two bodies. As we worked over the months, Ben's center of gravity slowly dropped from his head and seemed to embrace his heart, his solar plexus and his pelvis. Throughout our work, this movement downward and toward the core was catalyzed both by my releasing Ben's deep head and neck tensions with my hands, and even more often, by his nuzzling his brow and head into my brow, my hand, my leg ... my warm body."

Trauma and the body (2000[15])

Sensations, affective states and behavioral enactments are the language of traumatic memory (Janet, 1920). Van der Kolk (1996), Schacter (l987), Siegel (1993), and Perry (1997) document how this state-dependent experience is "remembered" as a re-experiencing of the event, rather than as a narrative placed in time.

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14 Lewis, R., 2001, The body frozen in transference: early traumatization and the body-psychotherapeutic relationship, *Conference presented at the Park Klinik, Bad Tothenfelde, Germany.*

15 Lewis, R., 2000, Trauma and the Body, *Journal of the IIBA*.

Traumatic experiences were initially organized on a nonverbal level. They are initially experienced as fragments of the sensory components of the event such as visual images, olfactory, auditory or kinesthetic sensations, intense waves of feeling, diffuse somatic sensations, and involuntary bodily movements. When the story told is in words that are dissociated from these body components, is of no help in desensitizing, habituating the above state-dependent 'memories.'

Bob asks us therapists this question: "Can you allow your patients to stay with body sensations/movements for which they have no words, or would such phenomena make you too uncomfortable to abide with them, and not encourage a premature translation into spoken language?" He answers: "When the embodied poems in my patients are too dark for me, I sometimes flee into my left brain and insist on a bright, explicit light."

On the other hand, Peter Levine's *Somatic Experiencing* (1997) offers us interesting techniques like instinctual fight/flight responses but that are not adapted to the kind of patient who presents a complex interweave of shock trauma and developmental trauma also involving attachment issues.

Scaer and Cognitive Behavior Therapy, for their part, tell us that through repeated exposure in a benign environment, habituation progressively diminishes the fear/arousal response in PTSD. "Ultimately, one must gain access to the insidious conditioned trauma response from a physiological and unconscious reflexive approach in order to extinguish, desensitize, inhibit, or quench it." (Scaer, 2001) But again, how can preverbal attachment issues be taken into account?

Siegel (1993) for his part explains the healing effects of Mindfulness with his neurobiological model such as the middle prefrontal cortex, the insula what he named the resonance circuitry. His clinical vignettes show an extreme sensitivity to his patient's subjective experience of their mind and body. However, how do we distinguish his neuro-scientific explanatory model from the healing effect of his relational dynamic?

What about the discovery of mirror neurons by Rizzolatti and Co.? These neural building blocks of the resonance and attunement can read the intention of another person by watching his behavior. They allow our intimacy and empathy with each other. But another area, the insula, seems to link the mirror neurons with the limbic system and the basic functions and rhythms of the body. So, in conclusion, we need a resonating body to be attuned and empathic.

Finally, Bob Lewis questions the origin of David Berceli's TRE (Trauma Release Exercises) (Berceli), a Certified Bioenergetic Therapist not making any mention of Reich nor Lowen who developed a number of tremor-inducing exercises then taken up by David.

Robert Lewis, that brilliant man, will undoubtedly leave an essential mark on the IIBA and beyond in the world of bioenergetic analysis. "Cephalic Shock", his fundamental contribution, is already part of the training content taught to bioenergetic trainees. It is now up to us to keep his work alive and to promote this book in the various regions of the world where bioenergetic analysis is developing today.

Guy Tonella PhD
November 2024

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Psychodynamische Grundlagen der Bioenergetischen Analyse [Psychodynamic Foundations of Bioenergetic Analysis] is a valuable resource, written by thirteen practitioners, that offers an almost comprehensive guide for both students and professionals. Drawing on a wealth of expertise, the book is deeply rooted in Austria – the birthplace of Freud, Reich, their followers, and other pioneers of psychodynamic psychotherapy. It embodies a rich legacy, interweaving psychoanalysis, psychodynamics, philosophy, bioenergetics, and even literature and theology, particularly from the German-speaking world. This multifaceted approach underscores its value as a good reference in our field.

The book is organized as follows:

Part 1: Paths into Psychodynamic Bioenergetics – This section explores Bioenergetic Analysis (BA), a therapeutic approach that merges body and mind within a psychodynamic framework. BA views mental and physical suffering as intertwined, emphasizing body-focused interventions alongside reflective processes. Unlike Psychoanalysis, which engages the body indirectly, BA combines experiential and analytical techniques to foster affect regulation, self-awareness, and emotional stability.