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Margit Koemeda-Lutz, Maê Nascimento
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Editorial Note

In 2004 »Bioenergetic Analysis« started to be produced by the well renowned German publishing house »Psychosozial-Verlag«. And since then the IIBA has been offering two editions, an English and a Portuguese one. As I said in the recent IIBA newsletter, »it's a long way from the author's to the reader's brain«. The formation of an intensely communicating editorial board has been very helpful. Nevertheless, after having directed the editorial work from 2004 till spring 2007, I need some relief. Therefore I am very happy to announce that Vincentia Schroeter has agreed to take over the chief editor's position. Maê Nascimento who not only served as a board member for the last three English editions but also provided translations into Portuguese, editorial work and publication in Brazil, will retire, because she was invited to serve in the IIBA Board of Trustees (BOT). We thank her for her dedicated work.

This issue covers a wide range of topics: It starts with David Finlay, who calls our attention to the ubiquity of trauma, to social amnesia and numbing and to the infancy of our knowledge as to methodologies of its treatment. His explication of a relational psychosomatic approach can be seen as (although the author does not state it as such) a contemporary bioenergetic approach to trauma treatment. He gives credit to several bioenergetic predecessors in this endeavour and defines the bioenergetic position within the professional field.

Helen Resneck-Sannes in her article focuses on salient aspects of neurobiological research, which are relevant for psychotherapy and particularly for Bioenergetic Analysis. She gives a brief overview of

the anatomy and functions of the brain, portrays some dialogues between the brain and other parts of the body and focuses on the constructive potency of empathic interaction between infants and their caregivers.

Philip Helfaer claims therapeutic work with shame to be an intrinsic aspect of Bioenergetic Analysis. He views shame within the context of the development of sexuality and self-hood. He discusses its nature from psychodynamic, energetic and characterological points of view and elaborates on specific treatment issues and approaches.

Christa Ventling points out the historically and culturally varying significance that has been appointed to mother-infant bonding for the survival of the child. She proposes the integration of educational elements into bioenergetic work with pregnant women in order to enhance healthy bonding starting – already – during pregnancy. Ventling demonstrates this with specific awareness exercises and two case vignettes.

Jörg Clauer asks if a psychosomatic approach like Bioenergetic Analysis is especially effective for psychosomatic disorders. Do we have specifically elaborated concepts and treatment techniques for them? Clauer asks these inconvenient questions, and his answers are alarming. He then furnishes us with some concepts and techniques which he has derived from relationally oriented concepts in Bioenergetic Analysis and developed in his work as a psychosomatically oriented medical doctor over the years. Clauer illustrates this with a case with ulcerative colitis.

Bob Lewis gives a very personal, stirring, and what some may find even upsetting account of the evolution of Bioenergetic Analysis, its treasures and pitfalls. He contends that the relational significance has been distorted in a manner that weakens the otherwise deep healing power of our approach – and that Lowen inherited this distortion from Reich. He warns us that this distortion must be understood and faced if we want to integrate our »powerful psychosomatic legacy with a more mutual and realistic model of the clinical encounter.« Lewis recommends the attachment paradigm to assist this endeavour.

Scott Baum concludes this issue with verbally sparkling and sophisticated insights into the doomed experiential worlds of borderline personalities. The author accomplishes an almost impossible task which

is to describe the pertaining »soulless truth of being« from within and at the same time to analyze the generating and maintaining forces for such states, as well as the dynamics emerging from them. Finally the reader is supplied with tools and information about the difficulties in therapeutically working with patients so afflicted.

In times of an increasingly technical orientation of psychotherapy, and the development of manuals specifically designed for the treatment of concisely defined disorders, I consider bioenergetic contributions focusing on specific disorders to be extremely valuable. If in the near or far future psychotherapy should become an integrated theory and empirically based canon of techniques, I would be happy if specific elements from our relational psychosomatic approach should not be missing. Therefore all articles in this volume deserve your attention. I wish you delightful and inspiring hours of reading. And please keep in mind: We need your continuous dedication. Try to write papers in order to inform your colleagues about your new insights, submit articles to our journal, be open to discussion with reviewers and the editorial board. Let us stay connected in our knowledge and wisdom!

Bioenergetic Analysis is presently published once a year. We hope that it continues to serve its purpose of being a medium of communication for the International Bioenergetic community and of presenting our theoretical concepts and positions, our clinical expertise and psychotherapeutic skills to the wider scientific community.

The opinions and theoretical positions of the articles published in Bioenergetic Analysis are those of the authors. They do not necessarily represent the opinion of the editors or an official position of the IIBA. Thanks to our review system we hope that they are skillfully written, scientifically well informed and sufficiently sophisticated so they will instigate serious discussion among our colleagues in the IIBA and from other schools of thought.

Lake Constance, Switzerland, 28.11.2006
Margit Koemeda

Energetic Dimensions of Trauma Treatment

David J. Finlay

Summary

I address both psyche and somatic dimensions of trauma treatment, emphasizing the key role of the client/therapist relationship. Somatic techniques are also emphasized.

Key Words: Energetics, Developmental and Shock Trauma, Embodiment, Metaphors, Vision, Processing

If trauma is the experience of the survivor most of the world lives in trauma producing environments. Those of us fortunate to have survival needs met live in proximate traumatic conditions. By this I mean that we are surrounded and inundated daily by traumas and while we might like to believe that these are events happening to others or some place elsewhere, this is little more than a manifestation of our disbelief system or numbing. The scope of traumas historically or from more recent events such as 9/11, Katrina, Iraq, Darfur, Lebanon or the murders just down the block, is alarmingly brought home to us each day by the world mass media. We are participants in these dramas whether willing or unwilling because they touch the lives of us all just as the threat of nuclear conflagrations have threatened our existence for years. They are also stressors which can activate seemingly unrelated traumas. Our recognition of the scope of trauma is relatively recent in terms of treatment and in some areas such as collective traumas, virtually non-existent except immediately after disasters and before social amnesia once again sets in. In this paper I attempt to bring closer together

psychic and somatic approaches to trauma treatment emphasizing the significance of the client/therapist relationship and embodiment – pieces of a larger picture.

Background

Behind the cloak of science or any academic writing there usually is a biographical statement. Therapists often write about their own issues and I am no exception. I'll be brief but the biases and limitations in my paper need to be exposed. Trauma was my introduction to life. I was an unexpected and unwanted baby. According to the doctor who delivered me I came very close to death my first day because my umbilical cord came untied. My father saw my pallor, called for the doctor and I was given a direct transfusion even though my father and my blood types had not been established. For many years I had this strange question of not knowing who really gave birth to me, mother or father, or whether I even belonged. If my father saved my life then why did he absent himself in the years that followed except for being in charge of discipline where he was often very brutal such as whippings with a harness strap? His disinterest made me wonder why he saved me. I began then to create my own fantasy world of hope. Those were first traumas.

A second one was subtle and really not fully known until much later. Both my parents were essentially orphans. They knew little about secure attachment except as child administrators. I sensed their abandonment problems which I adopted as part of me. This was strengthened by the fact that there was no warm emotional life in our family and I learned early that expressions of feelings were not part of acceptability. We were poor and there was no room or time for extraneous things since work and survival were paramount issues on the farm in an economically depressed environment. There were also incidents of sexual molestation by an aunt but for many years I minimized them by simply thinking she was crazy. When I started school I was an »outsider« because four of my six first grade classmates always spoke German and came from an encapsulated Mennonite sect

with restrictive and authoritarian values. This »outsider insecurity« persisted no matter what my accomplishments.

So these were parts of my early years where vulnerability, insecurity and threat always seemed present. By age nine I was fully cognizant of my need to escape. Athletics (which my father thought a frivolous activity) seemed the best opportunity but physical injuries destroyed this dream and my adolescent sense of identity. Eventually academics became a realistic alternative. It is not surprising though that I chose political science as a major in college. Politics are about who gets what, when and how and I needed to know. Another illusion!

I did learn that traumas are passed from one generation to the next. The tragedies in my family eventually came out – a sister age 51 and a brother age 62 dying of heart attacks (broken hearts) and another brother of alcoholism. My father's »adaptation« was Alzheimer's disease and my mother committed suicide. As for me I will quote the assessment of a dear friend who knows me well and is a therapist: »I know that you are someone who has held trauma in your body for many years, has been a direct participant in some horrific experiences, chose not to share them with most people for many years, and have walked with some incredible suppressed but conscious memory networks for decades.« The major consequence of this behavior was denial of what I needed the most – intimacy, that which heals the heart wounds. I learned though, that I was not alone in this. What kept me moving was the relational »therapy« from mentors and friends (and some would add stubbornness). So now I am less afraid to see intimacy needs in myself or in others. In assessing trauma I know they are always there.

Originally I was drawn to the »promise of bioenergetics«, that if I really, really, REALLY got into my body, I would be »cured.« It was an illusion of course, because the underlying problem of dissociation was not seen or addressed. Yet, looking back, I also realize that my traumas were not easy to recover from because of the defensive edifices I had constructed which only led to further traumas. Awareness and healing take time.

Thus part of the biases in my paper are an emphasis on treatment of delayed onset trauma and my belief in deeper trauma processes than

some of the surface procedures being offered to trauma victims. While I address certain techniques I also believe that treatment is case specific – I do not believe in formulas although some can relieve or do reduce levels of distress. What this leaves out then are procedures using group and family therapy as well as the kinds of treatment offered by humanitarian agencies. I also must set aside problems of dealing with collective trauma, a great threat as we watch our fears being manipulated. I shall begin with brief statements about developmental trauma and shock trauma.

Developmental and Shock Trauma

Developmental trauma usually results from inadequate nurturing, attachment and bonding during early childhood. Such traumas often occur, but certainly not exclusively, at a pre-verbal level where memories are often vague and inaccessible. The infant's first psychological task is to map out the personality contours (conscious and unconscious) of its caregivers, particularly to find sustaining channels of contact. When these needs are thwarted or entail abuse they create deficits or more pervasive and destructive organizing experiences around failed connections, relatedness and a sense of self which are carried over and seriously impair adult functioning.

Shock trauma is the result of an isolated event or series of events in which there is not necessarily any consistent history of previous trauma. It has been viewed as an inability to have a »normal« response (fight/flight) in »abnormal« circumstances, a definition which begs many questions.

As stated these typologies are rudimentary because developmental and shock trauma are often interwoven. However, shock responses are not gradual events of development. They are occurrences causing frozen immobilization or stimulating extreme activation of the nervous system. Both lead to chronic dysregulation in affect, learning, and behavior or Post Traumatic Stress Disorders (PTSD).

In both developmental and shock trauma there is an overwhelming of the person's capacity to cope or to integrate experience. Both effect

psyche and soma. There is unbearable psychic pain or anxiety, with concomitant somatization, that overwhelms the healthy self care system and appropriate defenses. At risk is dissolution of a coherent self, the destruction of the personal spirit. The ego at such times cannot provide an adequate defense and thus a second line of defense is formed to prevent the »unthinkable.« This can take many forms or has many different titles including dissociation, splitting, projective identification, trance states, psychic numbing, etc. They serve to preserve the life system of the person or to defend against annihilation. This »progressed« or dystonic part defends the regressed part against a repeat of that which is »unthinkable.« As D.W. Winnicott would put it, meaning is imposed on the mind-psyche or mind-object. Donald Kalsched states that »when other defenses fail, archetypal defenses will go to any lengths to protect the Self – even to the point of killing the host personality in which this personal spirit is housed (suicide).«

This dystonic or antagonistic part of the self-care system is a defense against further trauma but it also can become a resistance to all unguarded spontaneous expressions of the self in the world. And it can become »daimonic« making analysis almost impossible. In this sense it is like Freud's »death instinct,« Fairbairn's »internal saboteur,« Jung's »negative animus,« or simply the »bad object.« As an attacking figure it is similar to the actual perpetrator or events of trauma. As an ambivalent caretaker its function almost always seems to be the protection of the traumatized remainder of the personal spirit and its isolation from reality. Thus we have a Protector/Persecutor as an archetypal defense system. What is frightening is that this dynamic seems not educable i.e., it does not learn anything about realistic danger. All life then becomes a dangerous threat and is therefore attacked. Put another way, the traumatized psyche is self-traumatizing. Repetition compulsion is an inadequate explanation for it seems more like the self is possessed by a numinous diabolical power or malignant fate.

The inner world of the traumatized person is marked by a volatility in the gate-keeping of the self-care system. Affective systems become dysregulated often leading to a wide range of comorbidity disorders such as loss of impulse control. Homeostasis cannot operate or

achieve a balance between the »light« and the »dark.« This leads to a continuation of the trauma long after outer events or persecutory activity has stopped. The ego must be kept from feeling its own pain and symbolic integration cannot take place. Experience is rendered meaningless. It also leads to shame or a sense of being »bad,« »unworthy,« »worthless« or a composite self-destruct system. »Hope« is illusive. Conversely, however, sometimes opposites of such despair can arise such as megalomania, or delusions of superiority as a rigid defense against the trauma. Narcissistic disorders are a case in point.

> »Indwelling« or an activating source or force must be established for the life spirit to grow and mature or to be resuscitated or re-born. Look at it from the point where the child is coming from: »If I cannot find Mother, I cannot psychologically organize myself, at least not in a reasonable or healthy way. I may organize a world devoid of humans, a world of imaginary relations, a world that is not real, or a world of fragmentation and madness.« What the person is saying given whatever trauma or abuse occurred is that »I'll never go there again.«

»Indwelling« in therapy means sustained interpersonal relatedness through reliable interpretative holding and touch. It is an empathic middle way between compassion and confrontation. The reality is that the dreaded breakdown or death *has already happened in the past.* If indwelling can get beyond the most destructive impulses of the organism and the mind, then there is the greater and terrifying fear of connecting or learning how to do it. The self does not forget at some organic level that, for example, »if I had been good enough, mother would have been whole and there, so she could mother me the way I needed.« Yet both the positive and negative parts of the self-care system exist simultaneously, even in their warfare over control. Can the therapist anticipate and be prepared to meet the client fully in all of these dimensions?[1]

1 The sections on developmental trauma and shock trauma contain material directly from Kalsched, 1996, and Hedges, 1994.

Protocols in Treatment

There are no agreed upon protocols in the treatment of trauma. Yet there are many partisans of particular treatment approaches, often without solid empirical support even though measuring outcomes would seem to be critical to their advocacy. Partisans generally *claim* success and while this may have a certain validity in given populations, the range of methodologies also suggests the infancy of our knowledge or our lack of certainty even though the antecedents of trauma studies go back further than Freud's early seminal works on the subject.

Among the various approaches current are Elizabeth Marcher's Bodydynamics, Francine Shapiro's EMDR, Milton Erickson's neurolinguistic programming and an off-shoot called visual/kinesthetic dissociation, Roger Callahan's Thought Field Therapy, Irving Janov's Primal Therapy, Stanley Graf's Holotropic Breath Work, William Emmerson's Birth Dynamics, Peter Levine's »naturalistic approach,« David Berceli's and Liz Koch's Trauma Releasing Exercises, reparenting, desensitization, flooding, hypnosis, various modes of group therapy and advocates of pharmacological solutions – just to mention a few! There are also a significant number of dubious approaches, particularly when pursued with evangelical zeal. More standardized treatments are suggested in DSM IV from the American Psychiatric Association.

It is not my purpose to review, compare, or even discuss these variations.[2] I simply want to present more of an epistemological approach that has often worked for me and I am not suggesting it as an alternative to those already mentioned. In fact, I have incorporated certain aspects of other people's frameworks, particularly Peter Levine.[3] His cautionary approach to treating trauma and restoration of the self resonates within me as a person and as a therapist.

2 For a thorough discussion see: Bessel A. van der Kolk, et al.,(1996).

3 When I refer to the syntonic and dystonic sides of the self-care system I am referring in short-hand to Peter Levine's intricate concepts of the healing and trauma vortices (Levine, 1997).

Cautions

There is, of course, a chicken and egg question: Where do you begin in the treatment of trauma? Wherever it is – *memory or narrative, the somatic felt self and contractions, feelings or catharsis* – you will have to begin twice over again. Unless a client is particularly able, willing and open to confront traumatic events, whether fully known and acknowledged or not, it is almost a tautology to state that beginning work is based on the establishment of trust, the recognition of empathy, a time frame of the present, and the ability of the therapist to suggest or find words that might express the client's anguished meanings. So often the question is not what the therapist *does* but who the therapist *is* in the complex and personal dyadic process. As Jacob Lindy alerts us, »the trauma becomes imbedded in the victim's schemata of self and others, and rarely remains as an isolated fragment« (van der Kolk, 1996, 530). These schemata will extend and include the therapist.

Thus the client's capacity to tolerate openness and intimacy and the therapist's ability appropriately to provide an environment of empathic response, are crucial to the success of trauma treatment. Knowing, being seen and heard, and recognizing the other are intrinsic or existential qualities beyond descriptive words. Call them resonance or soul identification if you will.

The process is often slow in unfolding, not for all people but certainly for many, particularly in delayed or late onset trauma. I suffered from alexithymia, an inability to find words for feelings. Often I would need significant time just to absorb that an-other was fully there. Sometimes my therapist, Jack McIntyre, would just quietly sit or make a physical contact while I tried to relate my experience, senses and affect. There were other times when I was fully assured that we were both there and Jack could use interventions. He recognized my deep holding, confusion and fear around contact. His empathic responses facilitated emotional release but more importantly they built a connection between us based on mutual love, trust and acceptance of differences. Robert Lewis defines this essence of a therapeutic approach in the following statement:

> »When you have no words for your feelings, 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 sense and amplify this inner resonance until its movement comes close enough to the surface of your being to enter your consciousness. But we listen carefully to your words and we are touched by them when they come from the depth of your being that no one can put a hand on. We invite you to surrender to the spirit of your body and the body of your spirit – and in so doing, to embrace your true self« (Lewis, 1999, 109).

Traumas sometimes are very well disguised or sublimated, particularly when they are within bastilles of shame. When this is the case it takes considerable time, patience and intuition to find the »red thread« or denominator. For example, whenever Jack moved too fast with me, my accommodation was simply to give him what he asked for but sometimes it was not authentic. If he asked for anger I gave him anger, or tears or whatever. He soon spotted this pattern of accommodation and then would stop directions or questions until I could emerge real or not hide behind a false self. However Jack died before we completed our work and it took some time to sense, feel and then to own the very early traumas that had undermined my sense of self or indwelling. When the ingrained habit of sensing what the other wanted and adapting myself to that was broken it provoked a furious rage. I had lived by rules of accommodation and what that meant was a restrictive canon of fight or die. Accommodation was not flight. It was shame, low-grade depression and insecurity. With some resolution I sensed that something in my core essence had been missing or violated and it felt like *soul death*.

Finally, as already mentioned, another consideration is that the trauma you think you are dealing with may simply be a surface issue or a refraction of other and earlier traumas. This »tip of the iceberg« phenomenon is not unusual with trauma victims particular given the evidence around revictimization. I once contacted an agency of the Department of Veterans Affairs about a person who came to see me for one consultation after being released from a treatment facility for heroin use. I asked what evidence they had on Vietnam veterans staying clean. The answer was about one percent. The drug treatment had not

touched underlying traumas which went well beyond experiences in Vietnam and addiction. However the most pressing issue was that by going into a treatment facility, all of his »buddies« abandoned him for breaking a group norm of solidarity. He was alone just as he had been as a neglected child. He committed suicide.

So again we are back to the basic question of where to begin. Since traumas can so dramatically alter brain functions and personalities – from hysteria to absolute numbness – we often do not know exactly who or what we are dealing with or, by analogy, how wide, deep, and dangerous the iceberg might be. Freud's concept of »thought as experimental action« in a traumatized client is uncertain if not skewed or non-existent. Trauma can destroy any sense of personal agency such as resiliency or the ability to cope and manage stress.

Thus the first treatment frame is simply »who and where are you?« and »who am I with you?« I cannot assume I know what the trauma experience of a person might be, what they feel, how they view themselves or how they perceive events or me as a person and therapist. Thus I begin the work with the humility of a fellow traveler, not expertise or an inflated notion that I am the »guide«. This was dramatically brought home to me with a client I had worked with for over three years and we were approaching termination. She went on vacation to a Club Med facility and was brutally raped while a fish knife was held to her throat and repeatedly flashed at her eyes. This intelligent and competent adult (who was also a therapist) came back to therapy a frightened and paranoid child almost helpless. The trauma caused a total transformation. All reality was a threat and illusive to grasp including our history together. It felt like we were starting all over again with basic issues of trust and connection paramount. I had to discover her world anew. Parenthetically I might add that she had a very strong support system. This »environmental factor« is usually a key element in re-establishing a capacity for intimacy. It is a variable the therapist must always assess in treatment because it speaks to the crucial quality of healthy attachment patterns from the past and in the present. Such presence can strongly ameliorate the effects of trauma such as isolation and loneliness and enhance recovery.

With trauma cases the narrative may shift from one session to the

next. Memories may be uncertain or not stable. We also have to assess the balance, if any, between a person's healing and destructive gravitations. The healing self-care system must be re-discovered and opened otherwise the traumatized person is simply stuck in the trauma without safety or stability.

In somatic therapies such as bioenergetics there has been a tendency to emphasize techniques and formulas, initially in diagnoses (e.g., character) as well as to assess structure and functioning.[4] Thus the therapist watches closely patterns of respiration, metabolism and discharge of energy, emphasizing grounding and viewing such matters as determinates of personality and behavior. The unconscious is seen as conditioned by »energy factors«. Biologically energy can be measured but psychologically it is intuited and conceptually imprecise (Mahr, 2001, 117–133). Techniques do help identify »arrests« in development and they do expose the kinds of accommodations persons make in their own growth or lack of growth including character types. Techniques such as going over the breathing stool, stress positions or other mechanical means are, however, *secondary* in analysis and healing especially for the frozen and deep states of horror and dissociation traumas can produce. There have been, of course, »pioneers« in bioenergetic trauma treatment including Robert Lewis, Helen Resnick-Sannes, Michael Maley, Maryanna Eckberg, and others even though in the past the subject has not been systematically taught in training programs much to our detriment.

More psychic oriented therapies basically stress deconditioning through stabilization, education and identifying feelings through verbalization. The process involves a restructuring or reframing of personal schematas through symbolic representations such as »mindfulness«. Ego re-integration aims to release fight/flight responses and to restore healthy defense systems facilitating self-coherence and self-continuity.

I believe we know that these approaches are not antithetical and that treatment consists of their combination. Body and mind are in

4 See the various works of Alexander Lowen. Techniques are well described in Alexander Lowen and Leslie Lowen, (1977).

one sense synonymous and both contain their own forms of truth and lies. In trauma treatment both are of simultaneous and critical importance. However in what follows in this paper I emphasize physical dimensions of treatment and basically follow a Reichian format of segment ordering rather than the Lowenian approach where »grounding« through the legs and feet is emphasized. There is not one »correct« way of embodiment to connect with the earth or with reality.

Embodiment is vitality or aliveness, that which is ultimately destroyed by trauma. My suggested »epistemological« approach to trauma begins with words, then focuses on vision – our perceptual and conceptual apparatus – and then working with segments of the body from the ocular downwards. I conclude with some general comments about processing the content of the trauma experience.

(1) Metaphors

In dealing with words or verbalizations and adhering to Bob Lewis' listening perspective, I start with the heart/mind connection because the heart is the most pulsating part of the mind/body nexus and the life it commands. Opening the trauma through metaphors usually avoids the overwhelming negative power and effects of direct confrontation of the trauma experience(s). Metaphors are simulacrums of conscious and unconscious reality and are an entry into *titrating* the trauma, i.e., letting it slowly emerge. To find the metaphors I have the client listen to his own heart with a stethoscope while lying down. Then the process is one of assessing their associations or at times guiding them into deeper descriptions or explanations. Questions in this process might be:

- What do you hear?
- What does your heart sound like?
- Do you like or dislike what you hear?
- Can you find a metaphor for what you are hearing? Describe the metaphor.

We begin to examine the metaphor, particularly as it is elaborated and what identification the person has with the images presented.

Often the initial picture related is a very mechanical-like reporting simply of a »thump, thump, thump« as though they were describing a machine. Yet with many who have never had such an experience there is also a certain wonderment and curiosity. There also may be expression of boredom and reassertion of ego control or dominance if too much vulnerability is felt.

Metaphors reflecting the heart are sometimes difficult to find particularly with people who have experienced traumas even though their other imagery may be quite vivid. It would seem some element of focus or possibly imagination has been curtailed and any scene, for example, may be arid. At that point I might ask »is there any life or aliveness there? Anything you can identify with or imagine?« Such questions normally elicit a response and the tack then is to find ways to elaborate whatever life, movement or pulsation exists in their description. This becomes the focus and is part of the healing impulses by which the trauma can be balanced and dealt with or alternatives formulated such as a place of rest or peace. All movement toward homeostasis becomes a point of reference.

Let me illustrate with a case. A young woman in a workshop was frozen in immobility and numbness and I could feel her terror. It took her some twelve minutes even to hear a faint heart beat and then the sound frightened her (just as she struck me as totally frightened of people and life itself). I never pushed, just let her listen. After thirty minutes I asked her about a metaphor and she said her heart sounded like a herd of galloping horses out of control. I then asked her to picture the horses and what they were doing. She said »they are galloping in a large meadow, galloping, galloping – NO, NO, NO, they are playing with each other. Oh God, they are PLAYING!« She began to sob deeply and her whole body began to shake caught between terror and excitement. I asked her if she could see herself as one of the horses and very shyly she said she could and wanted to. This went on for some time interrupted by giggles of delight. Gradually the gross vibrations settled into a gentle streaming through her body. An embodiment, grounding and perhaps healing had taken place, however

transitory it may have been. Later I found out that her frozen shyness was partially the result of very abusive treatment in a Catholic girl's school.

(2) Vision

As »mirrors of the soul« I believe the eyes are key points for assessing trauma and for establishing the contact necessary for healing. We ground as much through our eyes as we do through having our feet planted solidly on the earth. The eyes inform the mind but they also reveal the secrets of the heart. *Vision involves the whole action system*. How one looks is as important as how one sees when dealing with complex visual and emotional tasks including deriving meaning from what is seen and experienced.[5] Eye language is more accurate than body language in how persons respond to information. Wolfgang Köhler summarized these processes as follows: »In the sensitive play of the eyes the inner direction, but also the difficulties, of a person become more easily apparent than elsewhere« (Köhler, 1957, 139). We do not necessarily see things as they are; we see them as we are. As projections the therapist is never an objective figure.

As with most trauma victims eye blocks always seem present whether in the fleeting movements associated with hyperarousal or the deadness resulting from numbness or dissociation. Contact raises the level of imagined threat as perceptions and belief systems may have been altered. Information (stimuli or sensory data) from the thalamus and mediated by the amygdala often is blocked from processing in the hippocampus, the cognitive map going to the pre-frontal cortex. Thus corrective information is distorted by the dominance of the trauma reliving in thoughts, feelings, images or actions. There are associated difficulties

5 The assertive mode of visual functioning is looking, sending energy out through our eyes; the receptive mode is seeing, taking energy in. Our ability to look is a measure of how much we can assertively perceive energy and our ability to see measures our capacity to receptively contain energy.

with attention, distractibility and discrimination if not more serious problems of neurological changes which affect all learning.

There are numerous approaches, protocols and techniques for working with the eyes (and thus the »I«) perhaps the most thorough being Francine Shapiro's Eye Movement, Desensitization and Reprocessing (EMDR) (Shapiro, 1995). Ms. Shapiro has been very rigorous in demanding scientific research on the techniques and protocols involved in EMDR. Her »discovery,« however, is not new. Rhythmic multi-saccadic eye movements were used years ago by Reichians (Baker, 1967) and different versions of the same thing were developed by William Bates (Bates, 1940).

My concern is not who gets credit for what but rather that the eyes must be mobilized in all dimensions in the treatment of trauma and especially for the *healing relationship* to develop between therapist and client. The first »touch« between them is the eyes and if one or the other is blocked there, the contact is limited. The traumatized person needs to know that they are seen as well as heard. Robert Hilton put it more emphatically concerning his own personal therapy: »I needed someone who worked with the body, but more than that I needed a person who wanted to connect with me; not just a body, not just a problem, not just a character, not just an energetic system, but me, with all my weaknesses and needs« (Hilton, 2000). The importance of that *connection* is described by Paul Tillich: »We can discover our souls only through the mirror of those who look at us« (Tillich, 1962).

There are two separate but much related issues in eye work: (1) improving visual acuity including the ability to see and look in their psychological dimensions, and (2) focusing on trauma images consciously and unconsciously held and the feelings or emotions associated with them. As related as they may be I believe eye work should proceed in this order to avoid the possibilities of the client or the therapist being confused or even overwhelmed by problems in one dimension or the other. Assessing the cognitive map of seeing and looking which reflects how perceptions and beliefs are processed takes precedence. One reason for this is that eye contact has a positive impact on the retention and recall of information. Lack of contact can suggest just the opposite.

If Charles Kelley is correct, vision problems denote blocked pain, fear and anger (Kelley, 1971). Similarly David Boadella has proposed that vision difficulties have a direct relationship in the ability to have insight and outlook (Boadella, 1978). Certainly such problems may be simply the result of stress, genetic factors or an individual's personality or character structure but definitely they are associated with traumas.

Mobilizing the Eyes and opening the Trauma

Wilhelm Reich viewed the body as having seven segments of armor, the first of which is the ocular. His description of the ocular segment has many parallels to those found in traumatized persons. »In the ocular segment we find a contraction and immobilization of all or most of the muscles of the eyeball, the lids, the forehead, the tear glands, etc. This is expressed in immobility of the forehead and the eyelids, empty expression of the eyes or protruding eyeballs, a mask-like expression of immobility on both sides of the nose. The eyes look out as from behind a rigid mask« (Reich, 1949, 371).

Opening or mobilizing the ocular segment too quickly as Reich (and also Alexander Lowen) tended to do by having the client simply open their eyes as wide as they could, can easily lead to retraumatization particularly where there are also early development deficits or where shame is a major factor. Why? According to one Reichian, David Shwenderman, »… for individuals with significant ocular armoring and accompanying psychopathology, there is no secure basis for exploring the world« (Schwenderman, 1988, 40–50). Shame induces a state of not wanting to see, be seen, or to look.[6] Thus it is advisable to

6 O. Fenichel states: »›I feel ashamed‹ means ›I do not want to be seen‹. Therefore persons who feel ashamed hide themselves or at least avert their faces. However, they also close their eyes and refuse to look. This is a kind of magical gesture, arising from the magical belief that anyone who does not look cannot be looked at« (Fenichel, 1945, 139). However, this view seems an over simplification of the impact of traumas such as rape. I believe Donald Nathanson, Michael Lewis and Michael Maley, among others, have greatly expanded our understanding of the impacts of shame in relation to trauma.

start with very simple exercises such as viewing themselves in a full length mirror. It is important in the beginning to have a sense of how they see themselves. For some traumatized persons no one is there (which is an indicator of their total lack of safety or security). The mirror work might also focus on what they see in their own eyes or how they project or mirror themselves in looking at the therapist's eyes.

Preliminary assessments might also consider left/right splits in the eyes. Some twenty years ago John Bellis argued that in the struggles against terror or horror they are »… *almost always manifested (when there is denial or disavowal) in a lateral (right-left) ocular split.* One eye reflects one set of feelings and attitudes, the other eye another« (Bellis, 1985, 156–167). This can be tested by having the client view through one eye and then the other. Usually the right eye would show the most hostility, distrust and reproach perhaps better locating or reflecting the extent of emotional damage. Bellis was also an advocate of the Reichian procedures of having the client follow a pen light (or finger) to mobilize the ocular segment. He also cautioned us by saying this may be slow work taking place over many sessions and warned »against therapeutic over-enthusiasm« in the use of any techniques for treating trauma. He was simply repeating the warning of Reich about the error of »*Too early* interpretation of the meaning of the symptoms or other manifestations of the deepest layers of the unconscious, particularly of symbols« (Reich, 1949, 371).

Opening the ocular bloc is enhanced by light finger touch on acupuncture or acupressure locations surrounding the eyes (or more precisely, points between the eyeball and the midpoint of the infra-orbital ridge). Acupuncture and acupressure points are sensory modulation techniques. In acupuncture the sites of insertion correspond to myofacial »trigger points« which, for example, inhibit pain reactions so often associated with somatization of trauma. More simply put, slight pressure on certain points relieves tension and reduces stress reactions and strain.

Corresponding to these procedures is work with the occipital-cervical muscles at the base of the skull. Pressure can be applied along the occipital ridge, again acupuncture points, and perhaps accompanied by blinking or movements of the eyes. David Berceli has pointed out

that »I have realized that the more attention I pay to my clients' necks, the faster they seem to be able to resolve their trauma issues, release the startle reflex, maintain an erect posture of their head and progress towards a healthy, integrated and grounded state in therapy« (Berceli, 1999, 14).

However, there is much more involved here than simple tension release, startle responses, postural correction or connections to the eyes. We often speak of the need for people »to get out of their heads« when, in fact, the need is for them to »own their heads« as a grounded part of their bodies rather than a »cerebral fortress« as Robert Lewis describes the anomaly. The traumatized or shocked person usually is dissociated from head and body with rigid defenses and thus the mind does not cease churning or obsessing. Lewis, reflecting the Reichian tradition, also suggests that »Deep work at the head end of the organism sets up a resonance in the diaphragm and pelvis. This is then an unsettling but powerful approach to opening the connection of self to heart and sexuality« (Lewis, 1998, 3).

At this point one might question »why all this preliminary stuff? What about the trauma?« The fact is that trauma gets stored in neural structures or neuron networks in our information processing system in the same form it entered. It is continually processed as a current event, not something that happened in the past (Shapiro, 1995, 40). New connections are not made. Eye movements, it is hypothesized, activate the information processing system to »metabolize« and to »assimilate« the trauma to »appropriate« levels of past and present time, particularly negative cognitions. These are then balanced or diffused with positive cognitions or healing images.

(3) Extending Embodiment

However, eye work needs to be followed by further processes of embodiment because the effects of trauma are stored in the entire nervous system and organs of the body critical to functioning. Images and memories may not be readily available and must be teased out from their unconscious retention in both body and mind. Those who have

active images and memories can easily be retraumatized by moving directly or too quickly into catharsis or attempts to purge destructive thoughts and emotions. On the other hand, simple »body scans,« the sixth phase of EMDR procedures, are insufficient in the process of embodiment (Shapiro, 1995, 72–73). This is one of the shortcomings of a cognitive based approach to treating trauma.

Bessel van der Kolk has listed various psychobiological abnormalities in post traumatic stress disorders (van der Kolk, 1996, 214–241) and others already mentioned have assessed the need to keep the negative and positive aspects of trauma treatment in perspective. However, many arguments simply focus on what happens in the brain and its regulatory functions.[7] What is less clear is how trauma is related to emotional anatomy (except by inference). Stanley Keleman has pointed out that »feelings are the glue that holds us together, yet they are based on anatomy.« Anatomy he states is the »ground floor of brain programs, consciousness, the way we think and feel« (Keleman, 1985, xii). A person's »normal« physiology or character structure – whether in a state of hyperarousal or numbness, bounded or unbounded, collapsed or rigid, braced or compliant – is a further factor to be considered in the effects of trauma even though trauma and anatomy correlations may be uncertain.

Thus I would strongly contend that embodiment/disembodiment are central problems in trauma treatment. The »felt self« and »sensations« are only a partial approach to the problem. The purpose of embodiment, whether from conditions of trauma or not, is to restore vitality and integration, again and again. The »out of contact« state resulting from trauma demands »being in touch« but also »being touched« to find the way home again. This is where somatic based psychotherapies are crucial because they are based on fully experiencing oneself, one's own grounding, centeredness and personhood, beyond the limitation of words and information processing. Only in such a way can a person experience a »world« in which the self is located (Lifton, 1983a, 71–72).[8]

7 The brainstem/hypothalamus, the limbic system and the neocortex.

8 Both »grounding« and »centering« are crucial aspects of restoration. While bio-

Understandably there are disagreements about the meaning, role and place of touch (Hedges et. al., 1997). Many psychoanalysts, for example, view trauma as a psychic phenomena whereas somatic psychotherapists see it as registered on a sensory-motor-affective level of the body (Lewis, 2000, 61–75). If touch is simply viewed as *resonance* there is a bridge between the differences but nevertheless questions remain about how that is expressed in the *alive* and *active* interactions between therapist and client.

I believe I have already declared my position by advocating »touch« utilizing acupressure points and their purpose. *Appropriate* touch allows us to respond to the world and for the world to reach those of us in our dark caves brought on by developmental or shock trauma. Trauma induces a state of emotional sensory deprivation as well as fear of contact, connection and intimacy. Feelings and sensations need expression but choices also must be available for their outlet including deepening the human contact between therapist and client. Therapeutic touch enhances movement between the sympathetic and parasympathetic nervous systems or, looked at another way, it also facilitates pendulation between the trauma and the healing impulses in the self-care system toward stimulating the recuperative process.

I began with Reich's first segment of armor and it seems logical to proceed with embodiment following his outline. This does not ignore the necessity to maintain grounding for the discharge of energy. The dissolution of the armor starts with regions farthest away from the

energetics stresses grounding, the concept of centering has not been adequately elaborated. Lifton illustrates the psychosomatic and integrative functions of centering in the following words: »I understand it as the ordering of experience of the self along various dimensions that must be dealt with at any given moment – temporal, spatial, and emotional. On the temporal plane centering consists of bringing to bear upon the immediate encounter older images and forms in ways that can anticipate future encounters. On the spatial plane, centering means unifying (proximate) exposure, including bodily involvement, with ›distant‹ (›ultimate,‹ ›abstract', ›immortalizing') meanings. A third aspect of centering is that of making discriminations in emotional valence between our most impassioned images and forms (what we call the ›core‹ of the self) and those that are less impassioned and therefore more peripheral. The configuration which constitutes the psychic core is unique to each individual« (Lifton, 1983a, 71–72).

pelvis (i.e., ocular, oral, deep neck musculature, diaphragm, abdomen, and pelvis) (Reich, 1949, 370). The therapist *lets the body speak* and through that can assess what is happening in the autonomic nervous system and can conjecture about what else is happening in the brain.

Helen Resneck-Sannes and Sylvia Conant have summarized Peter Levine's procedures for working with the »four diaphragms«, a system essentially following Reich's hierarchy.[9] The goal is to open each segment but also to break the feedback loop activating a fight/flight/freeze response from the *locus coeruleus* in the brain stem (norepinephrine-containing neurons).

1) Have the client lie down with their legs out straight
2) Put gentle pressure on the triceps
3) Gentle support to the occipital ridge, pushing in and slowly releasing in order to give support
4) Hands over the ears, heals of hands on edge of eyes
5) Heals of hands on the clavicle – use hands in the same direction
6) Touch inside of elbows with thumbs
7) Hands on outside of diaphragm (slightly above), fingers pointing in the same direction
8) Palm of hand slightly above the pelvic bone or on hip bones
9) Back to the eyes – one hand in back of the head and one hand in the middle of the forehead
10) Very light touch on closed eyelids
11) Return to the neck with slightly more pressure
    a. When working with infantile anxiety, hand on neck and one on lower back
12) Touch in the middle of the diaphragm
13) Gently massage the viscera

These simple techniques are designed to relax the body and allow sensations to flow which are correctives to the numbness or hyperarousal brought on by trauma. However a word of caution is necessary. It is important that the therapist fully evaluates his own empathetic re-

9 Personal communications.

sponse and resonance with the person. A traumatized person is often hyper-vigilant. He will read your touch as well as you might read reactions in his body and will spot phoniness immediately. If signs of distress occur, stop the process.

In these exercises talking should be kept to a minimum as it may simply trigger reactions from the sympathetic nervous system which increase arousal but not necessarily awareness. Debriefing is essential in terms of whatever thoughts or images occurred for they will provide a wealth of material around the ways in which the trauma(s) are being dealt with and the stage of the therapeutic process. The bridges built in the preceding procedures allow deeper openings into the images and memories of trauma *if* they have established safety and security – prerequisites for recovery.

However the process of embodiment is far from complete. Body tensions and contractions produced by trauma are often rigidly held and release is not a matter of will or evolution. They have their parallel in gate keeping functions for protection against greater pain but in so doing they hold the existing pain. Among somatic therapists there seems agreement that such tensions, contractions and the feelings associated with them must be released for resolution to occur. There is, however, no agreement as to the best way this should be done and there is inadequate evidence to back most claims of success.

For example, among Reichians there is often reliance on »paradoxical breathing« to charge and discharge the held body patterns. Bioenergetic therapists traditionally emphasize the same charge-discharge-relaxation model but also work with innumerable techniques for release such as inducing deep crying, holding stress positions until surrender and more vigorous activities such as kicking, hitting and shouting. Both agree that the negativity and pain held in the body must be confronted by one means or another. On the other hand, »Energy Psychologists« (Thought Field Therapy) contend that with mechanical like »tapping« on acupuncture points or meridians, joined by humming and/or eye movements, trauma can be »cured« in an amazingly short time (Bray, 2006, 103–123). There are many other illustrations of divergence and contentiousness.

However I believe the psoas release exercises of Liz Koch are

useful adjuncts given the preceding work described. They now have been translated as trauma treatment largely by David Berceli although, in my opinion, with an exaggeration or theoretical reification of the functions of the psoas muscle (Koch, 1997; Koch and Berceli, 2005).[10] It is claimed that through a series of positions producing »shaking« (or what is usually called »vibrations«), the body finds an inherent corrective or self-recovery process from trauma.[11] Despite an uncertain validity I find these exercises helpful. Opening the four diaphragms is insufficient in connecting the lumbar spine to the legs and the Koch/Berceli exercises are appropriate in that regard as well as releasing tension in the lower back and pelvis. Sometimes simply correcting posture or testing the hip for range of motion can be just as effective in dealing with the iliopsoas and referred pain. Tomography tests give clearer diagnoses of impaired functioning.

At this point in the embodiment process it is necessary to ping-pong between the segments and to work homologous structures such as the jaw and the pelvis. This evens and balances energy in the system and thus facilitates wholeness and unity. It also disrupts the defensive equilibrium, i.e., people will tighten in one part of the body as others are loosened so that you work back and forth between under and over-charged areas. This will affect the overall tonus of the body. Just as a certain tension is necessary for the body to retain structure, so also is discharge.

Such embodiment opens healing avenues in the body toward a self grounded and present in the realities of sexuality and personal bonds, learning and doing, home and place, playing and working, transcendence and death. These are images and symbols of our psychic core endangered by trauma (Lifton, 1983a, 72). Until that core or indwelling is re-established in both body and mind, the seeds from trauma can always germinate if not explode unexpectedly.

10 For a thorough view of the psoas and adjoining muscles and their functions see Travall and Simmons, 1992, Vol. II, 89–109.

11 For a related questioning of this assumption see: (Lewis, 1999).

(4) Processing the Trauma

My purposes have concentrated on (1) certain somatic interactions between client and therapist and (2), bringing the person into the treatment process in present time. The elaboration about certain techniques has been somewhat secondary. In both dimensions there will be a continuous telling of the narrative but I have not dealt with that. It is simply an assumption on my part.

However, in questions about processing the content of the trauma, once again we are in a field of controversy among practioners. I believe there is general agreement that the trauma must be *desensitized and defused* from the energetic charge it holds with such deleterious effects. Historical experiences must be differentiated from today's reality so that the person might live in present time without flashbacks and the like. I think therapists of all schools possibly could agree that key elements in happiness and well-being diminished or destroyed by trauma are (1) vitality, (2) curiosity and interest in the immediate world, (3) hope and optimism, (4) gratitude, and (5) the capacity to love and be loved. It is out of such factors that a healthy self-regulation exists with corresponding mental health, self esteem, positive emotions, and greater self-motivation. To me restoring vitality is a key point but a topic for another paper.

Where variations in treatment exist is in the preferred ways to facilitate the processing of trauma. A general review of approaching trauma has been suggested by Bessel van der Kolk, Alexander McFarlane and Onno van der Hart and articles in the same source speak to different aspects or schools of thought about trauma treatment (van der Kolk et. al., 1996, 417–440). Likewise the role of catharsis presents a continuing debate as Angela Klopstech has described so well (Klopstech, 2005, 101–131). The possible roles of the therapist are also contentious (Stark, 1999). There is no need to repeat all of these arguments here. While our knowledge increases we are still touching different parts of the elephant without knowing the whole.

One of the early themes in trauma treatment was the idea that the client must remember, re-live or re-experience the trauma in order to decrease the charge, put it into history and alleviate on-going symp-

toms. Sometimes desensitization processes such as »flooding« accomplish this and sometimes they lead simply to reactivation. They can also imprison both therapist and client in an endless repetition of the raw material and nuances in the narrative, or a continual search for memories and answers to »why?« questions.

Michael Maley has written that in both trauma and shame there is a breakdown of pulsations in the body and psyche and that a person can be trapped at the negative end of fundamental dualities – dualities which are part of normal development and without which development, growth and change cannot proceed. He illustrates this with concepts from Robert Jay Lifton concerning pulsations between connection and separation, integrity and disintegration, movement and stasis. In trauma separation, disintegration and stasis predominate and movement is lost. Maley emphasizes that »the duality of integration-disintegration can be restored through the mechanism that we all know about – *connection*« (Maley, 2006, 60; emphasis added). This parallels Peter Levine's ideas of developing resources that release the trauma charge without sending the person into retraumatization.

Theoretically this is fine but problems of implementation can be difficult. Let me illustrate with a brief description of a case. Some 30 years ago I saw a client for two years – a young man who as a child had been abandoned and by the time he was ten years old had been moved through five different foster homes. He had been incredibly brutalized including beatings, rapes, imprisonment, admonishment daily about his sinful nature by religious fanatics, and the like. My goal at that time was simply to help him stabilize his existence and I thought parts of that had been established. About two years ago he came back into therapy in a suicidal and homicidal state and to my utter horror it was exactly the same place as the first day or our previous work together. After I processed my »failure« what I slowly realized was that he had no sense of dualities (they were just words, perhaps to me as well). His only orienting belief was brutality – toward himself, toward others, toward all life. Thus I found myself focusing on re-education centering on compassion. Without such knowledge of another pole he had no means to evaluate experience other than trauma and no way to assess his feelings and their somatic states, let

alone establish secure social connections and interpersonal efficacy. Indwelling was never really established or, possibly, what might have been there was totally overwhelmed and lost. Fortunately I got him to enter Alcoholics Anonymous and he then joined a Christian living community and those alternatives and connections more than therapy gave him a structure and meaning which defused the tyranny of the past and saved his life.

Traumas always seem to carry with them a sense of loss and, if so, treatment processes have their parallels in the generalized stages of confronting death as enunciated by Elizabeth Kübler-Ross – denial, anger, bargaining, depression and acceptance. »These are the scenarios of loss«, according to Stephan Levine. »They are the stages of converting our predicament from tragedy to grace, from confusion to insight and wisdom, from agitation to clarity« (S. Levine, 1982, 233–234).[12]

Whatever the processes of debriefing or diffusion I believe there is a general rule that for client and therapist alike, *awareness precedes intervention just as understanding needs to precede interpretation*. We must go well beyond survival or coping as goals. If this occurs, then I believe there is the possibility of turning the horror, shame and guilt accompanying traumas into realities of change, into animation rather than stasis, into renewal and vitality. The daimonic becomes a memory not an active agent.

I have discussed two polarities in trauma treatment – those who primarily use a somatic approach and those who deal with trauma as a relational psychic phenomena. I did so because of my own experience at an earlier time when a more integrated approach rarely existed. Now I believe such integration is *slowly* developing but our »schools« whether in psychiatry, psychodynamics or various somatic approaches still lag and still seem rather entrapped by shibboleths and orthodoxies. Healing for me never came from a school of thought, an approach, a technique, etc. It was a relational somatic process that came through the empathic wisdom and humility of the therapist.

12 A more »classical« interpretation of trauma treatment processing is in the excellent book of Maryanna Eckberg (Eckberg, 2000).

That was my experience with Carl Rogers and Jack McIntyre, different but gifted men with enormous hearts and vision.

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The Embodied Mind

Helen Resneck-Sannes

»Put your ear down close to your soul and listen hard.«
Anne Sexton

Summary

Focus is on the salient aspects of neurobiological research, which are relevant for psychotherapy and particularly for Bioenergetics. This research concludes that the brain informs the body and the body in turn informs and sculpts the brain. The implications of this finding are discussed in relation to the Bioenergetic theory of character development. A brief overview of the anatomy and functions of the brain is presented with references to theories regarding the processing of traumatic memories. Finally, a more in-depth analysis of some of the findings from neuroscientific investigations are summarized regarding how empathic interactions between caretakers and infants build neuronal structures in the sensory motor areas of the brain.

Key words: attachment, Bioenergetics, brain, embodied, empathy, mirror neurons, neurobiology, trauma

In the September issue of the »Psychotherapy Networker«, Kathy Butler writes: »No longer is the skull a black box, its clockwork invisible as it was to Sigmund Freud, Carl Jung, and I will add here, Reich *and Lowen (italics are mine)* and the seminal thinkers and clinicians who have shaped 20th-century psychotherapy. For the past decade, in well-funded university neuroscience laboratories from Boston to Madison to San Francisco, the black box of the skull has been opening and spilling out diamonds. (Butler, K. 2005, p.28)

Understanding this research is important as I agree with Angela Klopstech's (2005) conclusion that:

> »At this point in time, 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 open itself and cast a curious eye on the research from contemporary neuroscience.« (p.101)

Because of the current interest in the field of psychotherapy in neurobiology, and in order to converse with our colleagues, I think it is important that we, in the Bioenergetic community have a basic knowledge of the anatomy of the brain and how it functions. This article focuses on some of the salient aspects of this research, which are relevant for psychotherapy and particularly Bioenergetics. This research, which is concluding that the brain informs the body and the body in turn informs and sculpts the brain, has implications for the Bioenergetic theory of character development. A brief review of theories regarding the processing of traumatic memories is presented. However the major focus of the article will be on early infantile attachment. Some of the findings from neuroscientific investigations will be summarized regarding how empathic interactions between caretakers and infants build neuronal structures in the sensory motor areas of the brain.

The Brain

As Bioenergetic analysts, we talk about being body therapists and learn the various muscles and their functions. However, we leave off the head, as if it isn't part of the body. I thought it might be interesting to take a look at these different brain parts and at least have some kind of visual representation of what we are talking about.

I will focus on those brain structures, which develop during the first three years of life and are important for the development of attach-

ment, empathy, emotional regulation, and the processing of traumatic events.

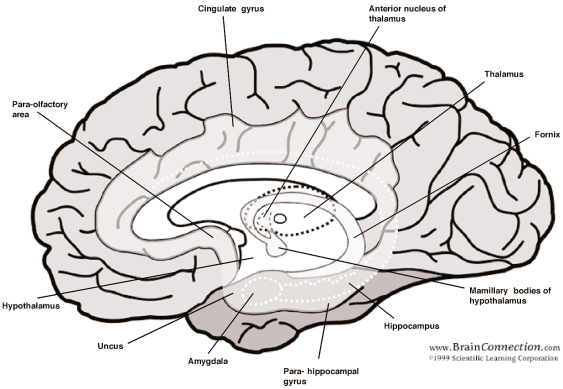
Daniel Siegel has a description of the brain, which he refers to as: »The Brain in the Palm of Your Hand«. If you take your thumb and bend it into your palm and fold your fingers over the top, you will have in front of you a surprisingly accurate rough model of the brain. Of course, the brain is made up of impossibly complex interconnections among 10 to 20 billion neurons and can hardly be reduced to a human fist. Nonetheless, we can take a shortcut and divide the brain into three major areas – the cortex, the limbic system, and the brain stem – and talk about what role they play in the larger system.

Now, hold your curled hand up – the »brain« – so that you are looking at your exposed fingernails. Unlike Daniel Siegel, I also have pictures of the brain. The »eyes« in this imaginary head will be just in front of the two center fingernails, the »ears« will be coming out the side, the top of the head will be at the top of your bent fingers, the back of the head will correspond to the back of your fist, and the neck will be represented by your wrist. Looking »inside« the head, your wrist represents your spinal cord coming up from your back. Then the center of your palm symbolizes the brain stem, which emerges from the spinal cord. The brain stem, the lowest area of the brain, is an interface between the brain and the outside world: it takes in information from perceptions, from the body, and it regulates states of wakefulness and sleep.

If you raise your fingers up and reveal the thumb curled into your palm, you're looking at the area symbolizing the limbic structures, which generally mediate emotion and generate motivational states. This crucial function influences processes throughout the brain. Emotion is not simply based or limited to the limbic circuits, but appears to influence virtually all neural circuits and the mental processes that emerge from them.

For clinicians, several regions of the limbic system are especially important to know. First is the *hippocampus*, which is important for integrating processes that result in »explicit memory« or factual and autobiographical memory. (Remember that the brain is divided into a left side and a right side, so there are really two hippocampi, as there are

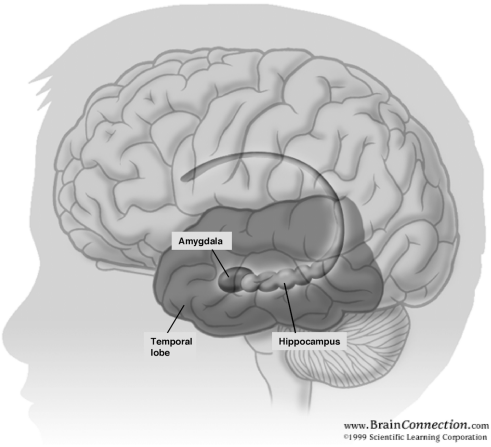
two of most structures in the brain.) As you can see the hippocampus extends up into the cerebral cortex.



The *amygdala*, represented on the second to last segment of your thumb, is more toward the center of the temporal lobe. As you can see, the amygdala is out there all by itself, only connected to the hippocampus. The amygdala evaluates whether an incoming stimulus is safe or is a threat and does this isolated from the cerebral cortex. The reaction is simultaneous, e.g. suppose I'm about to begin a walk with a friend. As we walk by the fence that is the boundary of the trail, we notice a sign that says: »I think I saw a mountain lion today, be careful.« Further on down the trail I spot a flash of gold out of the corner of my eye. Immediately, my heart begins pumping blood into my extremities, my neck lengthens, extending my head so that I can orient to the spot, where I think I saw the gold which now, in my mind's eye, appears as gold fur. My body is in a high state of arousal, hopefully instigating its fight/flight response and not freezing. Another 30 seconds passes and my mind is wondering, whether I actually saw a mountain lion or whether it is the pampas grass waving in the wind that appeared to me in that millisecond out of the corner of my eye as gold fur.

This entire arousal reaction happens without the direct involvement of the cerebral cortex. The amygdala is in fact, one of the important

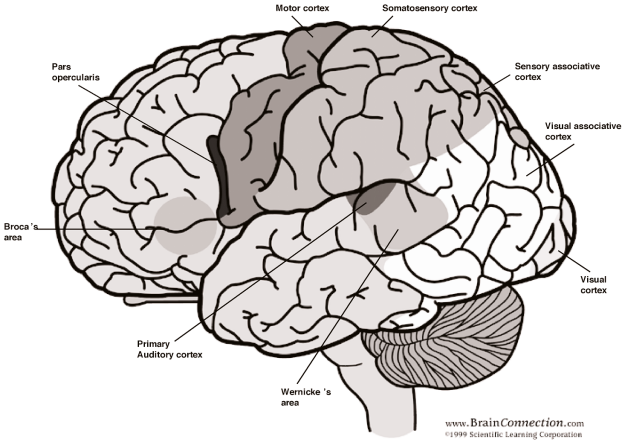
appraisal centers in the brain and may be part of a general purpose defense response system. It is important for processing emotions, especially sadness, fear, and anger. *Processing* means not discussing the meaning, but generating the internal emotional state and the external expression, as well as the perception of such states in others. The amygdala, for example, has face-recognition cells, which become active in response to emotionally expressive faces.



Then, toward your thumbnail, we can imagine the anterior cingulate cortex. Some people think of this region as the chief operating officer of the brain. It helps coordinate what we do with our thoughts and our bodies. Some experts include the hypothalamus here as part of the limbic system. The hypothalamus is a crucial neuroendocrine center, which initiates hormonal secretions and neurotransmitter flow involved in coordinating many brain-body functions, including the experience of hunger and satiety.

Putting your fingers back over your thumb will represent the third major area of the brain: the cerebral cortex. Also known as the neocortex or cortex, this region sits at the top of the brain and is generally regarded as the center of the most evolved functions of reflection and awareness – functions that distinguish human beings from other animals. The cortex has lobes that mediate distinct functions. In mental

health, we're interested in the frontal part of the cortex, called the frontal lobe. Symbolized by the front of your fingers from the second-to-last knuckles down to your fingernails, the frontal lobe mediates reasoning and associational processes. Its front part is called the prefrontal cortex, and is symbolized by your last knuckles down to your fingernails.



Two major areas of the prefrontal cortex are the side parts called the dorsolateral or lateral prefrontal cortex, where your two outside fingernails are. These are the centers for working memory, the chalkboard of the mind, which enable us to remember a phone number long enough to dial it, or a sentence long enough to say it. The middle part includes the orbitofrontal region, so called because it's behind the orbit of the eyes. In the hand model, the *orbitofrontal cortex* is symbolized by the middle two fingers, from the last knuckles down to the fingernails.

The orbitofrontal cortex is the only area of the brain that is one synapse away from all three major regions of the brain. It sends and receives neurons to and from the cortex, limbic structures and brain stem, integrating these three areas into a functional whole. This unique structural position gives it a special functional role in integrating the complex system of the brain. It appears to play a critical role in the human capacity to sense other people's subjective experience and understand interpersonal interactions. The or-

bitofrontal cortex regulates emotion and emotionally attuned interpersonal communication (often involving eye contact). This is the region of the brain where neuroscientists are beginning to believe that empathic understanding happens. The orbitofrontal cortex also has to do with response flexibility, i.e., the ability to take in data, think about them, consider various options for responding, and then produce an adaptive response. Finally, it is believed that the orbitofrontal cortex is essential for self-awareness and autobiographical memory.

It is believed that an important function of the orbitofrontal cortex is the regulation of the autonomic nervous system, the branch of our nervous system that regulates body functions such as heart rate, respiration, and peristalsis, systems we work with a great deal in Bioenergetic therapy. It has two branches: the sympathetic, which is like an accelerator (up regulates) and the parasympathetic, which resembles a braking system (down regulates). Together, the regulation of the two systems keeps the body balanced, ready to respond with heightened sympathetic arousal to a threat, for example the mountain lion, and able to calm itself down when the danger is past. In PTSD there is a malfunction of the system in that the danger is past and the body is still activated, as if the threat is still present. Optimal stress is an important concept emerging from the neurobiological research. As Cozolino (2002) says:

> »Although stress appears important as party of the activation of the circuits involved with emotion, *states of moderate* arousal seem optimal for consolidation and integration. In states of high arousal, sympathetic activation inhibits optimal cortical processing and disrupts integration functions. States of *moderate arousal* maximize the ability of networks to process and integrate information.« (p. 62)

Siegel has referred to this optimal state as the therapeutic window. I do want to highlight, that when Siegel is talking about integration, he is referring to verbal integration, as revealed in a coherent narrative. We, Bioenergetic therapists are tracking somatic coherency as well, by noticing not only the breaks in the verbal story but also by paying

attention to when the client's breath is shallow or held, when the shoulders rise in fear, when the thigh muscles contract and feet lift off the ground. We help move the energy of the body when it is stuck, and we also have mechanisms of somatic down regulation, discharge, and soothing, supporting the vibrations of the body to evolve into streamings of flowing energy.

Brain Research and Bioenergetics

Now, that we have a cursory understanding of this brain, you might say, that is interesting, but what does that have to do with Bioenergetics and character analysis? First of all, an important finding from the brain research, using pet scans and neuroimaging is confirming that the mind grows in relationship to its environment, especially during the first three years and that various parts of the mind are affected as a result of different parenting. The neurobiological research is supportive of Lowen's (1975) theory of character development, that the amount of trauma and support during the first three years of life influences a person's ability to develop emotionally and handle traumatic events. In my view it is also supporting his definition of character formation and its representation in the body.

Daniel Siegel (1999), Allan Schore (2003, 2003b) and others have summarized a great deal of research indicating that early attachment experiences primarily affect the development of the right brain, specifically the right orbitofrontal cortex. The right brain contains a more integrated somatosensory representation of the body, including the state of tension of the body's voluntary muscles and the position of the arms and legs. A major finding is that excitation, which follows from attuned parental stimulation builds structure by laying down neurons in those parts of the infant's brain that are concerned with sensorimotor functioning. Those neurons in the brain are responsible for sending signals to various muscle groups throughout the body as they mature and come into action at various ages. It appears that stimulation from caregivers during the first few years of life is necessary for the forming of those muscular, visceral, and sensorial structures that go into the building of

the form and functions that Bioenergetic theory has labeled as character. When a therapist analyzes character, she is gathering information about the form and function of her client's body and from that information, develops hypotheses about the early relationships that person had with her caregiver. These early interactions built a neuronal network in the sensory motor part of the brain. These neurons sent signals to the muscles to contract or to expand, to build structures. However, if the parts of the brain didn't receive the necessary stimulation, then signals weren't sent to those muscle groups, and the body wasn't built, or it was weak, or collapsed. Think of the pictures in Stanley Keleman's (1985) book, Emotional Anatomy. When there is a great deal of invasion, the body is dense, without support; there is an oral collapse. When the input from the parent is attuned, the body is represented in the development of a balanced musculature. Now, we also know that some people are born with more resilience to handle the stresses of life, while others are more easily over-whelmed and traumatized by the same events. Some of these differences may be genetic, and some people may from the very beginning already have a greater capacity for managing stress.

Our early relationships with our caregivers influence our reactivity, and sculpt the form and functioning of our brains. Daniel Siegel uses a computer model to describe how the mind works. Summarizing recent neurobiological theories, he says that the human mind emerges from patterns in the flow of energy and information within the brain and between brains (p. 2). He says: that engaging in direct communication is more »than just understanding or even perceiving the signals – both verbal and nonverbal – sent between two people. For »full« emotional communication, one needs to allow his state of mind to be influenced by that of the other« (p. 69). Allan Schore has talked about how the mother uploads information from the infant's mind and reprocesses it, presenting it back in a more regulated experience to the mind of the child. Notice the language. He talks about uploading and downloading information, terminology of computers, but one of the purposes of this transfer of information is to provide regulation of emotional needs (drive theory). Recently those neurons that are being affected in this emotional empathic communication have been discovered and given the name of: *Mirror Neurons.*

Mirror Neurons and Empathy

Like much of the early developmental research, mirror neurons were initially discovered in animals. Giacomo Rizzolatti and his colleagues (1992) attached electrodes to monkeys' brains. It was discovered that when the monkey reached for an object, a certain neuron was activated. Later it was discovered that the same neuron was activated when the experimenter reached for the object. It was called a mirror neuron, because it fired whether the animal itself was initiating the action or it saw someone else, like a mirror initiating the same action.

Although the experimenters eagerly inserted electrodes into the monkeys' brains, they weren't willing to succumb to the same treatment themselves. Instead, functional magnetic resonance imaging (*fmri*) was used to evaluate the neurons in the experimenters' brains. Keysers and his colleagues (2004) looked at »tactile empathy«, or how we experience the sight of others being touched. They found that the same area of the somatosensory cortex was active both when the participants, men and women were lightly brushed on the leg with a feather duster, and when they viewed someone else being touched in the same spot (Keysers, C. and Bruno, W. 2003). This finding is somewhat interesting in and of itself, but the researchers were interested in whether the intentionality behind the action made a difference. They discovered that different neurons were activated depending on whether the experimenter lifted the teacup to pour tea or reached for the cup to clear the table. Although they didn't find the identically same mirror neurons that were activated in the minds of the monkeys, they did find that similar neuronal systems were activated.

Researchers speculate that the amygdala, which resides in the limbic system, may be the area of the brain where the mirror neurons are formed. It is thought that the amygdala sends signals to the hypothalamus, which in turn stimulates the neuroendocrine chemicals such as: adrenaline, noradrenaline, dopamine, gamma-aminobutyric acid, thyrotropin-releasing hormone, neurotensin, enkephalins, and endorphins. These chemical reactions generate the processes of internal emotional states – sadness, rage, fear and their external expression – tears, trembling, etc. The amygdala is also capable of identifying the

emotional states in others. For instance, babies' understanding of mothers' emotions was demonstrated in an experiment in which young infants used their mothers' emotional expression to navigate a »visual cliff« (a sheet of glass over which the baby crawls, under which a bottomless cliff appears in the midway). The infants looked at their mothers, before crawling on the glass to get the toy on the other side of the visual cliff. When mothers displayed fear, no infant crossed the cliff, but when mothers showed joy, about two-thirds of infants crossed the cliff to get the toy (Hojat, 2004, p. 29). According to the theory of mirror neurons, the mothers' emotional responses stimulated the same neurons in the infants' brains, which then empathically generated the same state in their bodies. Researchers are very interested in mirror neurons, because this may be the beginning of how empathy is transferred and taught. By using functional brain imaging, it has been shown that the system of mirror neurons that was first discovered in monkeys also exists in humans' brains. The mechanism of mirror neurons is innate, and constitutes a basic organizational feature of our brain that can cause a set of neurons to »fire together« by observation of the mother's behavior, and subsequently »wire together« in later stages of development. It has been proposed that the mirror neuron activation could be the basis of action recognition and this mechanism can sow the seeds for understanding others and thus development of empathy in children.

They are also discovering that infants are capable of imitating facial expression, motor mimicry, and of understanding their mothers' emotions, which suggests that infants have a remarkable ability to communicate nonverbally in the early days of life. This can provide a foundation for the development of a capacity to share subjective states with others and fosters understanding of other people's happiness as well as pain and suffering. Although Bob Lewis (2005) doesn't explicitly refer to mirror neurons, he does review the work of Beebe and Lachman (1997, 2002), and Ekman (1983) and discusses the mirroring of facial expression as a precursor to empathy, and explores the role of expressive matching of body posture, and the rhythms of speech in terms of mutual regulation during the therapeutic process.

Additional evidence in support of the concepts regarding infants'

understanding of maternal emotion was provided by using the »still face« procedure (Cohn, J.F. and Tronick,E.Z.1987). In this experiment

> »interchanges between mothers and their 2 1/2- to 3-month-old children are filmed and played back in slow motion. In the first phase of the experiment the mother is told to behave normally as she and the infant sit face-to-face. Slow motion review shows the rapt interest with which they view each other. Next, the mother is asked to leave the room for a few moments; and on her return, to sit opposite from the infant *but refrain from making any facial gesture*.
>
> For a short time the child will exhibit a number of facial expressions in an apparent attempt to engage the mother in their normal mode of interaction. After a while the infant will exhibit one of two characteristics. Some children will cry in distress, but many will slump down in the chair with a sudden loss of body tonus, turning the head downward and to the side, averting their eyes from their mother's face. When Demos reviewed the »still face« experiments, she felt that these children were exhibiting a primitive shame response« (Resneck-Sannes, 1991).

I wonder if the neurons in these collapsed infants' brains are sending signals throughout their bodies about the lack of excitation and excitement from their mothers, which leads to a collapse. Once again, I direct you to pictures in Keleman's book, *Emotional Anatomy*, for visual representations of this phenomenon.

Neurobiology, Attachment, and the Therapeutic Relationship

Discussing the mother-infant interchange is important as the conclusion Siegel, Schore, and others have drawn is that there are two situations in which this full emotional communication is paramount: not only the attachment relationship of an infant and her caretaker but also during the therapeutic connection of a client and his therapist. The relationship of the mother and child in infancy has often been a metaphor for the therapy process. Empathy and attunement have been the heralds of a good mother-child connection, and these are the

same factors that seem to influence a good outcome in psychotherapy. Siegel (1999) says: »The alignment of the therapist's state allows him to have an experience as close as possible to what the patient's subjective world is at that moment« (P.69).

One of the outcomes of the neurobiological research is that it is becoming obvious both to developmental psychologists and psychotherapists that clients and patients are in an intersubjective relationship that is somatically based. Psychoanalytic psychotherapists are beginning to include the body in their writings. Shaw writes that »the body is the very basis of human intersubjectivity« (2004, p. 271). And Mathew writes:

> »The body is clearly an instrument of physiological processes, an instrument that can hear, see, touch, and smell the world around us. This sensitive instrument also has the ability to tune into the psyche: listen to its subtle voices; hear its silent music and search into its darkness for meaning« (l998, p.17).

For the last three to four years I have been following the notes from the Alan Schore study groups as they appear in articles in the journal, *The Psychologist / Psychoanalyst*. Contemporary psychoanalysis is now viewing psychotherapy as a relational process. The stance the neurobiologists are taking is that we are regulating one another. But as Allan Schore writes in the latest issue:

> »that intersubjectivity, an essential construct of current developmental, clinical, and neuropsychoanalysis, is more than a match or communication of cognitions, and that the intersubjective field co-constructed by two individuals includes not just two minds but two bodies« (Schore, 2005, p.18).

All those body states that we have been taught to attend to, i.e. facial expression, energetic arousal level, body posture, are now entering the purview of psychoanalysis, albeit in a primitive, and in a somewhat disjointed fashion, as one reads the transcripts. They are monitoring clients' laughter and smiling to assess degree of arousal, and don't

look much below the head. And to quote Bob Lewis (2005), »Of course, as Bioenergetic therapists we work with the expression of the entire body, not just the face« (p.14).

One of the classic Bioenergetic interventions is that of body mirroring. In order to empathically know the body of another, we arrange our body in the same holding pattern as our clients, to enable us to sense our clients' experience of their bodies by sensing ours. By aligning our bodies to that of our clients, we are activating a neuronal mirror of their neural activation patterns, and by engaging in this empathic encounter we may already be intervening or changing the neuronal patterns in the brain. And after all, we are in an intersubjective matrix, so while we are realigning our bodies to our clients' they are also, most likely, aligning their bodies with ours.

Mirror neurons may be one of the mechanisms of psychobiological regulation. Psychologists for a long time have known about behavioral contagion, i.e. when one person yawns, it tends to stimulate the desire to yawn in others. So, we can be »down-regulators« or calming, by grounding, slowing our breath, our rhythm of speech and speaking in a quiet voice, or we can be up-regulators by encouraging large muscle movements, loud voices, and being excited with our clients. Sometimes, we do this consciously, sometimes not. When I was in graduate school our sessions with our clients were videotaped. I vividly remember watching my first family therapy session in which my co-therapist and I were working with a hyperactive boy. My co-therapist and I were as hyperactive as the boy in the family. I'm not certain who was influencing whom.

Recently, I was working with a client utilizing a technique, which supposedly down regulates the amygdala. As I was holding the back of her head at the brain stem, I focused my attention on her body, specifically thinking about holding my hands on her amygdala, and then focused on my own amygdala. Whenever my attention was on my own area of my head, she would spontaneously report warmth, softening, calming in her head. Whenever I focused on her head, her energy would jam. The same process was true of other areas of her body. This client suffered from pneumonia, when she was newly born. Her mother was sick and depressed, most likely not very pres-

ent in her own body, or an almost »dead Mother«. This client has worked much of her life attempting to be available to others, trying to feel loved. In this exercise she described herself as feeling wrapped and held by the mother, without having to work to find the contact. The calm she felt was new for her and very much appreciated.

I feel that we as somatic analysts have much to offer the field of psychotherapy as many contemporary psychoanalysts attempt to influence and be influenced by a real body rather than just a metaphorical one. In my article published in the IIBA journal (2002) I wrote about the therapist as a psychobiological regulator. Such regulation is an essential part of therapy when dealing with clients with infantile trauma, and trauma in general. As Bioenergetic analysts we know that we need to stay attuned even when our clients present us with as Bob Lewis (2005) describes: »The kind of primitive, chaotic, visceral (gut wrenching) material that has no words and is delivered into the room sensory-motorically, and tends to be threatening to most of us (p.25)

Just last week I had such an experience with a client I have been seeing for a year and a half. I will refer to him as, Larry. What I know of him is that he is very smart, but has never been able to realize his intellectual gifts, has a good sense of humor and was beaten by both parents, not always certain of the reason behind the hitting. He is currently in a relationship with a woman who I feel treats him badly. She doesn't return his phone calls sometimes for days at a time, is often late meeting with him, and is reactive to his small lapses of courtesy. He has a non-essential tremor and startles easily. My only physical intervention at this time has been to ask him to relax his jaw by letting his feet rest on the floor and opening his mouth slightly. His body went into such violent tremors that I instructed him to close his mouth and tighten his jaw and slowly open and close his mouth.

The session before we talked about how frightened he is of me although I have done nothing to harm him. There was a sudden shift in the atmosphere of the room and I saw him looking at me with slanted eyes filled with such sadistic hatred that it felt like ice cubes were sliding up and down my spine and my stomach and chest had become a familiar iron plate. I saw that he had no idea of the look he was sending me, and I waited awhile, uncertain of whether to say something. Darkness

began to fill the room and I hesitated to move from my chair to turn on the light. I looked him directly in the eyes and said: »I know why you're afraid.« I described the look I had seen and then got up and turned on the light. You know how energy changes the tone of a room. Instead of being bathed in safe yellow warmth, the light had a sickening green tone. However, as we explored that look, his fear, my knowing of what he faced as a young child almost every day of his life, the room began to soften and the shadows seemed more familiar.

The next session he came in visibly trembling. His girl friend had accumulated a $300.00 cell phone bill during the Christmas vacation (they have the family share plan), when he was on vacation from work and at home alone. He had last seen her when they were together at a bar and she had left suddenly, without saying goodbye or later returning his calls. During this therapy session, the girlfriend was at his house, where after discussing the bill, they had had sex, obviously to keep him attached to her. I asked him if the sex was worth $300.00, and he said: »no«. He was able to verbalize his dilemma. He needs her to comfort him, even though she is the one causing his suffering. He has named the worse kind of traumatic attachment, when the child needs to go to the parent for comfort and that caregiver is the same person who is frightening the child. Larry was afraid that I would force him (as if I could) to end his relationship with her, and then he would have no one. And as we know, it is better to have an abusing caretaker than no caretaker at all, for infants die without their parents. But Larry is a grown man. He only thinks he will die without his tormenter/ comforting girlfriend. Oh, the limbic attraction. The unconscious zing to that old familiar flame and too bad if it is /was an abusive fire.

I would like to end this paper with a quote from *A General Theory of Love* (Lewis, Amini & Lannon 2002), which I think best describes the mind to mind, body to body intersubjectivity of the therapeutic relationship.

> »An attuned therapist feels the lure of the patient's limbic attractors. He doesn't just hear about an emotional life—the two of them *live* it. The gravitational tug of this patient's emotional world draws him away from his own, just as it should. A determined therapist does not strive to have

a good relationship with his patient—it can't be done. If a patient's emotional mind would support good relationships, he or she would be out having them. Instead a therapist loosens his grip on his own world and drifts, eyes open, into whatever relationship the patient has in mind – even a connection so dark that it touches the worst in him. He has no alternative. When he stays outside the other's world, he cannot affect it; when he steps within its range, he feels the force of alien attractors. He takes up temporary residence in another's world not just to observe but to alter, and in the end, to overthrow. Through the intimacy limbic exchange affords, therapy becomes the ultimate inside job.« (p.178)

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Shame in the Light of Sex and Self-Respect

Philip M. Helfaer

Summary

A bioenergetic perspective on shame and its treatment is presented. Therapeutic work with shame will be seen as an intrinsic aspect of bioenergetic analysis. The nature of shame from the psychodynamic, the energetic, and the characterological points of view are all discussed. The unique and specific contributions that a bioenergetic approach offers to understanding and treating problematic shame and shame related issues are presented. From a developmental point of view, shame is viewed within the context of the development of sexuality as well as self-hood. The significant concepts of ›self-respect‹ and the ›self-hate system‹ and their relevance to shame are elucidated. Specific treatment issues and approaches are presented from the bioenergetic perspective.

Key words: shame, treatment of; bioenergetic analysis; self-respect; bioenergetic therapy of shame; self-hate system

Shame and its Place in Bioenergetic Therapy

Shame is no longer an overlooked or obscure issue in therapy and will be an issue inherent in any depth psychotherapy (Morrison, 1989; Schore, 1994). *Shame, the Underside of Narcissism*, by Andrew P. Morrison (1989), in particular, is a pioneering, definitive psychoana-

lytic study. For several reasons I want to review some of the essential aspects of Morrison's work.[1]

The fundamental and inevitable centrality of shame in therapy is Morrison's (1989) »basic thesis«. Therapeutic failure and premature termination are often the result of the failure to deal with shame in treatment (Conger, 2001).

> »… the shame of patients is contagious, often resonating with the clinician's own shame experiences – the patient's own sense of failure, self-deficiency, and life disappointments. Painful countertransference feelings may thus be generated in the analyst/therapist, feelings that he or she, like the patient, would just as soon avoid, feelings that frequently lead to a collusion, preventing investigation of the shame experience. Frequently the therapist's own analysis or psychotherapy will not have explored shame, and thus both patient and therapist share various methods of concealment, blind spots unavailable to analytic exploration« (Morrison, 1989, p. 6).

The discussion of shame in therapy seems fairly recent. For example, in two of his important books, *The Fear of Life* and *Narcissism*, Alexander Lowen (1980, 1983) did not name shame in the context in which shame was clearly the referent. In *Fear of Life Sex and Self-Respect, The Quest for Personal Fulfillment* Helfaer (1998) addresses the issues of shame from a bioenergetic perspective. Self-respect is a body concept which provides a framework for understanding shame and guilt as well.

> »The significance of the concept of self-respect is grasped by considering guilt, shame, humiliation, and self-hate. Self-respect is their functional antithesis. Self-respect is the healthy alternative to unhealthy guilt, shame, and self-hate. Shame, guilt, and self-hate are commonly found entwined in the individual's sexuality in our society. Self-respect permits good feelings as well as mutual respect« (Helfaer, 1998, p. xii).

Self-respect is a body concept, not a psychological one. It is based on

1 A longer version of this paper is available from the author upon e-mail request.

the individual's capacity to regulate him- or herself according to his/her body or organismic states, desires, and feelings, and not only good feelings in the body, but all of the body's feeling states. Self-respect means to be in touch with one's deeper feelings and body states and to allow one's life to be guided by them. The capacity for self-respect is a function of the body's capacity for aliveness, motility, and a relatively unimpeded flow of energy; i.e., it reflects contactfulness. Self-respect can be overwhelmed by unrealistic, perfectionistic demands on the self as well as by unrealistic, grandiose images of the self. Self-respect can be undermined by feelings of low self-worth, as well as other manifestations of shame – such as, self-hate, humiliation, a sense of failure, self-diminution, sexual ruination, deficits in ego functioning, and a sense of neediness and lack of independence and autonomy.

The »self-hate system«, described in »The Hated Child«, (Helfaer, 1988–89), which I will touch on below, became the model with which I could understand shame and guilt. In self-hate, the person is turned against him- or herself in a powerful, intense way. Shame, guilt, and humiliation are expressions of the person being turned against him-/herself. In the case of all such persons, the only word for what they had been exposed to as children is hate, or hateful behavior, on the part of parents.

Shame is a universal experience. Everyone has felt it. We know what it is like to have feelings of worthlessness, low self-esteem, failure, and to feel lacking or defective. We know what it is like to feel that we do not belong, are outside of the clan, have lost our important connections. We know what it is like to feel ashamed for our behavior, wishes, comportment. We know what it is to have shame about our body or body parts, our genital expression, our desires. We know what it is to be filled with shame, to wish to sink into the ground or to disappear.

The painful affects of shame are all too familiar, such affects, for example, as the searing, even disintegrative impact of shame. Perhaps worse, the experience of humiliation is no less familiar – to be subjected to feeling put-down, our dignity destroyed in a painful manner by one more powerful, or seeming so. There is also an experience of

shame that is associated with one's very self and identity in such a way that one feels one's very being and identity to be shameful, that what I am is shameful.

We see the effects of shaming and humiliation on children. Mortification and embarrassment are other words for shame experiences. All of these experiences are not only unbearably painful, they also make being in the world very difficult for the one who experiences them on a chronic basis. It is notable that an affect as painful and universal as shame is not more universally acknowledged as a therapeutic focus.

Psychodynamics of Shame

If shame has received little attention, it must be because therapists have not looked at their patients in such a way as to relate shame to what they saw and experienced. From a psychoanalytic perspective, Morrison (1989) describes in intricate detail a psychodynamic picture of shame and its transferential manifestations which aid our seeing. He establishes shame as an intrapsychic, not solely an interpersonal, phenomenon. Altogether, he accomplished a unique feat of theoretical development and clinically useful elucidation.

Morrison's study of shame is also a study of narcissism. This gives a characterological cast to his approach, to the extent that he is dealing with »narcissistically vulnerable« patients who have a particular way of being in the world. These are individuals who have a sense of shame »based on an intrapsychic view of the self as fundamentally flawed and defective« (Morrison, 1989, pp. 134–35). In such individuals, »the essence of narcissistic concern is a yearning for absolute uniqueness and sole importance to someone else, a ›significant other‹«(p. 48). For them, shame »reflects the subjective experience of frustrated grandiose ambitions, failed attempts to compensate for unrealized ambitions, or unmet yearnings to attain ideals, (it) is the hallmark of the defeated self in a state of depletion, the self that has fallen short of its goals« (pp. 80–81). Shame thus »earns its place at the center of narcissistic experience« (p. 62). It is, in the final analysis, the

result of the »failure to meet the goals and expectations of the … *shape of the ideal self* (his italics)« (p. 78).

Morrison introduced his innovative conception of »the dialectic of narcissism« (p. 64).

> »… there is an ongoing, tension-generating dialectic between narcissistic grandiosity and desire for perfection, and the archaic sense of self as flawed, inadequate, and inferior following realization of separateness from and dependence on, objects. Similarly, a metaphorical dialectic exists between the wish for absolute autonomy and uniqueness and the wish for perfect merger and reunion with the projected fantasy of the ideal. Thus, shame and narcissism inform each other, as the self is experienced, first, alone, separate, and small, and, again, grandiosely, striving to be perfect and reunited with its ideal. … The narcissistic dialectic may also be formulated with regard to those tensions occurring within the self – intrapsychic conflicts regarding autonomy or merger – about the best means to attain uniqueness« (p.66).

This is a notable account. I would say this passage portrays inner chaos, confusion, turmoil, and possibly shock. With dialectical tensions between several conflicting and opposing psychic, motivational, and emotional pathways, what else could result? It would be equally accurate to say that if the person is in a state of chaos, confusion, turmoil, with cohesiveness of the self under threat, the mind is shocked into struggling to find some way out and to find some form of cohesive organization from amongst competing alternatives all of which, in fantasy, are possible, but none ever effectively functional. Further, it is obvious that this would occur only under conditions of adaptational necessity. Adaptational necessity means stress threatening the integrity, cohesiveness, or survival of the self. This picture comes close to the one of »the hated child« (Helfaer, 1988–89, 1998 Chapter 8.) It also describes the conditions of character adaptation.

A further, confounding, characteristic of the psychodynamics of shame is that in the therapy situation, shame is seldom presented directly as such to the therapist. First, and perhaps above all, »shame generates concealment out of a fear of rendering the self unacceptable« (Morrison, 1989, p.2). Often, what is presented is an attitude

that is best understood as a defense against shame. Some of the important and common defenses against shame are rage, contempt, envy, depression, hypochondria, mania, and, of course, narcissism (cf. Morrison 1989, Chapter 8, and elsewhere). Character traits of arrogance, superiority, as well as grandiosity are also well known defenses against shame. Shame or humiliation may underlie some somatic symptoms. One client traced her bothersome migraine attack to a specific experience of humiliation. Organizations support other forms of defense against shame. By seeking to bring a »small« or marginal organization into alignment with a larger, positively valued group, members can avoid the shame of participation in a group perceived as less valued.

For a deeper understanding of the development of the self and of the shape of the ideal self, Morrison turned to Kohut's description of the selfobject, both mirroring and idealizing. Morrison says,

> »In fact, failure of the parental selfobject to respond to the self's idealizing needs and quest for merger is a prominent source of shame vulnerability and a model for subsequent shame over the self's experience of its needs« (p. 79).

This language can be translated into bodily, everyday realities. It means that parental failures to respond to the child's needs in a positively facilitating manner result in the development of an ideal self that is incongruent with the real, bodily self of the child. Unrealistic and unrealizable ideals, aspirations, and goals develop as an adaptational compensation, and such development leads to shame vulnerability. In addition, the adult grown up from such a child will, in all likelihood, feel shame about and defend against, the needs which develop or remain from such deficits and unmet needs for parenting. Such needs will continue into adulthood in the form of needs for compensatory selfobject responses from another idealizable adult, or, more likely, they will find expression in the defensive characterological distortions of such needs.

The narcissistic needs of therapists, so famously depicted by Alice Miller (1979/1981), are still an all too relevant example, and while she

rarely mentions shame, we can re-read her book as a study in shame. The miserable lifelong quest for perfection is an all too familiar experience for many people, and it surely has sources in early life (Chasse-quet-Smirgel, 1985).

In the healthier situation, parental response allows for the development of aspirations, goals, and ideals that are congruent – as I would say – with the ordinary good feelings of the body and with bodily based self-respect. Healthy adults will still experience shame in the face of (inevitable) failure or indignities, but such experiences will not be of the repetitive, misery-making sort stemming from chronic shame vulnerability.

Characterological and Energetic Perspectives on Shame

Shame and the Body

There is little mention of the body in Morrison's book, although we can credit him with a very apt »body reading« of shame. »Slouching posture, inaudible speech, and averted gaze are hallmarks of narcissistic (primary internal) shame, reflecting abject apology about the self's very existence« (Morrison, 1989, p.136). The shame experiences Morrison focuses on have mostly to do with the shame experienced because of failure to achieve ideal aspirations or goals, the failure to measure up to the shape of the ideal self and a resulting sense that the self is flawed, defective. This is the shame of the social person in his aspirations for place, status, and affiliation with the clan.

A bioenergetic perspective immediately brings to our attention bodily shame, a shame that infuses identity, the feeling that who I am is shameful and that my body, body parts, and bodily expressions are shameful. This is the shame of the biological individual, the self as body, the sexual, erotic self, the person seeking fulfillment based on a basic good body state. This shame splits us from our erotic selves. Dream symbolization of shame not infrequently takes the form of

finding one's self naked in public, especially with the lower body, genitals and backside, exposed.

Social shame can be a defense against or displacement of the bodily shame.

> »Dr. A, a client of mine, became aware of the inhibiting effect of her fear of being shamed about her professional writing, which she feared was »not good enough, not acceptable, takes so much time«. She kept her writing vague and tried »not to make too much out of it«, in essence, hiding herself, not putting herself out in the world too strongly, staying safe, and avoiding shaming attack. I reminded her that she often had talked about her body in exactly the same ways, and that too expressed shame – about her body, her appearance, and her self on a body level. She talked then about what an unpleasant feeling this was, and that she was afraid to »make too much out of my body«, that in fact she was trained to »not pay too much attention to the body«.

Her bodily shame became the model for her work-related shame and underlies it. Perhaps the »underside« in the sub-title of Morrison's book is the body or body parts.

A bioenergetic perspective also adds something to Morrison's discussion of Kohut's descriptions of mid-life depression in men. This state, as Morrison describes it, is of a »depleted self. … Such a self lacks realizable ideals and is burdened by excessive and unattainable ideals and goals« (p.83). He also describes this state as an »empty depression« (p. 72 ff). The »emptiness« here, as well as the depletion, suggests essential information about the man's connection or lack of it with his own body.

In this clinical condition, the man remains fixated on unattainable ideals formulated in adolescence or even earlier, and, at mid-life, is struck by the realization that he will never attain them. Then the man is left with no defensive protection against the deprivations and deficits of early life, (the stimulation for the unattainable ideals). His resulting depression is »empty«, because he is left with the experiential (body) memory of those early states, the emptiness of deprivation.

Again, there is another possibility here. If the ideals and goals of the aging man fall away, leaving an emptiness, the aging man may, if

guided by self-respect, find a deeper connection with the bodily self in that very experience of emptiness. Without the guidance of self-respect, the emptiness left by the falling away of ideals may lead the aging man into an »empty depression«, until he can find a connection with his body and in this way establish self-respect and more reasonable expectations for himself.

Shame Affect

Shame is a difficult experience to describe and grasp by its very nature. It has a peculiar mix of affective and cognitive components. There is a painful idea, for example about the meaning of a failure, and there is a painful affect. The question is, what is the source of the affect? How can an inner process or idea result in such a painful feeling? The ideal self, after all, is a construct, an assumed mental structure, perhaps vague and fluid. It is essentially an elaborated set of images, fantasy, and ideas all colored by the peculiarly human capacity for idealization.

In shame experience, there is always a commingling of the cognitive and the affective. Ideas, ideals, ambitions, goals are inextricably, it seems, pinned to painful feelings. Each – cognitive content and affect – may have separate sources. The affect, the pain of the shame experience is a body memory having its origins in childhood experience, and the set of idealizations that go with the shame are illusory ideas that develop subsequent to, but in relation to, the earlier painful experiences and the relationships within which they occur (cf. Helfaer, 1998, »The Cognitive Peculiarities of Shame and Guilt« pp.144–47).

The essential painful experience for the child consists in having his/her movement stopped. In other words, there is contraction, a shrinking, in response to the environment. This is a bodily experience occurring within the context of early vital relationships. In childhood, when parents discipline the child, for example, they stop the child's movements, they create a contraction or a shrinking (Schore, 1994, pp. 203, 212).

The manner of stopping covers a very broad range, from respectful,

patient firmness to disrespectful, rageful violence. If we interpret Kohut's descriptions in energetic terms, we can see that certain kinds of neglect, contactlessness, and lack of attention can also stop the child's movement, create contraction, and shrinking, and these deficits can lead to the development of shame vulnerability.

When I speak of movement, I mean energetic movement, as well as literal movement. More specifically, I am referring to the movement that occurs in states of pleasure, excitement, and attunement (Schore, 1994, p.203). Movement is based on the basic pulsatory movement of the body and its tissues. This movement is life. When movement is stopped, to that extent life is stopped. Thus the shamed, humiliated child shrinks in, collapses down. Conversely, in the child who is seen and appreciated, the energetic function is supported, and she or he is upright, bright, and prideful. The abrupt switch from expansive, prideful excitement to shamed contraction can be the source of actual somatic illness (Helfaer, 1998, pp. 13–18).

Morrison (1989) mentions one possibility for bringing in the source of the affect in shame which has a more bodily referent. He quotes Tomkins' idea of »shame as a primitive, indwelling affect that reflects interruption of, or negative feedback about, excitement, interest, or joy in the infant« (Morrison, 1989, p. 53). This is clearly a conception very close to the energetic one I describe, that shame evolves from the stopping of movement in the child. As I see it, it is not shame as a specific affect that is »indwelling«. What is indwelling – in the sense that it is inherent in the biology of the organism – is pulsation, expansion, and contraction. What is indwelling is the child's natural sensitivity, on a pulsatory level, to the environmental inputs, that is, energetic expansion in the face of positive environmental response to the child and contraction or shrinking back in the face of »interruption of, or negative feedback about excitement«.

Self-Hate System

The self-hate system is the essential characterological outcome in children who have been exposed to parental hate, hateful behaviors,

and hateful family environments. In effect, their movement, at all levels is grossly stopped and disrupted, and they have to develop all kinds of compensatory attitudes, perfectionism, for example, in order to get along in the world.

It would seem to be no surprise that a child who is hated learns to hate him- or herself. However, it is worse than that, because it is more complex, torturous, and chaotic. For example, self-hate will develop in the child not simply because the parent hates the child, but because the child – in his or her own mind – could not become the person who could win the parents' approval or love.

Furthermore, within the hated child, there is not just a sense of self-hate, there is a self-hate system. The whole way of experiencing the world is dominated and organized by the fundamental, internalized »reality« of the hatefulness of the self. The ego organizes feeling, perception, and relational experience in a way that actually kindles the experience of self-hate. Any and every interpersonal event may trigger self-hate and defenses against self-hate or may engender inner feelings of self-hate (cf. Helfaer, 1998, Chapter 8).

Shame can be understood with this model. Thus the »shame-system«, develops from the chronic, painful shaming or neglect of the child. In this case, the affect of shame becomes embedded in a set of beliefs which may be quite vague and unarticulated, but nonetheless real to the individual. The beliefs, the system, in a sense, »explains« to the individual his or her pain. Mind follows body, one might say. In any case, the shame experience is integrated into the personality or character. In fact, it becomes an agent for the management of energetic flow and expression (Helfaer, 1998, pp. 144–153). The chronic contraction of the early shame experience is the foundation for establishing and maintaining this system.

Early shame experiences occur within the context of the child's vital connections. The shame-system or self-hate system is the developing child's painstaking effort to reconnect, to reconstruct the vital relationship as it should be, to establish love and lovableness. They are efforts to reconstitute a fractured self or construct a cohesive one.

Sexuality

Kohut aimed to delineate a line of development for the self separate from libidinal object development and structural theory. Morrison seems inclined to follow Kohut in this regard. When it comes to the understanding of shame, he seems to address it as a dynamic and a development that stands on its own. No relationship with sexuality is established.

As I see it, from an energetic point of view, sexuality and selfhood are very much related. They stand in the relationship of identity and antithesis. They are the same and different. The development of selfhood and sexuality go hand in hand, one informs the other, and a common energetic process underlies them (Helfaer, 1998, chapters 1,2 and 3). Thus, for example, the sense of genital injury can be very much at the basis of narcissistic injury.

> »Charles dreamed that he found himself in a shower room where he ›had to cut off the head of my penis‹. We traced this dream to an encounter he had with his boss the day before where he had felt humiliated, a problem that was the focus of our work« (Helfaer, 1998, pp. 136–37).

Characterological shame, guilt, self-hate, and humiliation may be understood as distortions of the healthy process of self-respect. Violations of developing sexuality, which take many forms, are a major source of these distortions. Shame vulnerability or humiliation vulnerability are direct outgrowths of some kind of violation of sexuality. I understand sexuality as a broad concept or principle, indeed one of the major organizing principles of personality, with selfhood being another. If sex is the actual biological expression of sexuality (both gender and sexual acts), then self-respect is the biological expression of selfhood. Sexual identity lies at the core of both selfhood and sexuality.

The development of sexual identity can be framed in terms of three main stages. In the early stage, involving the baby in the maternal relationship, the child can develop a sense of being »of the species«, being one like the mothering one. The intermediate stage has to do

with identification with the genital, occurring during what is usually termed the Oedipus period (Helfaer, 1998, chapter 2). The third stage occurs in adolescence. Here, the task is the integration within the self of sexual desire and a sense of a sexually mature body in such a way that the youth is able to function in the social world in choosing a partner and allowing him/herself to be chosen.

Each of these stages has distinct possibilities in terms of the development of shame. The developmentally earliest and maybe most fundamental experience of shame was expressed directly by a man who said, »I am beyond the species. I am so diseased. I am the one to be attacked by my own species. Thrown to the wolves« (Helfaer, 1998, pp. 126–27). Identification with the genital when disrupted by moralistic, shaming, rejecting, sex negative attitudes (violations of sexuality), results in genital shame and castration. I term the quality of shame that can arise in adolescence as sexual ruination, the sense that one is too defective, dirty, or ruined to be chosen or to be free to choose a desirable partner.

Humiliation

Humiliation, one shape of the shame experience, deserves special consideration, because it is particularly devastating. Humiliation is considered by Morrison as »that special form of shame experienced in an interpersonal context«, and the internalization of this experience results in an identifiable persecutor, a »persecuting introject« (Morrison, 1989, p.118). The developmental experiences leading to shame vulnerability entail the development of the ideal self; while in the case of humiliation, they additionally entail the presence of an identifiable persecutory object. This latter is closer to the experience of »the hated child«.

Treatment

Morrison states succinctly: »For guilt the antidote is *forgiveness*; for shame, it is the healing response of *acceptance* of the self, despite its

weakness, defects, and failures« (1989, p.82). From the point of view I am developing here, the therapist's healing response of acceptance is in the larger context of respect for the actual state, feelings, and reality of the body. It is this broader attitude, leading to the attainment of self-respect that is the basis of self-acceptance.
Morrison describes the psychotherapy of shame:

> »Protracted empathic immersion in the feeling state of any patient … will usually unveil deep and painful shame feelings. … [T]heir discovery, examination and working through by the patient, and the ultimate realization that therapist and patient alike can accept them, represent a major curative factor in every successful treatment. In achieving this goal, therapists should be helped and guided by recognition, through vicarious introspection, of their own personal failure to achieve goals and to realize ambitions and ideals, of personal grandiosity and failures. In short, therapists must be willing to face and acknowledge their own shame and the pain that accompanies it« (1989, p. 82).

This description applies for the bioenergetic therapist as well. Energetic work can be approached with the same kind of sensitivity to the shame proneness of the patient, his/her narcissistic vulnerability, and his/her needs for the selfobject functions of the therapist as should be the case in verbal psychotherapy.

Shame System

The distinctive nature of bioenergetics immediately brings shame to the center of the therapeutic stage. In my understanding of bioenergetics, its essence can be captured by the phrase »seeing the person« (Helfaer, 1998, chapter 3). Working with the body is based on a discipline of contactful looking and seeing. To the degree there is any shame proneness, it will be easily and sometimes immediately stimulated by the awareness of the eyes of the therapist, now experienced by the patient as his or her own »eye turned inward«, looking at him- or herself in shame.

Respectful looking and seeing must be based in the therapist's deep

acceptance of him- or herself on the bodily level, an acceptance that will be registered by the client as a sense of respect when he or she is looked at and contacted. Then the energetic work may be addressed to helping the patient establish a sense of self-respect which will ultimately allow him/her to find his/her own movement.

Bioenergetic analysis, by its nature, can also immediately and directly access another facet of the shame experience. As noted earlier, shame has a cognitive aspect and an affective aspect. The cognitive aspect of the shame-system is a set of beliefs, fantasies, idealized images and ideas, sometimes diffuse and vague, often very specific, which define what the self »should« be or must measure up to. The painful affects of shame are bodily experiences. Affect and belief system, feeling and ideals, need to be separated from one another. This separation is initiated from the moment when the body becomes the focus.

In our shame, we live in delusion. The delusion is that I have a horrible feeling because I have not fulfilled such and such ideal. In reality, it can be said with equal truth that I am convinced of the truth of my (idea that I am a) »failure« because I have painful feelings. As R.D. Laing wrote (1970, p.10):

> »I don't feel good
> therefore I am bad
> therefore no one loves me.
> I feel good
> therefore I am good
> therefore everyone loves me.«

Experience tells me that it is very difficult to relinquish the unrealistic expectations of the self embodied in the »shape of the ideal self«. What makes it so difficult? Why do we insist so on our sense of failure and defect? What makes the quest for the selfobject so enduring? All these rest on fantasy and unrealities, yet they may dominate the personality, indeed, dominate a lifetime. These questions bring our attention to the fact that we are dealing not simply with a »feeling« of shame, but a shame-system, or a self-hate system; and these are as-

pects of character. The shame-system and its attendant affects are, in fact, key components for maintaining the self-restricting functions of character. The above questions are usually painstakingly addressed over and over in very specific ways and very specific contexts in the course of therapy and often a lifetime.

Here, bioenergetic work makes its unique contribution in treatment by addressing the modifications of the energetic processes. Bioenergetic work, in part, addresses these modifications by addressing specific aspects of somatic functioning. These include muscular tension, restricted respiration, held affects, and autonomic imbalance. However, while a bioenergetic intervention is very specific in the way it addresses a bodily function, the person remains the center of focus, and contactlessness is always the underlying energetic issue. Thus, the actual approach to working with these somatic aspects of shame varies greatly depending on the clinical situation.

Bioenergetic therapy also addresses the over-arousal of the sympathetic nervous system, by encouraging a balancing with the parasympathetic system. This therapeutic goal is calming down. A calming of the autonomic nervous system can occur through rhythmic deep breathing, crying, and the release of anger. In other cases, with shock, frozenness, and with gastric intestinal symptoms, for example, the parasympathetic system is over aroused. Depression and anxiety, in different ways, also represent imbalance and over-arousal of both the sympathetic and parasympathetic nervous system, as well as other central nervous system and hormonal disturbances. Energetic work in these cases focuses, in different ways, on »calming down«.

Relationship Matters

In the course of empathically sharing the experience of the patient through the layers of defense, characterologically and energetically, painful shame experiences and their origins are reached. Through energetic work attuned to painful affects, fostering breathing that releases crying and grieving, amongst other processes, bioenergetic work fosters a healing of the painful contractions and related affects

and calming down. In the course of doing so, this work also revitalizes the capacity for self-respect through enlivening the body.

I am referring to a complex and ongoing psychosomatic process occurring within a therapeutic relationship. It is a biological process, a deeply personal experiential process, and develops within an interpersonal context with its own energetic and characterological complexities. There is no simple technique involved. The distinguishing feature of this work is the way it approaches character and personality through an energetic understanding of body process within the therapeutic relationship.

For those carrying any degree of shame, humiliation, or self-hate, their relationships are inevitably burdened with projective identifications. The inside is put outside, and the outside is little more than a stage for playing out the inner drama. The experiential outcome is misery compounded with confusion. There is confusion because we seek events, scenes, and relational episodes that provide the setting for reliving the painful experiences of shame and self-hate arising from inner sources.

The intention of therapy is to help the patient reach the experience inside, because in so doing, the patient establishes a deeper contact with him/herself, the self integrates estranged parts, and the energy involved in the estrangement, projection and projected experiences can be invested within the self.

The relational world is constructed, for those so vulnerable, in terms of the shame-system, and this is a terrible burden. Sometimes it would seem that the simple word »shame« can hardly encompass the nature and quality of the actual pain. In some way it does not encompass it, because the shame affect is often used in the service of self-punishment, self-restriction, and self-controlling. It can become part of a runaway punishing superego, used to control wanting, desire, excitation, and sexual expression. This kind of self-punishment, self-restriction, and self-controlling expresses the inhibition and chronic modification of the pulsatory system underlying character.

Here, the contribution of bioenergetics is helping the individual to find and reclaim his or her own movement, to free the pulsation from the characterological restrictions on the attitudinal and energetic levels.

This is done in the same spirit as described above, immersion in the experiences of the patient, and the gradual separation of the patient's own movement, excitation, wanting, desire, and personal aims from the old self-hate systems and the old energetic restrictions.

Self-Respect

In this context, it is very important to note that self-respect, in this process, *does not mean not feeling shame or pain*. On the contrary, it is the attitude toward the self that allows me to feel and »suffer« my shame and pain. It allows me to suffer the feelings, rather than suffer the effects of the struggle against them. In suffering the shame, I can, in a sense, complete an experience, feel it through to its sources and its end. I can then look at the sources of the shame within my personality and history. This too prepares the ground for self-acceptance, the antidote to shame, the acceptance of my flawed, failed self.

The difficulties posed by the idealizations, »the shape of the ideal self«, in bioenergetic therapy are enormous and cannot be overemphasized. They can sink the whole therapy if they are not constantly addressed. Idealizations are always an aspect of the self-hate system or the shame-system. In addition, the »dialectic of narcissism« (Morrison, 1989, p. 64) is almost always present. In other words, the therapist will be constantly faced with the confusing and seemingly chaotic swing between some form of grandiosity and some form of self-denigration. Both idealization and self-denigration often form the cores of partial identities, a negative one (»I'm worthless«) and an inflated one (»I'm special«).

Both poles – the negative and the inflated – are at discrepancy with simple bodily realities. These discrepancies are a constant source of the rejection of bodily experience which makes contacting bodily experience and feeling extremely difficult. In fact, this effect on the individual's inner experience of feeling is stronger than repression and more difficult to root out.

Under the influence of the shame-system and the flux between negative and inflated identities, every and any feeling can be immedi-

ately attacked, denigrated, and turned into something bad and worthless. The immediate benefits of energetic work – deeper respiration, greater aliveness – can be immediately undone by becoming attached to a sense of worthlessness, failure, inadequacy, or badness. Desire, wanting, and genital feeling is immediately shrunken in the face of taboo, dirtiness, shame, and badness.

To be established within the patient, the attitude and the process of self-respect must be continuously held within the therapeutic relationship. For both the bioenergetic and the analytic therapist, the therapist has to be grounded sufficiently in his or her own self-respect to tolerate the failures, the frustrations, and the lengthiness of the therapy. The therapist's own self-respect and the integration of his or her own failures and humiliations allow him or her to tolerate any disbelief and demeaning, shaming aspects of the projective identifications of the patient, the patient's disappointments in the therapy, and the patient's validated recognition of the therapist's failures.

The practice of working bioenergetically with the body is a great help in bringing out the unreality of the expectations of the ideal self, the quest for specialness, and other aspects of the shame system. Regular work with the body brings us back to the reality of the body and therefore the simple realities of the imperfect, mortal, and limited self. Facing the experiences of the body gives something very tangible to accept; it cannot be escaped that this is me, and the conflicts around self-hate versus self-acceptance can be experienced very immediately in the here and now. There is nothing to interpret or explain; here I am; here you are. In addition, working with breathing, grounding, and the release of tension directly strengthens the sense of self through heightening energy, feelings, and a sense of aliveness. In such a state, there is less need to put what is inside outside.

If shame, itself, has been an overlooked topic, so too, and even more, has been self-respect, the healthy state antithetical to shame. In my own therapy with Alexander Lowen, as well as experiencing him as a positive presence in my life, I realize also that he had a kind of *respect for me as a living body*. This is how I would put it: *respect for me as a living body*. This was the context in which I first had a healing experience of self-respect. I believe the patient can establish self-

respect when we therapists have the same kind of deep respect for ourselves and the other *as a living body*.

Pleasure

There is a direct connection between the treatment of shame, the development of self-respect, and the development of the capacity for pleasure and sexual fulfillment (Helfaer, 1998). Self-respect is distorted by subordination to the demands of the ideal self, and the capacity for pleasure is lost to narcissism, shame vulnerability, and humiliation vulnerability. Pleasure heals.

One process that occurs in the treatment of shame involves, essentially, the weakening of the dominating demands of »the shape of the ideal self«. Supporting the deepening connection with and feeling of the body strongly fosters this process. In encouraging self-respect, the subordination to the ideal self is weakened.

Within the shape and texture of the shape of the ideal self, there will be idealizations about a sexual self, ones which inevitably are out of line with the real sexuality of the body and the real sexuality that can occur in a love relationship between two real people. There will also be idealizations about what the body of a man or a woman »should« be which are equally unrealistic and which are deeply implicated in some of the most intractable and punitive functions of the shame-system.

In developing the capacity for self-respect and pleasure, the path inevitably leads through experiences of shame. Holding and tolerating these painful affects are the actual basis for the development of self-respect. As the painful affects of shame are accepted, tolerated, and held within the therapeutic process and relationship, the patient's contact with him-/herself deepens, and he/she is freed from the aspects of the shame system that, deriving from violations of sexuality, precluded the experiencing of pleasure, the identification of pleasure and the fulfillment of sexuality as guiding principles in life. As I come to have good feelings in my body, it is more and more possible for me to feel like a good person, to identify what is good in me, and to bring it to my relationships with others.

In almost everyone I meet, I find these longings: to feel the goodness of one's self, to free the genital from feelings of shame, to free the feeling of sexual desire from shame, sexual ruination, and fear, and to come to feel lovable and to have the capacity for loving. I see that when people find these capacities within themselves, they are able to face their life, find the pleasures it can offer, and find a sense of fulfillment.

Conclusion

Shame, shame vulnerability, defenses against shame, and humiliation will enter into any depth-oriented treatment situation such as psychoanalysis or bioenergetic analysis. Bioenergetic analysis has unique contributions to make to the understanding and treatment of shame. The bioenergetic therapist can facilitate the establishment of the positive, healthy body state of self-respect. In addition, by addressing the body, the inter-relationship of shame and violations of sexuality emerges clearly, as does the more general relationship between selfhood and sexuality. Self-respect and allowing pleasure and a good-feeling body state become the alternatives to the shame and self-hate states.

For now, what remains to be said in conclusion is only the following: For the therapy of shame, and that means virtually any therapy, to reach any depth of healing, there are at least three necessary elements: First, and perhaps above all, the therapist must have felt, lived with, and come to understand and accept his or her own shame, grandiosity, sense of defective and failed self, need for uniqueness, shame vulnerability, humiliation and humiliation vulnerability, self-hate system, and shame-system sufficiently to have found the path of healing that acceptance and self-acceptance can provide. Second, for the bioenergetic therapist, the therapist must have within his or her own bodily self the experience of self-respect, by whatever name he or she calls it. And finally, not only must the therapist have the capacity for detailed, patient, quiet, and empathic sorting out of and immersion in the actual shame related experiences of the patient. The

therapist must also have the same empathic capacity for holding and sorting out the highly charged maneuvers, games, and ploys designed for concealment, and other character defenses, with which we all protect ourselves from shame and humiliation.

And finally, we should never forget that it is hard work for both therapist and patient, and we as therapists need to assure ourselves that we find within ourselves and our environments the sources of support for an ongoing sense of self-acceptance and self-respect that we are ourselves deeply in need of.

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Sensitivity Training during Pregnancy: Key to Bonding and Possible Prevention of Neurosis of the Child?

Christa D. Ventling

Summary

The prime importance of the quality of mother-child bonding has been known for many years among psychotherapists; however, this is not common knowledge for most mothers-to-be. Thus a pregnant client is a chance and a challenge for a body psychotherapist: 1.We can assist the mother-to-be to form a deep bonding with the baby before birth already by educating her about the neurobiological changes occurring during pregnancy and the expected degree of development of the infant at birth. 2. We can offer special awareness exercises (described here in detail) which improve perception of all senses (seeing, hearing, touching and smelling) and thus sharpen the mother-to-be's sensitivity for her environment, especially for the signals the baby will send out. The work described here aims to help the pregnant client to tune into the body language of the baby as a prerequisite for a deep and loving bonding. It could also be a preventive measure for a later neurosis of the child. Two short case vignettes will illustrate the approach.

Key Words: Pregnant clients – sensitivity training – awareness exercises – newborn signals and body language – bonding quality.

Historically the awareness of the necessity of a mother-infant bonding for survival of the child goes back over 200 years, yet only for the past 50 years do we recognize the importance of the quality of this bonding. Whatever happens at the very beginning of life outside the uterus, sets the stage for the future personality structure of the child.

We know probably only a fraction of possible disturbing factors and we are still guessing retrospectively when we see a neurotic or depressed client coming for psychotherapy, what the beginning of her or his babyhood could have been like.

How to raise a child in a way that he will grow up to be a happy, healthy, mentally and emotionally well balanced human being is probably on every mother's mind nowadays and also a constant worry. Does she possess the necessary background information? Can we psychotherapists who after all have accumulated a precious amount of knowledge on the subject of mother-infant relationship, can we/ should we not be obliged to inform and educate, at least for some part of therapy? Centuries of suffering for both babies and mothers preceded the incredibly long process that ultimately led to our present concepts of the importance of the quality of the mother-child bonding as predicting the form and direction into which the child's personality and character structure will develop.

Most mothers (or fathers) who come to us for psychotherapy are not aware of the real importance of this early basis in life – but they are bound to find out when they make contact with their own inner child. And many mothers-to-be are fearful about the forthcoming life with a baby for various personal reasons. From the time I saw a pregnant client filled with *fear of not being able to love the baby* I have been thinking hard about the best way to work with pregnant clients which would instill love for the unborn and confidence for life with baby later on.

The two vignettes below are purposely short and much abbreviated. They are only meant to provide an explanation for how I developed the idea that therapies with pregnant clients should – depending on the status of knowledge of the client – also include some basic information about neurobiological changes during pregnancy and especially at the time of birth. The emphasis here is on finding ways to secure the bonding between mother and baby; not on analyzing the character structure of the client or going into detailed analysis of transferences or on giving an accurate account of the therapeutic process. Such details would go beyond the frame of this article. In both psychotherapies related here, I or better we, the client and myself, had less than 9

months to work towards the primary goal i.e.,. to help the mother gain sufficient self-confidence to establish a trusting secure bonding with the new baby regardless of his gender.

I am aware that I chose a rather unconventional way of doing body psychotherapy e.g. to mix in an occasional bit of teaching or »dispensing« knowledge when adequate with proper psychoanalytical body work. Yet the good result obtained in the first therapy encouraged me to try it again a second time. The so-called sensitivity training, explained further below is of course no proof that it could prevent a neurosis in the future but it certainly had an increasing effect on the mother's level of awareness in general and especially in the immediate peri- and postnatal time period. It is hoped that readers might be stimulated to also try what I did.

Jane, 28-years old, married for 3 years to an ex-Olympic champion, was beaten by her husband on several occasions so brutally as to require hospitalization. The couple had a 2-year old girl much attached to her father. This was the reason why Jane hesitated to seek a divorce and with this ambivalence came into therapy for help. Bioenergetic body work helped her getting in touch with her repressed feelings. The sado-masochistic marital relationship had a precedent: Jane's father also beat up his children. Jane had learned long ago to stoically bear the physical pain of these beatings, but after she gained the insight that her present situation repeated her childhood experiences and after she rediscovered her real feelings, she came to the conclusion that she no longer needed any of this and filed for divorce. During the following two years the discarded husband made numerous attempts to win her back, a stressful time also in therapy, but she managed to remain firm and obtained the divorce. Shortly thereafter she found herself pregnant – her ex-husband's revenge had been a violation. Jane was in a new dilemma: to keep the baby or to go for an abortion. She opted for the baby. Now we worked on her fears, that the baby would resemble the father, would display a similar character structure etc. and that she would never be able to love this child.

I discovered that Jane, although she had gone through one pregnancy already, did not really know much about pregnancy or a newborn. Our sessions from now on included information on the biology

of pregnancy (as described further on), on the development of the baby, on his abilities at birth, his body language, his signals etc. and the more she learned about this, the more curious and loving towards this as yet unborn and unknown baby she became. With this client I developed the awareness exercises as outlined below which she experienced as a completely new world. She said it felt like her body had opened up in every respect to let in sights and sounds never experienced like this before. Eventually the pregnancy came to an end and Jane gave birth to a boy. She gazed into his eyes, said she saw love and bonded immediately with him. She said that it was all so very different from the birth of her daughter. Her relationship with the boy remained good in spite of his occasional temper tantrums. Jane took him with her to therapy sessions for about half a year and we often had live demonstrations of previously theoretical points. We ended the therapy when her boy was 2 years old. A couple of years later I met Jane by chance and learned that she had a loving relationship with a new partner and was very pleased with the way her children developed.

Some time after the termination of this therapy another woman, whom I will call Paula, with an almost identical history came into therapy, except that she was already pregnant with her second albeit unwanted child, also result of a sexual assault by her divorced husband, from whom she had to flee to the »Woman's Shelter« with her little girl in order to protect the child from the beatings of the father. Paula also chose to keep the baby in spite of her worries that it might be a boy and turn out to have inherited the aggressive personality structure of his father. I once said to Paula: »if you can »read« the baby, his bodily and facial expressions, interpret the look of this eyes, you have won half the battle.«

With Paula I did repeats of the sensitivity training sessions because she often seemed to »go away«. They helped keep her grounded. She also got curious wanting to know more about the specific neurobiological development of the baby. I therefore included on demand intermittent short bits of psychoeducation. In the end she gave birth to a boy. She said that she loved him at first sight. She also brought the baby along for therapy sessions for the first 6 months. I could see that Paula and her little boy had built up a good and strong bonding. This

therapy came to an end after a couple of years because Paula moved away due to her job. She still writes me a letter every Christmas and tells me in details about the progress everyone is making in her family.

In the following I will highlight some historical landmarks the knowledge of which I consider crucial for us psychotherapists. Some may be strictly background material for the therapist, others lend themselves to be told to the client.

How the Concept of the Importance of Mother-Child Bonding Developed Historically

The Medieval Age: Lack of Interest in Children

The medieval age, writes Barbara Tuchmann (1980) was characterized by a striking comparative absence of interest in children, emotion in relation to them rarely appeared in art or literature or other documentary evidence; half of all children born died before the age of six through lack of care, lack of food or infectious disease and half of all the mothers died sooner or later from childbed fever or other disease. On the whole, babies and young children appear to have been left to survive or die without great concern in the first five or six years. Up to the 13th century it was customary to test the viability of a newborn baby by dipping him into a very cold brook (Hrdy 1999, p. 464). The Catholic Church then actively renounced infanticide – which this dipping custom often was – and as a solution for an unwanted child recommended they donate the child to the Church. How many newborn babies were then dropped at doorsteps of nunneries is a guess. It is left to our fantasy what psychological effect this early rejection and abandonment may have had on the character and history of the survivor. A cruel period indeed which makes us shudder when we read about it.

The 18th Century: Sudden Interest in Children

The 18th century, *Age of Enlightenment*, was characterized by major changes in rational thinking with effects extending into all areas: politics, law, science, religion, art and for us most interesting: education. Now suddenly there was talk of the possibilities of a happy process of the natural unfolding of the character, of learning from observations of nature and from the experience within nature, of the free and uninhibited development of one's own abilities to reach a happy and joyful adulthood. The *»Art of Becoming a Human Being«* was defined as leading the growing child and young adult to develop a sane, healthy body and mind, a moral character, an intelligent brain, and teaching restraint and *self-denial of one's feelings* in order to comply with the requested social behavior.

This only would ultimately lead to happiness. These remarks were made by *Jean-Jacques Rousseau* who describes in his novel »*Emile*« published in 1762 how he envisions the realistic adaptation of his ideas on child rearing. He says that he would start by convincing the nurse taking care of the baby to take off his diapers as often as possible, as they tended to inhibit a proper growth of the limbs. Then he would convince the mother to nurse the baby instead of giving it to a wet-nurse, because a wet-nurse could possibly hurt the child through being cruel or negligent with the baby or she could win the child's affection which should be directed to the mother as the first source of love and first tie to form an orderly family unit. Nursing would guarantee a stronger and healthier baby.

Rousseau was absolutely right, both from a hygienic and an affectionate viewpoint. While mother's milk is sterile, water, used to dilute cow's milk, in those days was often contaminated. Dysentery was in fact the most common cause of death of small children. Registered rural wet nurses took care of babies in order to make a living, as money meant survival of one's own family; but the life of a stranger's baby did not count, and an emotional attachment to this baby was unthinkable (Hrdy 1999, p.11, 351). Infant mortality soared and death of children was everyday news. Rousseau's plea went unheard, his conclusion that a responsible, loving mother was needed, did not

get the attention it deserved and thus was forgotten. Although Rousseau was a controversial figure in many ways, I consider him the founding father of the concept that an early close physical relationship between baby and mother is necessary for survival. It is tragic that it took almost 200 more years until the attachment theory of Bowlby proved Rousseau right.

The 20th Century: Wars Provide Insight into the Importance of Mother-Child Bonding

The 20th century was a century of repeated wars and drama with uncountable children becoming orphaned. Small children ended up in institutions, older ones often struggled by themselves. As a result of all these wars orphanages all over were overcrowded and understaffed and in deplorable conditions.

After 1940 the first of many publications by a number of researchers appeared producing evidence of the traumatizing effects of even short stays, let alone year-long ones in these homes (Durfee & Wolff 1934; Lowrey 1940; Bender & Yarnell 1941; Bakwin 1942; Goldfarb 1944, 1947; Dührssen 1958; Spitz 1945, 1946a, 1946b, 1950). Most startling and impressive was a black-and-white silent movie made by the German physician and psychologist *René Spitz* about children he visited in an orphanage in Mexico, called »*Grief: a peril in infancy*« (Hrdy 1999, p.395). He became famous with this movie and followed it up with a number of publications (Spitz 1945,1946a, 1946b, 1950) on careful and detailed observations of children in such institutions. Here is what he found:

- separation from the mothers invariably was harmful, even life-threatening, and the situation got worse with increased length of separation from the mother,
- the lack of loving care, of cuddling, of close physical contact with the nurses plus the problem of undernourishment produced symptoms which included retardation in language comprehension, in muscular skills and in social behavior if the children survived long enough.

➢ The worst-off children became apathetic, refused contact, refused to eat, made not a sound anymore and finally died like a candle going out, all signs of what Spitz called »*anaclitic depression*«.

Spitz concluded that regular and maintained physical, sensual and emotional contact between the caretaker and the child was absolutely essential for the formation of a life-sustaining relationship.

Spitz's conclusions formed the basis for the attachment theory of *John Bowlby (Bowlby 1951, 1969). Its central premise is this:* Infants seek a secure attachment and need a secure attachment base for healthy emotional development. Bowlby thought that this base is best provided by the mother, but caretakers can also be other persons, as long as they are available on a regular basis and maintaining a strong emotional contact and as long as the quality of the attachment is a secure one (Ainsworth & Wittig 1969, Ainsworth & Bell 1970, Main 1981, Main & Solomon 1986). The important point to remember is that it is the infant who *actively* seeks the attachment.

Bonding as Preventing Neuroses: the State of the Art

Wilhelm Reich's Utopia

The question whether it is possible to avoid later neuroses by taking appropriate measures very early on in life was a challenging one for Wilhelm Reich**.** He founded a center where pregnant women could receive therapeutic care before birth and where they could return to afterwards with their baby. The center was staffed with competent social workers and doctors. Reich also envisioned a journal where the latest research data would be published – this was in 1949, at the time when René Spitz's findings on the orphanage children became known all over. A year later the dream of Reich for his »Children of the Future« as he named it came to an end, for a number of reasons, one of them being his demand that the women there should not have any

»character armoring«, in other words be free of any neurotic trait. His selective search for such perfect women to become perfect mothers with perfect children was far too unrealistic and bound to fail.

Modern Approaches

Nevertheless the question whether neuroses of adult life can be prevented remains intriguing enough. If we start to look at what time in life one should actually start, the time of birth seems the most logical. And in fact it is a good time. The mother-baby dyad is being formed now if it has not been formed already earlier during pregnancy, mother-baby interactions take place according to the mother's know-how, her sensitivity, her intuitive feeling for what is going on in the baby and how the baby is affected by the environment. But many unforeseen crisis events can happen at birth or any time thereafter, upsetting the attachment of mother and child and therapeutic repair work becomes necessary. Thus it could be that the birth process is unexpectedly complicated and delivery difficult for the mother and in consequence has an anatomical or psychological effect on the baby or both. Sometimes medication during delivery becomes unavoidable and this influences the baby's emotional and cognitive presence, delaying the bonding process. Or it could be that a happy mother-child dyad is suddenly disrupted due to separation from or loss of the mother. Or the bonding process is disturbed due to unresolved neurotic problems in the mother stemming from her own childhood or going further back to her own insecure, disorganized or avoidant bonding with her mother (Ainsworth & Bell 1970). Or the young mother must go back to work immediately after birth and childcare is inadequate, the mother worries, gets depressed, is not capable of giving her best in the little time she has available to establish a secure bonding between herself and the child.

Bonding remains the key word and every effort should be made, with the help of the therapist, but also by the mother or caretaker, to keep the quality high. What approaches then for preventing a later disorder in the growing child actually exist? Let me summarize:

Mother-Infant Dyad

Daniel Stern (1998, 2000) and his coworkers (Stern et al. 2001) did pioneer work in analyzing the interaction of mothers and their babies by taking videos of them in various situations, nursing, playing, etc. Since it is the baby who sends out signals for the mother to respond to, one can determine whether the mother understands the body language of the baby – which is what it is! They stop the video at fractions–of-seconds in intervals and analyze the reactions and expressions of both mother and baby.

This method is ingenious. Not only does the therapist see what could be improved, the mother sees it also and is convinced. With the appropriate coaching or maybe therapy, she can modify her behavior for the better. Micro-video-analysis is fast becoming a method of the future. George Downing, Vita Heinrich, Martin Dornes, Peter Geissler and others are applying it in their work with young mothers and their babies (Downing 1994; Kühntopp & Heinrich 2001, Downing & Ziegenhain 2001, Dornes 1992, 2000; Geissler 2006). I think we can look forward to many more papers testifying to the efficacy of this method. The learning effect on the mother has a direct bearing on her behavior towards her baby: Bonding is improved. Consequences of an insecure bonding in childhood are known to lead to split personalities later in life (splitting the feelings off, living from the brain; Rand 1996, Tonella 2000). Munzel (2002) suggested that it could even lay the ground for serious somatic disorders like multiple sclerosis.

A baby, even if he had some bad experiences, can still relatively easily »heal« – in the Piaget sense (1975), because accommodation leads to a new assimilation and vice-versa. The neocortex is still in a phase of continuous biological and neurological growth and so pliable that new structures are continuously laid down over the old ones, modifying them constantly. In summary then, working with mother-baby dyads is a very promising direction and I would predict holds an excellent prognosis!

Baby

Eva Reich continued one of the interests of her father Wilhelm Reich with regard to the »unarmored« child, but shifted towards small babies. She developed what is termed »gentle baby massage« or »butterfly massage«. The baby through the physical contact with the hands of his mother feels good, relaxes and tensions disappear. Eva Reich has taught her method to many people and several institutions have sprung up offering »emotional first-aid« to problem babies, notably in Bremen, Berlin and Rome (see Harms 2000, Reich & Zornanszky 1997, Wendelstadt 1998). The therapist teaches the mother this massage. It is actually based on an old tradition in India from where Francis Leboyer, initiator of the natural childbirth, brought it back and taught it to Eva Reich. How good this method is in terms of preventing neurosis is probably too early to tell as most of the babies treated so far have not yet reached adulthood and to my knowledge no scientific data exist as yet.

Mother-Child Dyad

How mothers and their preschool children present themselves in play and what conclusions to draw from their interactions in terms of quality of bonding was studied by Jens Kühntopp under the guidance of Vita Heinrich (Kühntopp & Heinrich 2001). They used some of the bioenergetic exercises modified for children by Halsen (1992, 2001). They not only diagnosed the type of relationship but provided therapy as well. The sessions were recorded on video and played back to the mothers who with the help of the therapists could discuss changes of interaction patterns if necessary. The videos were also presented to neutral therapists, who did not know the mother or her child or anything about them. By answering a questionnaire referring to the scenes on the video, an independent and neutral critical viewpoint leading to suggestions for altering the behavior of the mother towards her child was obtained and could be evaluated statistically. To see herself and her child on video can lead the mother to new in-

sights and initiate change. This is an excellent method. It could not only be truly preventive in terms of later neurosis, but it entails a scientific approach for research. Having such early data would provide a base line for testing the adult the child has grown into.

Child and Adolescent

Somewhere during childhood, between the age of the preschooler and the school-age child an invisible line exists, where a neurosis-preventive approach is not possible anymore. Maybe there is maternal deprivation, maybe an unusual behavior pattern has set in. We may have entered the field of early traumatizations leading to neurosis. From here on, instead of prevention we should talk about treatment and healing (von Klitzing et al. 2001, Ventling 2001).

Let us return to the subject of neurosis prevention. What stage is left? Let me come full circle and go back to pregnancy. How much and which information we give or how we give this information about the neurobiological changes during pregnancy, about the development of the fetus, about the birth and the chemical basis for bonding, about the importance of the mother-baby bonding in terms of consequences for the development of the personality and character structure etc. all remains an individual decision for the psychotherapist and depends very much on the curiosity of the client, on her trusting the therapist and last but not least on the bonding between them. It is actually a triad, for the baby whether unborn or born, is very much at the center of attention.

I think that one can do excellent preventive work with pregnant clients, provided one sharpens their awareness for the baby's »language«. Fear of what is about to come, »life with baby« can be a strong deterrent for bonding. As a therapist I feel challenged to turn the client's fear into joy, her ambivalence into tender love and her hesitancy into a warm welcome of the baby. I do this in 3 ways, always spontaneously, when the situation lends itself:

➢ I inform my client what happens during pregnancy in the mother neurobiologically and what she can expect to happen in the baby.

- ➢ I relate to her what I call the baby's »Starter Kit«.
- ➢ I work on her sensory awareness for seeing, hearing, touching and her olfactory sense and thus prepare her for »reading« the baby.

Pregnancy to Birth: Mother and Baby

Neurobiological Aspects of Pregnancy

Pregnancy and motherhood forever change a woman (Hrdy 1999, p. 94–95). Pregnancy alters the chemistry of her brain, preparing her for labor and motherhood. The pituitary gland (also called hypophysis) enlarges greatly in size. It produces a large number of different hormones which in turn control the activities of several other endocrine glands. Some of the hormones are of the endorphine type,- the word is derived from *end*ogenous m*orphin*e-like –, indicating that they produce a calming, soothing, well-being effect.

One of the best known and best studied of these endorphins is oxytocin. The name is derived from the Greek word *okus* meaning *swift* and *tocin from tokos* meaning *birth*. Oxytocin as its name indicates makes the pain of childbirth bearable. During pregnancy the number of oxytocin receptors increase greatly in the brain and uterus, getting ready for the birth. When the production of those hormones responsible for maintaining pregnancy stops, this then signals *go* for oxytocin production and labor is induced. When this is not happening the natural way, synthetic oxytocin is often given intravenously to a woman to initiate contractions.

During the latter part of the pregnancy specific neural pathways are laid out for the accentuation of certain sensory capacities in the mother, such as smell, hearing and also feeling. They enable a mother to be constantly aware of her baby. New mothers can smell better, hear extremely well, most can pick up an irregular breathing of the baby next door and all can hear the baby crying ever so faintly at night which their husbands rarely can! Many new mothers feel their

baby so much as part of themselves, even while physically away from him, that seconds before the infant begins to whimper, needle-like sensations can be felt in the nipples and warm milk leaks out.

The »Starter Kit« of the Baby

What can a newborn baby do already at birth? He can smell, he can differentiate sweet from sour and already favors sweet (like the milk of his mother); he can grasp and differentiate cloth from skin and he favors skin – that of the mother; he can hear and locate sounds, like the heartbeat of his mother and when placed on her belly, he will attempt to root toward her left nipple. He recognizes the voice of his mother, he recognizes his father by his smell due to the pheromones the father has emitted and the mother has breathed in all during pregnancy and thus passed onto the fetus – and he can see clearly the face of his mother while nursing, though not yet in color or in three dimensions. He can express hunger, pain, and the wish for contact with his voice and a few gestures. That is the baby's *»Starter Kit«* as I would like to call it. The infant is biologically prepared to engage in a dialogue with his mother and to form a firm bonding. But is his mother ready? Not necessarily.

Bonding in Neurobiological Terms

We know from research with rodent and primate mothers that affiliate behavior has a chemical basis and that it involves oxytocin (Panksett et al. 1985). A monkey mother whose brain receptors to oxytocin were blocked with a specific antagonist, made fewer overtures toward her infant and was less likely to put her face near the baby's. She tolerated the offspring alright but it was left to the infant to cling for dear life (Keverne, 1995). We conclude from this and from similar experiments *that loving feelings are not automatic, but are promoted and that the promoting factor is oxytocin.*

In humans the endogenous production of oxytocin after birth is di-

rectly related to the sucking of the newborn. When the baby is suckling, oxytocin levels rise sharply and stimulate the synthesis of prolactin. Prolactin needs to reach a certain concentration in order to induce milk production. This takes about three days. Sometimes oxytocin production is delayed (Robson & Koumar 1980), when e.g. medication was necessary during the birth process. All of this explains why perinatal bonding is not love at first sight (Shore 1997), but a process whereby strong feelings of attachment to the baby grow within days, when the mother holds the baby close, makes skin contact and gazes at her little darling. The process of attachment continues over weeks following birth.

Bowlby 40 years ago suggested that vision is central to the establishment of a primary attachment. He was partially right, chemically speaking at least. When the mother gazes happily into the eyes of her baby, oxytocin – we know this today – is produced in her brain (Shore 1997). The happiness seen in the mother's eyes by the baby in turn triggers high levels of oxytocin in the child's growing brain and he will glow with happiness. This shows also clearly that while sucking of the baby is wonderful it is not a prerequisite to bonding, as the production of oxytocin also works through other sources. A woman who adopts a baby and thus fulfills her long-kept wish will also relay her deeply felt happiness to the baby. The chemical reaction behind it is the same as with a biological mother.

Now of course mother or caretaker and baby are not just *looking* into each others eyes, they are using the voice and gestures in their dialogue, not to forget the physical contact. These early social events are circulatory in nature –Spitz spoke about a »duet« and Stern about a »dance« (1998) – and they are imprinted into the biological structures that are maturing during the brain growth spurt that occurs during the first two years of life. The organization of a hierarchical regulatory system in the prefrontal areas of the right hemisphere of the neocortex is of particular importance, for here the basis is formed for social functioning later on in life. While these structures are laid down the brain continuously grows – in fact it has reached 70% of adult size within one year (Aiello 1992, Aiello & Wheeler 1995) and full size within two years (Himwich 1975).

The first two years of life are thus crucial indeed. Traumatic experiences within this time lead to bad or faulty imprints, lack of experience to no imprint at all. Again we know from animal experiments that lack of stimulation of specific nerves leads to their irreversible degeneration. When e.g. an eye of a newborn rat is taped closed for several weeks, no visual stimuli reach the visual nerve of this eye and it degenerates. The same is true if one closes an ear of a newborn rat with paraffin – he will never hear with this ear because the auditory nerve degenerates in the absence of auditory stimuli. We assume this pattern to be valid for all nerves: Nervous impulses reach specific areas of the cortex and lay down the structure corresponding to the stimulus. This is the neurobiological equivalent of what Piaget (1975) called »assimilation« and »accommodation«.

Furthermore we have good reasons to assume that the findings from animal research are valid also for human babies. For lack of bonding – as we know now – occurs through lack of skin contact, lack of sensual stimulation. It can lead to a shutting down of the development of the emotional (right) hemisphere of the brain in favor of the thinking (left) hemisphere which matures later than the right one. In other words this could be the beginning of the mind/body split. Poorly bonded babies will grow into insecure adults, driven to figure out how to get by, how to cope and how to control situations (Rand 1996). They live their life from their heads and prefer to ignore their emotional center, which could throw them out of control.

Possible Roles of the Therapist

Since early events of life have such an inordinate influence on literally everything that follows, what can we as body-psychotherapists contribute? I would say, several aspects are possible and this independent of whether the therapist is a man or woman.

➢ We can establish a caring, mothering relationship with a pregnant client, a sort of bonding on a different level. This is key to help her with her anxieties about the growing fetus, his signs of life

after the 16th week of pregnancy, the birth and the relationship with her child thereafter.

- We can educate her. Infants need mothers to keep them warm, safe, stimulated, clean, fed, and most important, to communicate tenderly and responsively their commitment to go on caring. Caretakers need not be the mother, or even one person, but they should always be the same so as to provide constancy. We can point out to our client that good bonding takes place when there is skin contact and stimulation of all senses. We can tell her about the need of the baby to bond and how he is trying to achieve this. We can teach her about the »Starter Kit« of the baby and about what she as a new mother is offering and help her »read« the signals of the baby. The better she is prepared for this, the easier is the establishment of bonding. Telling a mother-to-be that all she has to do is to carefully read the signals of the baby and *respond*, *not initiate* the »duet« or »dance« takes a lot of pressure off of her.
- We teach her that quality, not quantity of time is important. Attachment does not mean enchaining the mother and does not require a 24-hour presence of the mother or caretaker. We must be careful that we do not inflict guilt feelings on working mothers who preferentially give quality time after dinner and on week-ends.
- We can help her increase her perception so that her awareness for the baby's expressions is increased with exercises which increase perception and sharpen awareness in general and which are easily done during a therapeutic session. They are even fun to do and as I was told by my pregnant clients most helpful. (For more details see Ventling 2001).

Awareness Exercises

For all the exercises – and I only do one type per session – I first give directions, but then I let the client explore in silence for a while, then we talk about her experience. As a start I ask the client to find a comfortable position, to relax, maybe to place her hands over her belly

and breathe normally. Enough time (several minutes) should be allowed and further exploring by the client should be encouraged.

Awareness of Color

I ask my client to let her eyes wander about the room and out of the window and to note in her mind everything she sees which has the color pink. It is a good idea to specify a color which is *not* predominant in the session room. After a while of silence I ask her to repeat her »walk« with eyes closed. And after some more silence I ask her to tell me what all she noticed, whether the »walk« with closed eyes was different from the one with open eyes and, if yes, in what respect, whether there were images emerging having something to do with the color pink or memories etc. The client may want to know which colors the baby can differentiate and at what age.

Awareness of Shape

This exercise is done exactly alike except that I choose a *common* shape, e.g. everything round. Clients are often shocked to find that they speak about a certain object as being round, because they *know* it is round, yet from the position they are looking it does not appear to be round. This then leads us usually into a discussion about what and how the baby sees things.

Awareness of Noise

For this exercise a not very sound-proof session room is of advantage. The client is asked to notice anything she hears, again first with open eyes and then with closed eyes, each time for about 5 minutes. Noises can be in the room or coming from the outside or from inside the client's belly. The surprise here is usually the notable difference between perceiving noises with closed eyes and with open eyes, of locat-

ing noises, again of combining hearing with knowing and it may lead to a discussion about what all the baby can discriminate by hearing.

Awareness of Odor

I ask the client still sitting, to start out recording the odor of the room, through deep breathing, with eyes open and also closed, to notice a possible difference. I then ask her to walk around the room and feel free to put her nose to the furniture, the desktop, the window or the rug, for example, always with eyes open and then closed, sniffing and recording. Finally I ask her to smell her own skin on her arms, her hands, maybe her hair. Clients are usually amazed how many odors can be differentiated and how they are related to specific memories. Again they usually want to know what the baby can smell.

Awareness of Touch

I ask the client to touch with just one finger or two various regions or parts of her hand, forearm, elbow, upper arm, neck, face, calves etc. again once with eyes open and once with eyes closed, to stay quite long on one area, to apply pressure maybe, to compare and note the differences. Later we talk about the experience. The difference in sensitivity of the various areas is readily noticed and it raises curiosity about what the baby can feel.

Conclusions

To have a pregnant client in therapy is in my mind an excellent opportunity to promote future bonding of the mother-to-be with her baby, integrating facts about pregnancy and development of the baby into the therapeutic process. This creates an emotional climate very much suited to receive the newborn baby with love and form a strong bonding. Furthermore perception exercises tend to bring our pregnant clients

to a greater sensitivity and awareness of the body language of the baby and provide a good basis for being able to »read« his signals.

For the two described cases here this modified type of bioenergetic therapy seems to have resulted in a very positive effect. Both women were extremely fearful of men after what they had experienced during their short marriages and also full of rage. During therapy some of these strong negative feelings could be released and the danger that they might turn them against their unborn babies was much diminished. One patient managed to enter a new and happy relationship with a man who cared very much for her children and thus was a good substitute father. The other patient had retained her mistrust toward men at the time she had to move. I gathered that her traumatization from her husband would have required much more therapy. However, the relationship of these two mothers with their boys turned out to be a good one and this I consider a very important result of the type of therapy I provided. Whether my approach could actually be neurosis-preventing, cannot be answered at the present time and must be left for future researchers.

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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.

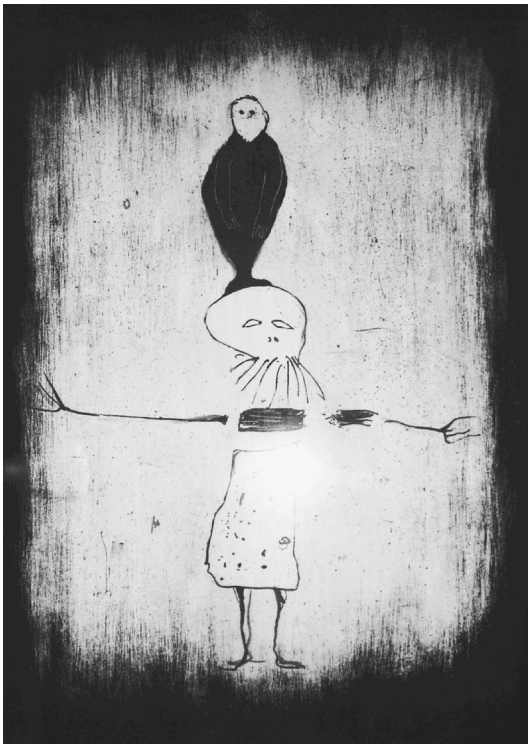
The History of her Life

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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Bioenergetics in Search of a Secure Self

Robert Lewis

Summary

This paper, based on my personal experience and more recently available biographical and autobiographical sources, is an attempt to re-evaluate classical (Lowenian) bioenergetic analysis from a perspective based on recent research from the attachment paradigm. Specifically, it explores the use of the body, its energy and sexuality as substitutes for a secure relationship with a caregiver.

Key words: attachment, secure base, avoidant, shock, dissociated, psychosomatic unity.

(In this paper I will use the masculine pronoun for purposes of stylistic simplicity.)

I. Introduction

This paper[1] is an important clarification for me and I hope for others. In it I am relying heavily on my own experience of Al Lowen over the 48 years that I have known him. For years as a young man I idealized Lowen and felt soothed and secure that he had the answers to life's

1 I would like to thank Marlee Manning and David Campbell for first calling my attention to attachment research and literature. I also thank Margit Koemeda, Peter Fernald and David Finlay for their substantial editorial assisstence.

problems. Unfortunately for all of us, I would argue, he called the therapy he created »Bioenergetic Analysis« rather than Lowenian therapy. Furthermore, like many therapists, as he became aware of problems in himself, he saw them in his patients. He also saw them as givens in the human condition, at least in our western, contemporary culture. As was and still is his style, he expressed his beliefs with great conviction.

Because of my personal history with him, it has been important to me over the years that I gain a more objective perspective on his life and work. Lowen's candor in his Festschrift interview in the IIBA Journal (1990) and his autobiography (2004) helped me to understand with more clarity the relationship of his mind and body. This, in turn, enabled me both to preserve the bioenergetic treasures he gave us and to better see how easy it had been as a bioenergetic patient to surrender my psyche-soma in the hope of being cured. This is an intensely personal paper, perhaps a later day version of a paper (1996) entitled: Bioenergetic Analysis: My voyage to self-discovery. But the paper is also at the same time a commentary on a topic with which the IIBA (International Institute for Bioenergetic Analysis) is currently struggling as it attempts to chart a realistic course with Lowen no longer at it's helm. The topic I am referring to is the proper scope and importance of the therapist-patient relationship in the theory and practice of Bioenergetic Analysis.

A. Underlying Assumptions: In this regard, the central thesis of my paper is built on a number of underlying assumptions.

1. Therapists pick the modality that suits their own proclivities … specifically, their own capacity for intimacy/autonomy, their own attachment style.
2. There is always a relational significance to any therapy process; it may be explicitly and fully acknowledged or not.
3. In the latter case, regardless of the explicitly stated vehicle of healing, the relational process will operate, out of awareness, on an implicit, nonverbal level.

B. My Central Thesis is that

4. in bioenergetic analysis (better described as Reichian/Lowenian therapy), the above relational significance has been distorted in a manner that weakens the otherwise deep healing power of a relational somato-psychic approach.
5. This distortion, which Lowen inherited from Reich, is at the heart of a poignant attempt to find a personal solution to Lowen's deep woundedness. Further, this distortion:

a) is richly documented in recent autobiographical material from Lowen himself;
b) must be understood and faced if we are to integrate our powerful psychosomatic legacy with a more mutual and realistic model of the clinical encounter.

While the above propositions can probably be illustrated from a number of relationally-oriented perspectives such a self-psychology, object-relations theory, etc., I have found the attachment paradigm (with its empirically derived model of normative development) particularly helpful in illuminating how relationship issues are woven into the fabric of bioenergetic analysis.

It is clear that Lowen has left us a rich legacy in the clarity and depth of his understanding of the body and its dynamic interaction with our thoughts, feelings and emotions. He and Reich are indeed the giants on whose shoulders we who follow stand. Lowen's passion and penetrating insights about the life of the body are clearly unmatched. But we are also left with the practical question as to how therapy actually works. I am suggesting that to properly evaluate any school of therapy, the interactive field is so complex, that, for a start, we are well advised to understand the relationship between who the founder is as a person and the »method«, the therapeutic edifice he is presenting as »the way«. Finally, I am aware that many of my colleagues no longer practice »classical« or Lowenian bioenergetics. They are no longer poor copies (as I was for the first five or more years of my practice) of Dr. Lowen himself. Nonetheless, it behooves us to look carefully at where we come from, and, to date, I am not

aware that the message in this paper has found its way easily into print.

II. History and Background

My Early Training and Therapy:

Bioenergetics and the three charter members of the institute in New York City were my second family. I bonded deeply and early in my career with Alexander Lowen, John Pierrakos and William Walling who were each at one time or another my therapists and mentors. For years, their truths were my dogma. Slowly this changed, as I had to face how little I had actually been able in my bioenergetic therapies to deal with the pre-symbolic, nonverbal issues that had drawn me in the first place to a body-oriented approach. Actually, all along the way I had the occasional experience in which reality disturbed my dogmatic use of bioenergetics.

One occurred during a workshop in New York in which Bill, John and Al each worked in a different area of a large loft space. Participants would move around the room and be worked with by each of my three idealized attachment figures. It was both frightening and deeply relieving to discover that Bill, John and Al each focused and worked on completely different issues with the same person. The message landed: Either there was not a story that could be read in the form and motility of each workshop participant's body, *or that story was so complex* (currently, I would add, and so influenced, moment-by-moment, out of awareness, by the unique limbic conversation with each therapist), that each of my three mentors trusted themselves to work with that part of the story that spoke to them at the moment. Slowly, I became able to maintain my respect and affection for colleagues, experienced pediatricians for instance, who found some of the Reichian/Lowenian propositions about parents and children simplistic. I could value them as people and even consider that bioenergetics might not have all the answers.

Winnicott and my Abiding Professional Interest in Early Terrors for which there are no Words:

Then there were my »unthinkable anxieties«. I felt deeply spoken to by the work of Balint, Guntrip and especially Winnicott. Indeed while I was still in bioenergetic therapy I formed a transference to Winnicott; I found myself wishing that my own body-oriented therapy had been more informed by Winnicott's deep understanding of pre-symbolic issues. In particular, the essay in which he described the »mind as the locus of the False Self« (Winnicott, 1949), galvanized my sense that the head was a misunderstood part of the body in bioenergetics. Over several decades, I elaborated the somatic aspects of this alternative, Winnicottian view of the dissociated mind and body. I called it ›cephalic shock‹. I consider it my most important contribution to our work, and it plays a central part in the main thrust of this paper.

The Attachment Paradigm and its Implications for Relationship:

The attachment paradigm is a work in progress, generating further empirical research that in turn enriches its models and lends them more detail and sophistication. Mary Ainsworth and colleagues (1978) did the first empirical, observational studies that focused on the normative (healthy) developmental psychology of attachment. A multitude of confirming studies have brought an exciting new empirical and predictive power to our field. Not surprisingly their model stresses the importance of sensitive and responsive parenting as the heart of what results in a secure, vital child. I would imagine that the entire bioenergetic community is as excited as I am by empirically rigorous findings that we can intuitively embrace, that make psychosomatic sense to us, and that confirm the truth of what Ferenczi, Balint, Spitz, Winnicott, Stern and others have already given us.

But there is a problem here. In the attachment model the relatively secure mother possesses an essential quality that enables her to be

sensitive and responsive to her child. This is the capacity to see, consider and relate to her child as an autonomous being with rhythms, feelings, intentions and perspectives of its own. Her secure infant senses his (for simplicity's sake I will use the masculine pronoun) efficacy in the many exchanges every day, from the earliest moments, as he both regulates and is regulated by the mutual interaction with his mother. Further, he experiences her recognizing his movement as a gesture, his babbling as the beginning of speech. Thus, to their surprise, Ainsworth and her colleagues (1978) discovered that the factor that distinguished the mothers whose infants were rated as secure at one year from those rated as insecure was not the quantity of physical contact that their children received, but the quality of contact. Quality referred to attunement, the ability to tune into the child's unique rhythms that was, for instance, reflected in the space given or not given for the child himself to initiate the contact.

The bioenergetic problem that we are left with here, I would suggest, is that the Reichian/Lowenian developmental model tends to be so exclusively quantitative that it simply does not map onto the qualitative factors supported by controlled, longitudinal research. The classical bioeneretic model is about the amount of time (three years) that the baby should be nursed and given body contact. I will return to this theme, but for now, let me say that it would be reassuring to believe that Lowenian bioenergetic theory takes for granted the above crucial parental capacity to tune in and consider the child's unique rhythms, intentions and desires. But this is not the case. The Lowenian bioenergetic infant's self consists of a desire/need to be nursed and held for three years. The parental qualities that predict a child who will be nursed and held in such a way that it becomes a secure individual are simply not in focus and therefore not dealt with in Lowenian bioenergetic theory and practice. These same qualities were sorely lacking in the parents of both Reich and Lowen. Thus Lowen is not able to describe what he never experienced. What he can tell us about is the attributes his parents did have. For instance, his mother's obsessive and shaming preoccupation with his bodily functions, his father's easy-going, un-ambitious nature.

Attachment research (Fonagy et al., 2002) has now followed in-

secure infants whose insecure parents did a poor job of reading their intentions and desires into early adulthood and found that they are lacking in this same ability to reflect on the inner life of others. Attachment-oriented clinicians such as Holmes (1993) and Lyons-Ruth et al. (2004) tell us that the way a secure parent is with his child is a good model for an effective therapist. A basic tenet of the bioenergetic model is that one can read a person's secrets, conflicts and traumas in the form and motility of his body. While most of us value this insight deeply, I would suggest that this tenet also curiously reproduces the way an insecure parent inadequately appreciates and therefore diminishes the autonomy and ultimately unknowable inner life of its insecure child.

On a practical level, over the years, many colleagues have come to and then left bioenergetics, often citing its lack of relationship between therapist and patient as an integral, embodied part of the therapeutic process. In Lowen's written corpus the emphasis is strongly on the therapist as a guide, and on the transformative process as between the patient and his body. Many therapists who have stayed involved in bioenergetics were able to do so by not directly questioning Lowenian bioenergetics, but rather by finding their own way to be present to the two-person relationship going on in the room. Others (Clauer, 1995; Finlay, 1999; Heinrich, 1999; Hilton, 2000) have argued strongly for a more relational focus in our work.

III. Main Thesis

Proposed

Over my many years in the bioenergetic community I have contributed articles that attempted to integrate a developmental, relational perspective into our psychosomatic approach. But it was only last month at the IIBA conference in Massachusetts, thirty-six years after my first article, that I was able to get to the heart of my lingering dissatisfaction with the official Lowenian model of bioenergetic analysis. I was helped to do this by looking at some recently available

biographical material about Dr. Lowen from an attachment perspective.

What became clear to me was that both Alexander Lowen, and his teacher, Wilhelm Reich, came from families of origin in which they had two strikes against them. Both were insecurely attached and sexually overstimulated children. If you want to check this, I refer you to Sharaf's biography of Reich (1983), Lowen's recent autobiography, and an interview of Lowen on his 80th birthday (1990).

I believe that these two gifted men, each in their own way, created a school of therapy which reflected their doomed attempt to compensate for the inner emptiness that in turn resulted from their lack of ever having had a fundamentally secure relationship with their fundamentally insecure parents. Their solution was to substitute their bodies, their sexuality and energy for the missing external secure base. This is not to minimize the deep and abiding gift they gave to our field and society with their pioneering focus on the body and its vitality. It is rather to illuminate the subtle lack of focus in classical bioenergetic analysis on the qualities that enable a person to parent a child whose sexuality is a natural part of a secure self. Indeed, the wounded healers of any persuasion, body-oriented or not, are an unlikely source for the requisite parental qualities of basic security in oneself and a natural sensitivity to the people in one's life. Thus, the debt we owe to the prospective, normative research of Ainsworth and others in the attachment tradition.

Impressionistically Rendered, by Putting the above Proposition in a First-Person Narrative of Al Lowen's Experience:

> »I never became attached securely to my parents … they weren't present enough, attuned enough, affirming enough … so I became attached to my body, its athleticism, its sexual feelings … but it left a void; the endorphins only go so far … with no core sense of security and belonging, I became inflamed by my prematurely awakened sexuality; I was driven by my sexual feelings; I sexualized things that were not sexual in their

> nature … (sexuality became the solution to problems that were not sexual). Never having bonded securely as an infant, true intimacy was difficult for me. Not having the comfort in and with myself of a child that was attuned to, as an adult I could only make contact with someone, see them as a person, if they needed me, that is, if they came to me as a patient. Sadly, that also meant that I could not surrender myself to a therapist who might help me, by *how they were with me*, to repair my narcissistic wounds. So I tried to use my brilliant mind to heal via understanding. But being a psychosomatic unity, one cannot be sexually driven without being also mentally driven. So, while both Reich and I have made deep and abiding contributions to our field and the larger society, we are also accurately described as brilliant but wounded healers who could not tolerate opposition to our ideas. Our minds and ideas were both our salvation and our torment.«

Even brilliant ideas can become maddening when they are an attempted solution to an insane anguish: If you doubt this, contemplate two such gifted men as Reich and Lowen spending their lifetimes trying to get us out of our heads and into our bodies, in a vicarious search for a peace of mind which they never found. Some of you know that I have called this cephalic shock. In the biographical and autobiographical material that I will be citing, Lowen frequently mentions the threat of insanity, which is often warded off by masturbation, athletics, sexuality and working with the body. He is, in my opinion, describing cephalic shock, or as Winnicott understood it, psychotic, unthinkable anxiety. Lowen calls it the mind/body split, Winnicott (1962) also called it »falling forever, having no relationship to the body« (p. 58).

So, to reiterate the central issue which I will attempt to illustrate in the remainder of this essay, bioenergetic analysis can be understood as a life-long attempt to find in the body a better substitute than the dissociated mind for the missing, attuned, maternal (parental) care. We are describing here an attempt to restore psycho-somatic unity by escaping the dissociated mind (mind as the locus of the false self) and getting back to the body. This attachment to the body is then a more wholesome, but still inadequate replacement for the original failed secure base with one's parents.

Consequences

There are a number of consequences that I believe follow from the above proposition.

1. The underlying fear of insanity in both Reich and Lowen is responsible for the paradoxical failure of bioenergetic analysis to include the head (which is experienced as housing the dissociated mind) along with the rest of the body as part of a truly *psycho*-somatic unity.

2. The belief system, which I will call Reichian/Lowenian bioenergetics, that results from this inherently flawed attempt to restore psychosomatic unity, is, by definition, a rigid system of thought. On the one hand, the product of two brilliant minds, it is a truly profound contribution to the understanding of psyche and soma in health and in illness. But, inevitably, on the other hand, it is the product of two dissociated minds, and as a substitute for the missing security that comes only from a secure relational base, cannot be questioned.

3. As already stated, the Lowenian bioenergetic vision suffers from a subtle, at times not so subtle, lack of understanding of the personal qualities in a parent that recent research has shown to predict a secure child. The subtlety is to be found in the way Reichian principles are imposed as explanations that oversimplify life issues.

4. There is an alternative model (there are many) of the function of the therapeutic relationship than that which Lowen has given us that I will attempt to illustrate; first, by describing my own bioenergetic therapy experience, and then by exploring our differing views on grounding and shock.

IV. My Journey into Bioenergetic Therapy

These are cautionary tales about what may well be going on psychosomatically in any therapy approach that deals explicitly with the body, but does not view the central task of therapy as engaging and reworking the patient's embodied attachment relationships. The tales are also a commentary on how *the attachment style of each therapist*

and of his preferred therapeutic method impose a specific attachment dynamic on the patient.

Towards the end of my 10 years of therapy with the three men who founded the bioenergetic institute, I finally found the courage to be fully in the room, that is, there were two of us present. Most of the rest of the time my compliant, avoidant self was quite comfortable surrendering my body to the therapy with the understanding that once my underlying stasis and biopathy was corrected, I would somehow be returned a healthy psychosomatic self. In hindsight, I was only too happy to go along with this understanding of what bioenergetic therapy involved: I would not have to deal with relational intimacy of which I was terrified. In this story we look at the *shifting attachment relationship which my avoidant style makes with my therapist's own attachment style and, additionally, at the attachment significance of the therapeutic method in question.* Therapists choose and work in a modality that matches their gifts and personal comfort level with intimacy/autonomy.

In my first therapy the talking and the body work did not threaten to get too close to my hidden self and seemed a small enough price to pay in exchange for a relationship which, crucially, kept me from feeling alone. One time Bill, my therapist grabbed me and we wrestled, and I actually felt that some of the frozen shock in me let go. But I continued to dread the silences that threatened whenever there was a pause in the activity of our bodywork and talking. Bill died seven years into my therapy with him. In the midst of my grieving for him, I felt what seemed like too much shock of an abandoned infant that cannot survive and conserves what energy it has by freezing down close to the core. I sensed that it was this abandoned infant in me that had been so terrified of the inchoate abyss of silence, and I developed an abiding professional interest in early terrors for which there are no words.

In my second therapy, this time with Alexander Lowen, I was still watching the interaction from a secret, broken place within myself, but I was a little less avoidant. Less terrified of my grief and brokenness, I was less content with a bioenergetic method that never asked me about my internal experience. The use of my body and its energy as a

self-object to stand-in for an attuned, responsive relationship with another human being was not working as well for me as it allegedly had for Dr. Lowen. As I lay back over the Bioenergetic stool, I barely heard a whisper from my secret self, wishing that I could just lie there in my oral collapse and not do anything … just luxuriate in my apnea … slow down and face the part of me that was mostly dead in my chest, and maybe even come to life a bit as a result. But I am not sure that I really made sense of the whisper until some time after the therapy ended, and so I »breathed« on top of this half dead, low energy, despicable part of me, convinced that Al had no patience for such lack of energy.

In the grounding position, the dynamic shifted slightly, but as I had done for most of my career as a patient, from the unattached place where I lived, I never stopped watching the interaction between my therapist and my body. From the waist down, my body had a higher charge and energy than my upper body with which I was more identified. So, for some minutes, as I stayed in the grounding position, Al Lowen sat, seemingly fascinated, perhaps, I thought, even enraptured with the energy and vibrations that emanated from my legs and pelvis. The mostly dead child in my chest, who has never been enough, felt deeply envious of my strong lower body which did not have to do anything more than to release its tension and energy to hold the attention of my therapist.

My final bioenergetic therapy was with John Pierrakos. About a dozen years earlier, I had an important experience with John as a member of a group of bioenergetic therapists that he was leading. Actually, generally speaking, in my contacts with John as a senior colleague, I was very drawn to the warmth and considerateness I felt from him. While John was focused on the identified patient in the center of the group circle, I somewhat avoidantly sat down next to him … wanting the contact, thinking that he wouldn't notice me absorbing his warmth. So I was a bit startled when I felt his hand on mine, but I was really stunned when I turned towards John to show my appreciation and I realized that he was focused intently on the »patient« in the center of the circle. Indeed, he seemed barely aware that he had touched me. John's implicit gesture went beneath my

avoidant, False Self and found me in a way that no touch done as a body technique could have. I knew and felt in that moment something about secure attachment that was new. John had touched me not just with his hand, but with his humanity. I am reminded of Conger's (1994) words:

> »… only genuine presence and true contact brings forth the deep healing of our injured humanity…there is no technique, no clever use of words, and no substitute for the intuitive nature stepping forth as human soul« (p. 90).

This was definitely a »now moment« as described by the Process of Change Study Group (Stern et al., 1998). In that moment there was a shift in my »implicit relational knowing« (Lyons-Ruth, 1998) about how I could be with someone and thus my attachment status shifted, even if fleetingly, towards secure. In that moment John was with me in a way that a secure parent is with her soon to be secure infant many times a day, and for a while my isolated psyche was not watching from someplace in my head; I was just there, in the room. As opposed to the moment with Lowen when I felt excluded from his attachment to my lower body, this time, on a level below self-consciousness, John's hand sent and my hand received a message that my bodily self need do nothing other than be alive. Although the »thank you« I was about to give him was genuine, it was from a false self place that did not know love freely given.

Fast forward to twelve years later, and I am in an individual therapy session with John. He is pounding on my chest chakra, and suddenly my entire career as a patient flashes before me. When, as Woody Allen might have urged, I asked myself, my heart pounding much louder than John was pounding, am I finally going to show up? As some of you may know, John was particularly interested in energy, charkas, and auras. But, determined this time not to lose myself in his therapeutic belief system, while he was still pounding on my chest, I said, »I don't know if you are interested in what's going on for me … but while you are working on my chakra … I am thinking, ›what a stupid shit you are and that I would like to tear your head off your shoulders!!‹«

John stopped and seemed genuinely interested in what I had said, even though it had interrupted his work. Nothing succeeds like success, so I then told John what had been happening spontaneously in my body recently in my daily life outside the office i.e., I had a new sense of unity when I held my head up in a way that released the tension at the base of my skull. This was truly attachment individuation at work. I was in the room with John, putting my subjective reality on a par with and even ahead of what I perceived as his belief system. I then asked John to confirm my body reality by reading my aura while I held my head in this position. He liked the blue hues he saw. I cannot convey the intensity of joy and aliveness, the inner light of integrity that came over me as I left that session, and which stayed with me for several weeks. I must have sensed from my earlier encounter with his implicit warmth that John would stay present and receive the first direct expression of protest and hate I had ever made to a therapist. In doing this John made me feel that he valued me more than the chakras, energies and procedures to which he had seemed so attached, and which I would no longer accept as a substitute for a contactful, secure relationship. In conclusion, a therapist who, by his sensitivity and responsiveness to your body and soul, fosters a secure attachment with and in you, is a blessing.

V. The Nature of Healthy (Secure) Relationships in Life and in Therapy: A Bioenergetic Model amiss

The following quotes are from an interview that Lowen gave in 1990 (Lowen, 1990). Here Lowen speaks about Reich, and, as I read it, many therapists, himself included:

> Well, »naturalness is a funny word for Reich, because while he says »natural«, I don't know if he ever knew what naturalness is. How can he, given that background? Being that tormented, that obsessed with sex, how can he know what naturalness is? All he knows is that he has a

> tremendous sexual drive« (p. 4). Now remember, Lowen is not just talking about Reich; I submit that he is talking about the world that he knows best, that includes himself and the patients and therapists that have been a big part of his world. If you doubt this, listen to his response to a question as to how secure in her sexuality Reich's mother was: »No, of course not. If she were secure in her sexuality, Reich might not have been a psychoanalyst!«

A minute earlier in the interview Al is asked what he makes of the fact that Reich had such early sexual relations with his nurses:

> »I think that saved his life and his sanity. You can see that this boy (and man) was sexually tormented all his life. And that is not normal. That is compulsive. He is obsessed with sex. But that doesn't mean that he is screwy! We are all obsessed with sex in this culture. I know I am. Once in a while you meet somebody who isn't obsessed with sex, and you realize what a difference there is between the way you feel and the way a really healthy person feels about sex … and the reason he (Reich) was obsessed with sex is because it came upon him at an age when he couldn't deal with it. How can you deal with it when you are over-excited as a child with a mother who is beautiful, seductive, voluptuous and soft?«

I have no problem with this as far as it goes. Why should I? I am probably as obsessed with sex as most of my colleagues, and I credit my mother's seductiveness with me for a good measure of it. But what is out of focus, what is missing in Lowenian bioenergetics, is a description of the qualities that enable a person to parent a child whose sexuality is a natural part of a secure self. My wife for instance, is not obsessed with sex. But what was it about her parents that gave her a secure base, a sense that she belonged, a basic comfort with herself and a natural sensitivity to the people around her? It must have been something balanced and secure in their own beings that would never have allowed sexuality to become so seductive, so acted out, so crazy-making. They were like the relatively secure parents who tend to raise children who test (in double-blind rating) as secure. These people, who van Ijzendoorn & Bakermans-Kranenburg (1996) and other attachment researchers consistently find, make up about 60% of

not-at-risk populations, are sensitive and responsive to their children, give them firm boundaries, and accept their protest without retaliation. In this regard, Tuccillo (2006) has recently proposed a much-needed somato-psychic, relational model for the healthy development of human sexuality. If the reader is a therapist, this description may strike him as a touch unreal, because such people do not spend much, if any, time in therapy and therapists, who work a lot and spend a lot of time with colleagues, may not meet such people very often. I say this because of a personal conviction that most therapists (wounded healers) were not securely attached children, even though their own therapies may have helped them rewire their limbic imbalances in a more secure direction. I do not know if anyone has done research on the attachment status of therapists, but I wonder how many of us recognize ourselves in this description (Lewis et al., 2001) of 3, 4 and 5 year olds:

> »Happy, socially competent, resilient, persistent, likeable, and empathic with others. Had more friends, was relaxed about intimacy, solved problems on his own when he could, and sought help when he needed it«. This is typically the way teachers describe children who showed secure attachment behaviors at 15 months (p. 74).

Turning to the rendering of Lowen's family background in his autobiography (Lowen, 2004), I find once again that something crucial is missing. As in Reich's story, the conflicting parental personalities are described. We are told that as a child Lowen was severely shamed around sexuality, and that he did not have a warm emotional life at home. Considering the obsession with sexuality, the narcissistic lack of contact with people in everyday life and the lifelong struggle to accept failure that he shares with us in his interview, it rings hollow that turning to his body via masturbation and sports could actually substitute for the lack of a fundamentally secure relationship with his fundamentally insecure parents. Lowen (2004) tells us that,

> »every infant or child needs an unconditional commitment from its parent … Whenever a parent fails a child in this regard … each such ex-

> perience undermines the child's feeling of being secure in its world … once childhood ends, one cannot be fulfilled by another person. We must then stand on our own feet … But it is not hopeless, because we have our two legs to stand on, even though they feel insecure. As an adult, one can take appropriate measures to strengthen one's legs and to make them feel more secure, and one may need some help in that endeavor« (pp. 155–156).

I find that if this is to mean more than any physical trainer does to strengthen your leg musculature and your balance, then it is about an attuned caregiver/therapist helping you to tolerate the deep feelings of despair, rage, terror, etc. that open up as you get in touch with your body and open up its feelings. I believe that something paradoxical occurs to the extent that patients experience a significant deepening in their sense of grounding in their work with Lowen. They bond with him deeply via sharing his conscious belief that he is just a guide and that the essential process is taking place exclusively in their bodies.

I believe that one experiences the missing security and one's body slowly changes in the way that Lowen describes in his chapters on grounding, *but as part of a process in which one becomes deeply attached to the person who is doing the shepherding.* The specifics of what kind of nonverbal interventions … attunement, acceptance, being seen, quality of contact, etc. … are optimally effective in changing the psyche-soma of each patient vary with the specific relational history that is embodied in the form and motility of their body. This also depends naturally on the body and soul of the therapist; on what kind of shepherd he/she is … how attuned, how sensitive, how accepting of protest. The details vary as to how, in his daily life, each patient learns to live closer to the life and feeling in his body. What I have not seen in my forty-five years in the bioenergetic community is a successful outcome when the attempt is made to substitute an attachment to one's own body for the original missing secure relationship. »It is relationships with people that break our spirits and our connection with our bodies. It is relationships with people that heal them« (Hilton, 1988/89).

Lowen's (2004) vision is quite different: »Bioenergetic therapy does not offer treatment for emotional problems. Therapy is a self-healing

process in which the therapist is a guide and facilitator «(p. 221). I find this quite divorced from a grounded description of two real people in a room together, one of whom is witnessing and being entrusted with the other's unbearable anguish. Lowen's stance here follows from my main thesis: He employs his mind and his sexuality to defend against deep emotional woundedness, insecurity. Thus he cannot really be in the room with his patient's terror and agony and thus retreats up into his head as a guide who depends on his understanding of »the human condition …« (p. 221).

VI. Groundng and Cephalic Shock

A third source that has helped me to formulate this essay is Helfaer's review (2005) of Lowen's autobiography. Helfaer says, »From this voice (Al's) I gained insight into my own life journey and a deeper understanding of Bioenergetics« (p. 135). While I might have written the same sentence, Phil and I come to very different conclusions about Lowen's recent (1990 and 2004) autobiographical revelations.

Actually, it was back in 1976 that I first put in print my divergent understanding of the relation of the head to the rest of the body (Lewis, 1976). Over the years, I developed my clinical construct, cephalic shock (1984, 1986, 1998), more fully. Lowen (2004), as he tells his story, sensed, following his therapy with Reich, that his basic insecurity was still with him. He also realized that Reich himself had not dealt with his own deep humiliation and resultant messianic grandiosity. So, going his own way, Lowen pursued a more secure connection and contact with the earth through his pelvis, legs and feet. This, then, became the unique focus on grounding of Bioenergetic Analysis. In his autobiography Lowen makes it clear that he has struggled mightily to personally achieve this secure connection to the earth right into the ninth decade of his life.

I, on the other hand, following my first Bioenergetic therapy with William Walling, realized that I did not experience my shocked head as part of my body and could not trust it to another human being. So, although Lowen and I both sought a more grounded body, mine in-

cluded the head. He tried to let down into a connection of his legs and feet into the ground; I tried to deal directly with the shock in my head that had been causing me to unnaturally fight the force of gravity since I was an infant. Neither of us had had much peace of mind. Until his autobiography, Lowen has not written directly about his being in a state of shock. Without using the word, however, he has previously shared the story of the spontaneous screams that came out of him during his initial therapy session with Reich. As he describes it in the recent book (2004):

> »… but I felt something in my personality that was not healthy. The screams had surprised me, because I did not feel any fear. My conscious mind, which was split off from the action, was an observer, unconnected to what was happening« (p. 39).

I would argue that this is a very clear description of a state of shock in which a trauma has split a dissociated mind from its anchorage in a feeling body. Lowen tells us on the same page that it was his mother's eyes which caused him to freeze and that »I knew that I had to do a lot more work in therapy to free myself from that fear« (pp. 39–40). I believe that the older he got, the more Al Lowen realized that the grounding, as he originally understood it, did not do the job unless it also included his shocked-since-infancy-head. I would ask the reader to view the touching photo of Lowen as an infant in the autobiography (2004), about which he says, »even as a baby my head is straining from my body« (p. 95).

In 1995, when Lowen was 84, he tells us that he suffered a breakdown in his knees secondary to the way he unconsciously held his head forward (got ahead of himself) in reaction to his basic Oedipal insecurity. His knee cartilage took the brunt of this un-centered, imbalanced stance. »Even though I tried to keep myself straight, I could never find the position of my feet that would give me the good sense of security that many other people have« (Lowen 2004, p. 198). Lowen explains, »This problem is not solved from the head but from the ground up. We must start with the feet« (p. 138). He continues:

> »I had come to some awareness that the neurotic character structure was a frozen state, as if the person had been shocked at some earlier point in his life (p. 142) … I had been in a state of shock that prevented me from seeing the deeper dynamics of my problems. The issue was still grounding, but I needed a technique that would help me break through the shock state« (p. 143).

The older he gets, the more Lowen puts in writing the basic insecurity and shock in his structure and his life long, poignant struggle to free himself from the *driven sanity of a man who cannot risk losing his head*. Each innovation is presented as finally creating the energetic connection he is seeking. He has the patient raise his head while kicking the bed; he has the patient do somersaults; he hits the patient on the head. Al explains, »At age 87, I began to feel the tensions in my neck muscles, and I realized that it was associated with my fear of losing my head or breaking my neck. This fear of losing the head or breaking the neck is common to all of my patients« (pp. 164–165). At 93 years of age, Lowen is still on the quest with a new exercise, which he calls »connecting the feet to the earth«, the goal of which is to »have the vibrations begin with the feet and move up the body« (p. 240). In summary, Lowen's odyssey is about never having come to terms sufficiently with the shock in his head (cephalic shock) to find the peace of mind that eluded him. I do not know if I have done any better with my own shock, but I believe I had no choice but to look it more directly in the face/head.

Finally, in a number of earlier papers I have made the following point (Lewis, 1986), which, I believe, bears repeating. *Sometimes our words reveal what we truly believe. In all of Lowen's books and on p. 145 of Helfaer's essay (2005), the head is designated as something other than a part of the body: »After that, he (Al Lowen) was equally excited about re-discovering the somersault, age 93, as a way to work with the cervical block, allowing a better connection between head and body and, thus, fuller grounding« (p. 145). I would ask the reader to ponder the absurdity, the anatomical impossibility, one might even say the insanity, of it being common practice, in a discipline dedicated to psychosomatic unity,* to understand and thus refer to the head not as part of the body, but as something additional.

VII. Belief Systems Help us to Cope with Personal Tragedies that are too Painful and Shameful to Grieve

In this regard, Reich and Lowen, like all of us, needed a set of beliefs to help them with the intuitive sense of how small and frail and unknowing they really were in the larger scheme of things. In fact, in the event that the reader has been discouraged rather than encouraged by the drift of my essay, I hope that my written work over the past thirty-two years demonstrates my continued passionate commitment to our evolving model of bioenergetic analysis, which strives to stay true to the life of the body, even as it is enriched by attachment, relational and neurobiological perspectives. But this paper is about missing pieces in a puzzle that I believe most of us can use in our journey as therapists. We all become attached to our patients, to their pain, to their vitality. We become attached to our beliefs, to our techniques, whatever adds to our security and makes us feel more alive. We are therefore always well advised to check that there are two of us in the therapy office, each with an inner life.

So, even if, too often, I take for granted how much life and health I was given by my Reichian/Lowenian therapies, please bear witness that I also feel grateful. It is somehow easy for me to forget that my bioenergetic therapists were a second family to me, that they brought me to a place where hope outweighed despair. Paradoxically, in spite of the limitations of the classical bioenergetic model that I have been addressing, the therapy it spawned was fundamental to the rich, full-bodied personal and professional life that I have enjoyed. But the paradox is more apparent than real, because, praise the Lord, *the healing humanity of my three bioenergetic therapists pulsed through, both in spite of and with the help of the model that made them feel most whole*. Additionally, Lowen's clarity, for instance, about the physiology of panic (1967), and many other somato-psychic dynamics were gems that focused my embodied sense of the timbre and tension and flow and gesture of the other person in the consulting room. But this is NOT the topic of this essay. In truth, it is partly my lingering dis-

appointment that I was not more relationally healed by my therapies that fuels the searching look I take in this essay at the inherent limitations of the bioenergetic model which prevailed in those years.

In this final section, I am going to explore a bit further what I have already called the rigidity of a model that attempts to substitute for the missing secure relational base. From this perspective, the model can be seen as a rigid system of thought, a belief system in support of which limited or no data are offered, and which cannot be questioned. I find that another attribute of this model, which I will explore in regard to sibling relationships, is its unreality. I will just touch lightly on a number of areas in which I see the model's rigidity and unreality come to bear. I refer those readers who are interested in more detail to my website (www.bodymindcentral.com) where a slightly longer version of this paper will be available within a year of this publication.

One basic area in which I believe this rigidity and unreality plays out is the issue of childrearing. In this regard, there are two qualities in a parent that I would highlight as signs of his being a secure person. The first is his acceptance of his inner intuitive sense of how to raise a child, and the second is his awareness of his relative helplessness and limited understanding regarding the complex mystery of the young life that has been entrusted to him. Lacking this inner security, Lowen tells us repeatedly in the autobiography (2004) and the Festschrift interview (1990), of the two linked belief systems that informed his work and brought a measure of sanity and meaning to his life.

The first is an amalgam that I will call socioanthropology, for lack of a better word. It enables Lowen to project his personal guilt and shame out into the culture at large and make them into everyone's problem. While there is truth in his formulation, there is also a denial of the particular shock and trauma through which he lived in his family of origin. Here, for instance, Lowen (2004) discusses the dynamics of the Oedipal situation:

> »… most people in the Western world have both success and power. The collapse of their world is the impoverishment of their inner or emotional lives. Having committed themselves to success and power, they have little else to live for. And like Oedipus, they have become wanderers

> on the earth, uprooted beings who can find no peace anywhere. Each individual feels alienated, to some degree, from his fellowman, and each carries within him a deep sense of guilt that he does not understand. This is the existential condition of modern man« (pp. 121–122).

The second is a set of principles, most of which he inherited from Reich, which impose order on and offer oversimplified explanations for the messy business of raising a child. A central belief, for example, that appears throughout his writings is that a child will be healthy if it is nursed on demand and in contact with the warm body of the mother for the first three years of life. This belief system also specifies the grim results of *any* break in this continuous contact. Lowen (2004) explains:

> »When a baby is born its ground is the warm and loving body of its mother. In most cultures before the turn of the century, the baby was connected to the mother's body by being carried on the mother's back for about three years (p. 153) …. This allowed the mother to nurse the baby any time it needed to be fed (p. 154) … Every infant or child needs an unconditional commitment from its parent to be there for the child every time that the child needs that assurance or connection. Whenever a parent fails a child in this regard … each such experience undermines that child's feeling of being secure in its world. That lack of security will be carried throughout life …« (p. 155).

Lowen's words have great intuitive appeal. But is any data, any research offered in support of them? Lowen does not tend to offer empirical data in support of his assertions. He often gives descriptions of childrearing and other practices in cultures distant in time and place from our own Western industrial/technologically advanced societies. Since they are not referenced, they must be taken on faith.

On the other hand, off the written record, Lowen spoke with much more common sense. He knew that one can not actually raise a child according to a consciously held belief system. He and Leslie, his wife, only tried it once. Although he has remained committed to the Reichian principles in his written work, the life lessons of raising his son Fred were not lost on him. He told me personally on several occa-

sions during his son's teen-age years, that the only way to really raise a child was to »muddle through it«. This advice helped me with our two adopted children. I must confess that after surviving the Watsonian behavioral principles which my own mother employed, and sensing the unreality of some of our own bioenergetic principles, I was actually somewhat relieved that my wife, Barbara and I, and our two adopted children would have to do the best we could without the prescribed three-year nursing experience. We would have to settle for less than perfection.

VIII. Some Empirical Data

After several decades of careful observational research led by Mary Ainsworth (1963, 1967, Ainsworth et al. 1978), the attachment paradigm provides us with an empirically based model of normal development. There is now a vast number of controlled, longitudinal, infant and mother-infant observational studies that have given us a new model of how a baby develops into a healthy child. While Ainsworth initially spent several years studying mothers and infants in Uganda, most of her definitive work was done in white, middle-class homes. It is difficult to relate recent empirical attachment research to Reichian/Lowenian principles, belief-systems, and statements about the necessity of unconditional availability in raising a child. Even parents of infants, who prove to be secure children, are only in a matching, attuned state with them 30% of the time (Tronick, 1989). Parents who match the emotional state and rhythms of their infants in the midrange, rather than the extremes, have the best outcomes: They and their children are rated as secure. Similarly, it is the quality – the sensitivity and attunement to the physical contact – rather than the quantitative amount that codes for secure outcomes in the cutting-edge research (Ainsworth et al. 1971, 1978) of this era.

And finally, although they are acutely aware of bonding issues, attachment researchers find the strong correlation to be between a secure sense of self in the parents and security in their offspring. They have not come up with data to support the Reichian/Lowenian hy-

pothesis that **any** quantitative break in the »unconditional« availability of the mother leads to life-long insecurity.

IX. No Man is an Island unto Himself, or where are my Siblings?

This section details a legacy of unreality that I believe we inherit from an unexamined aspect of Al's narcissism: his relationship, or more accurately, his lack of relationship to his siblings. Again, because it bears repeating, I am exploring these issues in the hope that if we really face the ways in which Reich and Lowen, in the company of other heroic figures, had their Achilles' heels that weakened their roots, we will be both a humbler and more vital Institute. Our practice of bioenergetics will move towards an ever more sober and grounded somatic psychotherapy. In his recent essay (2005) Helfaer tells us how touched he was by the way Lowen spoke to him in a tender and protective way about his younger sister. I was as relieved to read this as I was shocked to learn five or ten years ago that Al actually had a younger sister named Sylvia. As in his conversation with me about »muddling through« childrearing, I believe we are dealing here with a profound split between the reality of what Al Lowen can in rare moments acknowledge in a private conversation, and the unrealities he enshrined in his self-healing vision of a bioenergetic model of health.

Over the years, Al told us old-timers time and again about his nuclear family-of-origin, himself, his father and mother. I listened carefully, and, as I say, was startled to discover that a sibling existed. The only place in all his writings that a sibling is mentioned is in his latest book (2004). Here, however he does not mention Sylvia, his living sister who was born when Al was four years old, but rather Sylvia's twin, the sister who died in her infancy. His comment is that her death did not affect him. Now, while Al was certainly not your average person, most of us come into this world either as only children or we learn early that we must share the joys and pains of life with our brothers and sisters. Al Lowen, however, seems on some level to accept what he tells us was his mother's image of him as her savior,

whose success gave meaning to her otherwise empty life. Common sense, not to mention clinical experience, tells us how deeply a family is usually haunted, at least in our Western culture, by the death of a child. While Lowen may not have picked up a »messianic« (Lowen 2004, p. 92) strain in his personality until his encounter with Reich, he somehow created himself into such a special child that he was the only child.

The theory and practice of bioenergetic analysis has paid the heavy price of an impoverishment of both the rivalry and richness of an embodied sister-and-brotherhood. Children, no matter how brilliant, who cannot make peace with their brothers and sisters, are at risk for becoming thinkers who overvalue their own perspective. This seems more dangerous for an applied discipline that concerns itself with a model of psychosomatic health than, for instance, Kepler's predictions about planetary motion. Kepler's laws are easier to prove or disprove. Let me confess how immediate (non-theoretical) this issue is to me: Perhaps the purest murderous feelings I have ever felt were towards my own younger sister at the dinner table whenever she took the spotlight to say something, anything at all! But, finally, my concern with Lowen's siblings is about *the main thesis of this paper: the blurred focus in Lowenian bioenergetics on his own crucial family dynamics and the consequently flawed model of the quality of relationships in a secure, healthy family of parents and their children.*

X. And … Speaking of the Truth

About five years ago I wrote this definition of bioenergetic analysis:

> »When you have no words for your feelings, 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 that no one can put a hand on …«

I have italicized the sentence about spoken language, because words have long been second-class citizens in the pychosomatic equation of Reichian/Lowenian therapy. This has been the case because, in spite of the brilliant vision of psyche-soma equivalence, both men had a strong belief that words could not be trusted to convey a person's deeper truth. They, in common with most victims of family of origin trauma, had very personal reasons for this mistrust. Their primary attachment figures consciously disavowed and/or were unaware of their feelings, thoughts and behavior – such that their verbal descriptions of what took place denied Reich and Lowen's experience of that reality. This is commonly described as a particularly destructive aspect of trauma within the family. As is also well known, these patients, for many reasons, »live in their heads« and are both cut off from and do not trust their deeper feelings. But we also tend to filter our experience of others through our own structures: What if both Reich and Lowen, sensing their own cephalic shock (dissociation), assume that others' words are also not to be trusted as direct expressions of their essential being?

So, on the one hand, we bioenergetic therapists are lifesavers when we pay less attention to the words of the dissociated patients, and help them to come down into the life of their bodies. On the other hand, let those of us bioenergetic therapists, like Reich and Lowen, who have felt traumatically betrayed, be cautious that our deep mistrust of our own parents' words, does not blind us to the moments when our patients' words, come from a depth of their being that no one can put a hand on.

I hope that this essay has kindled an ongoing curiosity both as to how our attachment styles affect the mix of intimacy and autonomy we embody as therapists, and, how we are all at risk to attach everything from our own beliefs to our patients' vitality, in an attempt to heal our less than secure beginnings.

It may bear repeating that our creations are always more or less about ourselves. Most of us hope that they will speak to and touch others. In our field we offer personal help to others who have been significantly broken by life. I believe that the more genuine we can be, as wounded healers, about our own personal brokenness, the more

healing our help will be. My work on cephalic shock is nothing if not about my struggle to live more fully in the moment. I hope I have been as candid about this as I ask of Reich and Lowen.

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Living on Purpose: Reality, Unreality and the Life of the Body

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Summary

This article is the author's account of the experience of choosing to live the life of his body, even when that means entering a soulless truth of being. The forces which generate such a state are examined, as well as the dynamics which emerge from and maintain such a state of being. This paper attempts to provide a framework for understanding, in an immediate felt way, the experience of the person living in this reality, one common in people organized as a borderline personality. It also attempts to illuminate some of the grave difficulties faced by the therapist trying to work with people so afflicted.

Keywords: borderline personality organization; soul-murder; unreality; psychosis.

Introduction

For some people in psychotherapy, myself included, it turns out that the outcome of therapy that can be hoped for may be ultimately to live in some contact with what is real, even though that contact may be agonizing, terrifying, and so disturbing as to make life hardly livable. There is little relief available in such cases from the dysphoria, the distress and the despair, that we experience, in contact with our own internal process. This may be true even after many, many years of hard work on the part of both patient and therapist. In such cases,

what is available that makes psychotherapy a worthwhile endeavor? In my case it is the decision and commitment to living in reality, and to living on purpose which provides the answer to that question.

It is by no means an obvious decision. Faced, as I am, and some of my patients are, with a state of being so pain-filled, so immersed in horror, and so limited in positivity, it is not at all obvious that the choice to remain defended against the knowledge of one's reality is a bad one. So what does it mean when someone chooses in the full awareness of the implications of the choice, to live in reality and to live on purpose, that is, to choose actively to encounter an unbearable inner reality? And having made that choice what are people in this position likely to encounter? And what of the therapist, what is her or his role, and what can she or he do?

This paper is an exploration of these and related questions. It has been my experience that it is very hard to convey the felt experience of someone living in these states of being, and also of the therapeutic process with someone organized in this way. But if I speak of my own experience and process, I am able to convey it with an immediacy and depth which otherwise would elude me. Doing so enables me to illuminate for the reader difficult painful spaces of experience in the therapeutic process. And it enables me to speak my truth, which is a matter of urgency to me.

Furthermore, there is a long tradition in psychotherapy research of using the fruits of self-analysis in the explication of clinical practice. In the area of borderline personality organization, which this paper focuses on, any illumination of the complexity of the internal process and structure, as well as the therapeutic process, is likely to be useful to therapists faced with the daunting challenge of working with people organized that way. So much of my understanding and knowledge about both the internal experience and the clinical process comes from self-analysis. To leave out the source for my insights may cause them to seem arrived at mysteriously, or leave the reader wondering how I can assert conclusions with such confidence or fervency.

Finally, I know how hard it is for therapists to face and be with this material in their patients, even if it is not strongly present in the therapist herself or himself. In the development of this personality organi-

zation, the parent of the child who will be organized in a borderline personality structure is deeply threatened by the life force of the child. Any persistent need, or autonomous movement, by the child creates terror and rage in the parent. The vulnerable, empathic infant sees the terror and the rage in the parent, and turns against her or his own life force to annihilate the developing self within. The infant learns to be repulsed by her or his own life energy. In this vulnerable dependency relationship with the parent, merger with the parent, smothering psychic death and acceptance of blame for the parent's dysphoria calms the parent. This is accomplished by providing the parent with an extension of herself or himself in which to deposit negative feelings, or to supply love and admiration as needed by the parent regardless of the child's needs. Allowing this, the infant or child reinstates the attachment necessary for his or her survival.

In the therapy the therapist will have to experience this process the patient underwent as an infant and child. First as a witness and a validator of experience, later the therapist will be seen and experienced as a perpetrator of the same kind of destructive attack on the patient. And finally (although these do not inevitably happen in this order), the therapist will experience the same victimization the patient did as an infant, face the ways the patient perpetrates that victimization on others in the present, and challenge the patient to face it as well. It is a daunting task, and the therapist must do it without succumbing himself or herself to despair, demoralization, or defeat. I hope in this paper to support those who attempt this kind of a therapy with more information, insight, and a greater sense of the value of being real than they may have had before.

The Body as Guide

I originally wrote this paper in preparation for a presentation whose theme was: Living on Purpose: The Body as Guide. Bioenergetic Analysis affords us a unique discipline for following and understanding processes which are nonverbal in the most basic sense. This refers to experience that cannot be organized in language both because the ex-

perience occurred before language and cognition were sufficiently developed to enable the experiencer to render the experience into language. And, also, because the experience itself was overwhelming in the reactions it engendered in oneself, and in others. This inability to organize and convey experience in language means that the person having the experience cannot share it with another adequately, and it means that the person cannot memorialize – cannot bear witness to – her or his experience.

Without the capacity to bear witness to one's experience, it is impossible to create the intrapersonal and interpersonal structures and processes to validate experience and feel seen and understood by others. Faced with this reality, people memorialize their experience, and especially their traumatic, damaging experience, in their bodies. In the body's shape, habitual form, chronic habits of action, and the person's modes of experiencing, is the record of their suffering. Inaccessible to language and unavailable for self-reflection, the suffering appears in the unconscious communication of the living statue. A statue, in the case of people organized around devastating early life experiences, which undergoes constant shatter, fragmentation, blowing up into a million pieces, only to be desperately reassembled each time, an infinite number of times. But the glue necessary to hold the statue together, a cohesive sense of self, the capacity, to feel real to oneself, the ability to <u>feel</u> the realness of another, has been totally, or nearly totally, destroyed in its nascent form in early childhood. And then the structures and processes which create and maintain that glue – loving connection, a feeling of safety, positive self-regard, for example – continue to be destroyed as they emerge, both by the force of the ongoing emotional and interpersonal tsunami the person lives in, and by the systematic, if often unconscious, predations of those on whom the child in this excruciating drama is most dependant for physical, psychic, and spiritual survival.

Specifically, the damage done to the personality in these situations is so severe that basic human functions are deranged. For example in my case, I think about food all the time. It is so pervasive a process, it cannot be broken down into discrete elements for analysis. Although it is far less powerful as a force in my life than it was, the anxiety, the

craving, the desperation around the consumption, the effects, both experientially and concretely in weight, is continuous and ever pressing. It is intrinsically related to a thoroughgoing and unyielding self-loathing, one part of which is a hate for my own body – its appearance and experience. One part of this was undoubtedly engendered by my mother's relationship to me. In one of the only photos I have of her, she can be seen looking up at the camera, smiling, with me on her lap laid out stiff as a board in obvious distress. And I know from my father, who left her when I was one-and-a-half, that she was often in an alcoholic stupor when he came to pick me up for his twice-weekly visits.

One thing bioenergetic theory and practice should teach us, is that the appearance of functioning is not the fact of it. Although I appear to maintain adequate oral (in both the nutritive and characterological senses of the term) functioning, in my eating and self-sustaining habits, my perspective as a bioenergetic therapist tells me that, if we could study it, we would find the undeveloped and deranged aspects of basic processes of digestion, on cellular and systemic levels, as well as in the psychic representations of those processes (for example, characteristic neediness or clinginess; or an experience of oneself as depleted, and unable to be fed). In fact, my ability to feed and nurture myself, and to metabolize nutritive elements of the environment, both physically (food) and emotionally (love and support) is severely limited, dysfunctional, and in some respects there is atrophy of metabolic function.

The forces, the treatment, which initiated the development of these phenomena, began to afflict me in infancy. Before language could organize and communicate what was happening. Still now, language barely serves. I have to struggle to embody language as meaningful, finding that no language exists for the sensations, the feelings, the states, to convey them adequately – or at all. What would language reveal, could it be employed? It would reveal the toxic forces that create this state of affairs, in me and people like me. The malevolent, soul-murdering treatment, the vampirish theft of life energy from the infant, and then ever onward, the destruction of any capacity for pleasure, life left in a state of living deadness.

Reality versus Unreality

One of the deleterious effects of being raised in this toxic stew of parental hatred, murderous envy, desperate clinging, and profound manipulation of reality covering it all up, is to leave the child in a state of existence that can only be described as unreality. Unmoored from basic contact with what is real. The basic contact with internal reality – sensation – has been destroyed. Terror of annihilation, unendurable grief at continuous ruptures in attachment, utter uncomprehending confusion as the reality portrayed by authorities, parents and often others, shifts and morphs to suit the exploitive and security needs of the authorities. The total effect of these interpersonal processes is to create a zombie state in the dependant, making him or her a compliant partner, who will function as an extension of the personality of the authority, rather than as an autonomous self.

Unreality turns out to be unbelievably painful in its own right. It represents contact with the emptiness, the void, the black-hole which exists at the core of the person so organized. It is made up of contact with the parents' emptiness and coldness, it is the effect of the hate and hostility directed at the child, and it is inevitable because the child has been cut off from contact with the life force in the universe, and in particular from connection to the reality of benevolence, of goodness, as manifest in the experience of pleasure. Often, an experience of ecstatic merger or fusion with the parent takes the place of a centered, grounded self. The merger, and hoped for continuation of it, become the only relief for the patient from the annihilating death of the soul necessitated by the demanded merger from the parent. The therapist, in representing and supporting reality, becomes the agent of a process felt by the patient as prying her or him out of the body of the parent. This is the only way an autonomous self can even begin to develop, and it is an excruciatingly painful process. This process entails an almost Sisyphean struggle with the compulsion to succumb to the merger, bringing with it the state of living-death it entails.

After quite a few years of anguished wandering in the wilderness, and with many yet to come, I remember finally saying to my therapist of those years, Vivian Guze, that I realized that I preferred reality,

however painful, over unreality. I said that unreality was the most painful thing of all. In a rare moment of connection in reality, with her, I could feel her process of deliberating, perhaps unconsciously, about whether to tell me her feeling and position on this, finally saying she too felt the same way. The decision to live in reality, given the daunting experiences attendant on that choice is momentous. It has to be made progressively, and over and over again, because the awareness of the dire straits one is in, the awareness of the damage sustained creeps up slowly. It is appalling, and terrifying to become aware of the irreparability of that damage.

Artie, who has been in therapy with me now for some 15 years, batters me with his futile rage at being so damaged. He hates me for not having faith in him – which is inaccurate, I do have faith in his commitment, his insistence on struggling. But he demands that I assure him, as other therapists have done, that if he works hard enough, digs deep enough, expresses himself forcefully enough, he will pass through his vale of death and darkness. When I fail to do so, he hammers me with criticism of my passivity, my inability – or unwillingness – to guide him to the shores of serenity. Transferentially, he hopes to convert his mother who held him tight, then told him he would amount to nothing, into the loving admiring woman he needs. He wants to extract the reassurance from me, and I hate having anything extracted. I realize finally that this is how he felt when his mother flaunted her sexuality and taunted him with her unavailability. She extracted from him his longing, his hunger for her. When he stops pounding me he is faced with the truth of his situation, alone on the black sea, in a hurricane, occasionally able to reach his hand out and know I am there.

I cannot reassure Artie because, of course, I don't know how far he can make it out of the desperate hole he is in. He has changed greatly in the time we have worked together; more, probably, than either of us thought likely. But I also cannot reassure him because I don't know for myself. That is, I don't know for anyone how much of this very deep damage is reparable. When I tell him what I tell myself, that I can help him become more self-possessed, more in contact with himself, he scoffs at me. What kind of wimpy drivel is this from a

bioenergetic therapist who should be proclaiming the virtues and possibilities of a life of assertive pleasure? And what is the point of being more aware and being more self-possessed, if it means endless defeat, darkness, unrealness, rage and despair? Indeed what is the point?

I do not reassure Artie because I am not there to assure him, as others have, that nothing is really wrong with him that cannot be cured. I bear witness to the realness and value of his truth, and I share his commitment to that truth and its meaning. When his demandingness activates my impulse to withhold out of my own oral hostility, I enter with him the place in which the truth of his trauma can be enacted. I am his mother, the sadistic withholder; I am him who tried to free himself from her by refusing to give her everything she demanded; I am myself, the rigid, sadistic withholder I am; and I am the victim of his sadistic violent attempt to wrest from me an untruth which will comfort him at the cost of my integrity, as his mother did to him. This is the transaction we live out again and again, each of us trying to see the truth to be seen in the other's experience, surviving it each time with slightly more capacity to be in the present reality.

Following the Body to Realness

Before taking up the question of the intrinsic value of living in this devastating reality further, let me say that a body-oriented approach to the issues raised here has certain distinct advantages. One is that the course of following raw, unmediated sensation allows a person to follow internal realness without language. Since these states of being stem from experiences taking place initially in a time before language is available to mediate and communicate what is happening, having sensation allows for the possibility of communicating with oneself and another. When language does develop in such a toxic interpersonal environment, as being described here, it is unhinged from the felt meaning of experience. Language thus severed from sensory, visceral experience can be easily used for purposes of manipulation and mind-control. Working in therapy directly with felt sensory experi-

ence, however dimly apprehended, however truncated or undeveloped, allows the patient to connect with meaning and realness. This has to be done while fighting off – and assists in the fight with – the internalized attempts to render the truth empty of meaning, or twist it into other meanings derived from outside (i.e. from introjected parental communications) not inside.

The thing about choosing to follow my body experience that I discovered is that I have to decide to go where it leads. Not where I would like to go, or wish I could go, but where it does go, to where I truly am.

One of the central functions of therapy with people so profoundly traumatized, broken, and eviscerated, as I am, is to develop skills by which the life of the body can be lived truly. Meaning that distortions in the understanding and direct experience of experience are sufficiently recognized and comprehended to allow for as full an immediate experience as possible. The therapeutic relationship acts as a holding environment for the truth to emerge. When the truth is like mine – as characterized once by my therapist as my mother having torn out my psychic heart and guts, and my father having decimated me – it becomes a challenge also for the therapist to stay in her or his body and follow the experience where it may lead.

What I mean here might be best exemplified by a quote from the writing of my current therapist, Mike Eigen (2001), who has written about our work together.

> There were periods of little distinction between shattered self and shattered / shattering object. Milton [my assigned pseudonym] would try to »ground« (his term) himself in the face of shatter, but often the ground shattered too. Yet each session he started at square one, aiming at ground zero, the point of cataclysm. Whatever he saw and felt, was a taste of what he could not see and feel, he kept stretching – a snake with infinite elasticity expanding around infinitely expanding shatter. Can the infinitely shattering self- and -object ever be encompassed? (p.73)

It has turned out that for me to live in reality at all, and to have any hope of modifying its most painful and most destructive elements, which I experienced as a small child, I have had to throw myself against this wall again and again.

Embedded in this truth is one of a number of very painful paradoxes I encounter in living in my body. My body is the only memorial to the truth of my devastation that I have. In the continuous pain, the unending terror, the brokenness, the immaturity, the collapse, the dread, the confusion, the panic about food and weight, the disorientation, the unending rage, the body states and body structures, are written the truths of my history. This reality confounds every one of us whose early history was so devastating to the body, mind, and soul. So as I, and my patients who are like me, seek to modify our experience, to release long-held pain and tension, to soften rigidity, to breathe and expand, to heal and straighten out, every effort, every second, brings the threat of the dissolution of the only testament to the truth of our experience there is – our bodies, in their broken, collapsed, fragmented truth. If all remnants of the holocaust disappear, how does one challenge the charge that it never happened, that it is just a made up story (a phrase my father used on me repeatedly)?

On top of that, part of the affliction imposed on us is a brainwashing so profound it affects the intelligence of the very cells of the body, the most basic self-information available, ridiculing and vitiating knowing, killing truth, rendering language meaningless. But, while the body may not lie, it can tell a story. And while the story is true, it may not be what is happening right now. And so, I have to be the body that memorializes the truth of my story; tells it as it unfolds even now; and still allows for experience that is new and may contradict or modify the story as embodied in the memorial.

Therapeutic interventions based on bioenergetic principles are very useful to people like me because of their capacity to return to, and amplify felt experience. But there are limitations to their use. In the somatopsychic structure of people with borderline personality organization the capacity for integration of meaningful experience in all domains has been severely damaged. Also, dynamically, any development of autonomy threatened both child and parent powerfully. Thus interventions that should leave behind potent residua of self feeling, and self-identification, instead are experienced as if the internal process runs out of the body and mind like the sandcastle washed away by a wave. Years of active work, in sessions and out, hitting,

twisting things, striving to feel and express the immense rage in me, yielded moments when my hands felt engorged with energy and alive, powerful. Not long ago, more than 30 years into my own therapeutic process, the feeling of power and energy stays more durably in my hands. Or my neck, where the scalene muscle on the right side was chronically tense and enlarged enough to cause a chiropractor I consulted to remark on it. Years of screaming and biting have reduced the enlargement substantially, but stimulation of that area by virtue of a thought, a feeling, or a contact with another sends powerful sensations through me, which require that I go and find a place to scream again. Now it happens less often, and the urgency of the need for expression is less, but it is still palpably present, and can disrupt my state of being at any time.

Artie speaks of the active, cathartic work as giving him a moment of contact with the possibility of feeling good, and of goodness in the world. But the window closes in a few seconds, and he has to contend with a return to the dark void of his existence. Ilene uses my work on her shoulders to awaken herself yet again to the predations of her narcissistically self-preoccupied parents, but quickly falls back into trance. Over the many years each of us has used our bodies to return to reality, we have all made progress at building structure on a cellular level, laying down minute sediments of changed patterns of experience and organization.

Anhedonia

For many people the incentive to soften and modify the memorial to one's suffering is pleasure. Here we come to a bedrock reality for me that is crushing as patient and therapist alike. The basic belief in pleasure in Bioenergetics as the wellspring of meaning and life energy, a kind of basic law of psychophysics, does not apply here; so that cannot be the incentive to change, although it usually takes a while to realize that. One of the earliest elements of understanding people with borderline personality disorder, like me, is that people organized this way experience anhedonia, that is the inability to experience pleasure.

I am using pleasure here in a very complex way to mean an experience of the basic connection to the goodness and benevolence of the universe. Feeling good in the most elemental sense of the term. I am not talking about relief, or gratification. These may be related to pleasure, but they are different functions, and have different meanings and significances.

And I am talking about inability, not about limitation. This is one of the hardest things to come to terms with. Most therapists come from the groups in society whose lives have been compromised and disturbed by emotional trauma. But the majority have not come from backgrounds wherein such severe damage was done that basic life forces – body processes – have been so severely devastated as to be non-existent. We like to believe that human beings and their bodies are nearly infinitely plastic. Only in the case of the most dramatic and observable conditions do we accept damage that devastates so. The reality that the damage is so great that access to pleasure is impossible, is a piece of reality that can be devastating and profoundly demoralizing for both the patient and the therapist.

Years of clinical work, with raised consciousness, tells us now that this is so. As Harold Searles (1951) said, starting in the 1950's in his seminal works on psychoanalysis of the very disturbed, soul murder is all around us. In devastation like this, the damage can be such that no soul is left. That is, there is no connection for that person with the benevolence and goodness in the universe. An inner attachment and deep knowledge of what is safe, healthy, and positive is unavailable. That connection was destroyed for me by both the gross, and the insidious treatment by my parents, who psychotically believed that everyone is ultimately actuated by the need and desire for self-aggrandizement, self-gratification, and superiority. They focused that paranoid belief, and its contingent contempt, ridicule, and rage on me.

My parents taught me to be repulsed by my own soul. In their relationship to me, they taught me every day that I, like everyone else, was solely motivated to deviously manipulate them for my own self-aggrandizement. They projected this on to me, brainwashed me with this ideology, and got me to attack my own insides, to add to their assault on my integrity. They did this, especially in my father's case,

while proclaiming themselves, and seeming to be, progressive forward thinking persons, who could have, and claimed to, in my father's case, raise an emotionally mature son. And I, eager and disposed to merge with him, to please him, took it in, believed it, and became the image he desired.

My parents were, and are, of course, correct in their indictment. Having had the connection to goodness torn away from me, left only with a sense of superiority with which to console myself, I am in fact the monster they consciously or unconsciously made me out to be. The soul was destroyed, development and growth into soulfulness not an option. My attachment to what humans understand as the grounded moral underpinning for positive self-regard, love, and empathy for others was twisted and smashed – obliterated.

Soul Murder

A number of forces converge to murder a soul. The first is the direct effect of terror. The terror is engendered by the experience of the immediate threat of annihilation. The annihilation occurs on two levels. On the first, the integrity of the person's body, mind, and spirit are threatened by overwhelming physical and mental abuse approaching death. The person feels himself or herself threatened with death, and that is accompanied by the unbearable experience of impotent rage, since it is clear the victim cannot protect herself or himself from harm. The second is a persistent, pernicious manipulation of reality. In this psychotic version of reality, the child is a monster threatening to overwhelm, possess, and consume the parent. In fact, it is the other way around. But any accurate perception of the predation the child is actually experiencing at the hands of the parents is systematically deprecated and psychopathically converted into something other than that which corresponds to the victim's sensory-based data.

In my own life experience, these dynamics are concretized in: my mother's alcoholic stupors when I was an infant which rendered her insensate; the overwhelming stimulation of her internal deadness; the paranoid delusions of me as a dangerous invasive entity; my represen-

tation to her of my hated father; and my father's denied, but palpable, hatred of my mother; his denial of his own perception of the danger I was in from her; his willingness to rupture connection when he was narcissistically offended; his contempt for my weakness and fear; and his willingness and ability to insist on my conformance to a version of reality emerging almost entirely from his fantasies; all even as he was saving my life.

Facing one's terror and victimization are hard enough. Feeling the horror of seeing oneself viewed as a monster by those one loves terrible enough; the horror and despair of acknowledging oneself as a monster unbearable. The truth of this monsterousness is validated by the somatopsychic experience of hateful, implacable, murderous rage. The total effect of all these dynamics is to shatter the emerging soul, the unique person developing in that body. As a way to cope with this toxic, psychotically organized environment the child enters a *state of living death*. This state is the result of exposure to death and annihilation, and the terror that ensues. It is also demanded by the relational dynamics; that is to say, my parents required that my soul die, that I develop no positive connection to my own life force, or any real capacity for autonomy. Living in this state is the unrealness that I, and others, find so unbearable. In this state things look real, but they are empty, hollowed of their truth and meaning. It is a place of ultimate confusion, despair, and emptiness colder than the void of outer space, but it exists inside the body. A person in this state sweeps the attentive therapist into a maelstrom of deadness, emptiness, despair, and terror with no exit.

This is also the place the therapist has to live through with the patient, without any certainty of returning to sanity. The underlying dynamic of paranoia is that if the soul of the child lives, the parent must die. The child's autonomy terrorizes the parent, evoking her or his traumatization as a child. The parent sees and takes the opportunity for revenge against her or his abusers. She or he also feeds off the child's desperate clinging for protection, as well as the perverse adoration the child feels for a predator, who alternately terrorizes and soothes her or him. The child empathically sees the parent's terror, even if the parent is unconscious of it, and the child must submit,

through his own psychic and emotional suicide in order to comfort and contain the parent's overwhelm of terror and murderous rage. The demand for death, that is, the turning against self and autonomy is made early, from birth and consistently onward. If that demand is not met, then the infant perpetrates terror on the parent. The infant is the monster who takes away the life force of the parent, an untenable intrusion in an exquisitely vulnerable dependency.

This is the space that the therapist must occupy with the patient. It requires that the therapist accept the reality of this place and be able to tolerate long stretches of time in it. But it also requires that the therapist maintain her or his hold on the reality that exists outside this space. Often the therapist has to insist on the validity of that reality, even at the risk of engendering the rage of a person being told once again that her or his truth is no truth at all. In order to know and facilitate the revelation of all the aspects of this toxic, deathly, twisted reality, the therapist has to make herself or himself available for immersion in it, and be subject to the attempted perpetrations of the patient. It is in this way that hope is maintained; the therapist survives it all, not as the patient did, broken, hollowed out, twisted, but rather, the therapist survives, stays alive, with vitality and integrity intact, and with a deep empathy and sympathy for the patient's struggle.

Ilene tries to claw her way back to awakeness after feeling herself succumb to the gravitational pull her parents exert on her. They demand, and expect her to re-enter their orbit, to take care of them physically and emotionally. She is to ignore the alarms in her own body that remind her of her mother's hatred of her, and her father's narcissistic exploitiveness. She loves them, although after these many years of therapy she knows so much about the damage done her. But she cannot separate from them, and declare her own true, unique identity. She feels she would die emotionally and spiritually without them. They have signaled her they would judge her as evil were she to assert herself fully, and the guilt would kill her. As she swoons in the auto-hypnotic surrender to their embrace, she asks me to work on her shoulders. I work hard, digging into muscle. She uses the stimulation to feel and express some of the rage she feels. She struggles to wake up from the trance. Often she does, and collects more awareness of the

truth of her past, and present. But the knowing leaves behind little sediment, most of it running out of her body like the disappearance of a wave as the water runs down into the sand at the beach. Often enough, she staggers out of the session reeling from her own awareness, trying to organize herself for the very responsible job she has, taking care of others.

Ilene leaves me trying to recover, to regain my own energy, and to wonder at the place I hold in her life. I am a representative of life, of the possibility of benevolence, of acceptance and adherence to truth. She depends on me profoundly. Even to represent the truth of her reality when she denies, or discards, or disdains it. And I am who I am; able to stay in the morass of death, depravity, and despair. But I wonder at the impact of my truth on our relationship, and how it enters the space we both occupy.

What is a Therapist to Do?

Odila Weigand (1987) tells us, rightly, I believe, from her own experience that the first step is unhinging the therapist's need for the patient to recover and be well, from the actual situation the patient is in. This may not go far enough, however, or be enough. The challenge to the therapist is to join the patient in the decision to live on purpose, to choose to encounter the destruction and explore its unique nature for that person. It requires that the therapist openly encounter and bear witness to the person's damage and suffering, but also to the ways the person has become a perpetrator of the same atrocities perpetrated on them. This way of being permits the building-up of body and ego. But it does not require that build-up to lead to anything more than the capacity to be more in reality, to choose integrity and truthfulness, and active restraint of negativity as soul functions which can be autonomously chosen and pursued. This even though the soul itself, the emotional seat of truth, love, empathy, honor, compassion, and integrity has been obliterated, or at the very least, shattered to smithereens. It is the choice for autonomy, the choice to live on purpose, that is left to the person whose soul has been murdered.

Bioenergetic therapists offer a very precious set of techniques to people whose insides are in deep disrepair. In my case, years of gagging and throwing-up, although occasionally put to destructive uses, has on the whole helped me to mobilize internal sensation and touch affective processes. Artie uses breath and contraction to move him to literally shake himself out of the grasp of his symbiotic-parasitic tie to his mother.

My own body abandons me, unable to sustain charge and organization. For years my hands felt puerile and weak. Endless episodes of hitting, twisting things would fill them briefly with energy, and the tissue would swell, only to have it all run out moments later. That has changed; my hands feel full most of the time. But my voice, sometimes resonant can shift in a moment to a high-in-the-chest phlegmmy tightness. As I lose the resonance I lose myself, the connection to inner process shifts, again I have to mourn the loss of identity, of integrity, of cohesion. Similar things happen fifty times a day, or more. What does a therapist do with a client like me in this swirling, fragmenting mix of despair, terror, disintegration, and toxic energy and emotion?

If we could investigate cellular and organ function at the deepest levels, I believe we would find the organic changes and destruction that the kind of early in life treatment I am describing here causes. These are most certainly not ›in your head‹; as if the basic underlying physiology is intact and attitudes and emotions are disrupting it. It is very difficult for us as a society to accept that emotional and interpersonal trauma can cause this kind of deep, psychic and physical damage, and that it is the kind of trauma one sees all around us in everyday life. It is daunting to a therapist that her or his patient not only cannot attain an ideal life, but that even a good-enough life may not be available. This means that the therapist, no matter the effort put in, cannot heal the patient by being the good-enough parent most therapists strive to be, and from which they derive so much meaning and satisfaction.

Ilene's, and my, choice to go again and again to the place of truth despite the disorganization and anguish that brings, after all these years of work, can take a person to some terrible places. I remember

quite well the night I realized how crazy I am, that is, how the disturbance in me would not yield to self-exploration, catharsis, and self-renovation. I had been on a scouting trip to locate a site for what was then a three-week workshop each summer for the Bioenergetic Institute, which I had been asked to direct. I was accompanied by my companion then, now for many years my wife. We had fought, as we would many times, over what was in truth the combination of my narcissistic vulnerability and irritability, my transferential rage, and the embodiment of my identifications, especially with my father's superiority and contempt for others. Finally, I broke down, as I always eventually did, and in my despair I had a moment of perspective on myself, and I remember saying: »I can't be this crazy.« I saw, however vaguely, the essential truth that I was damaged in ways that could not be repaired simply by recognizing the damage and working it through.

This recognition is something I have had to come to again and again, day-to-day. It is hard to characterize the depth of the disturbance in being and function. Even interventions at a body level, which have an enormous potential to restore life to nearly dead psychic and physical processes, and which provide a vehicle for ever-deepening experience, do not hold.

It is essential that the therapist be willing to enter the space of damage and deadness that created the person so afflicted. At the very least the therapist is charged with validating – and often insisting on the truth of – the depths of agony, despair, hatred, emptiness, abandonment, and grief the borderline person experiences, even if unconsciously so. In the beginning it is the therapist's choice to be real and value truth that creates the space in which the patient can agonizingly emerge from the state of living death that the relationship with her or his parents engendered in her or him.

Artie tells me now, after these many years of therapy, that he feels himself coming out of a cocoon. He sees, he says, that the cocoon is the result of his mother's demand for merger with him. His terror of her, and his rage at her, facilitated a state in which she could use him for her own needs and he could make no protest. Now he wants out; out of the cocoon, out of the altered state of consciousness that ac-

companies and facilitates its continuation. Out of the worshipful, adoring, sexually-charged, demeaning, intimidated state he is in when he relates to his mother – which he does all the time, as she is omnipresent in his internal life.

Facing the Perpetrator

Occupying and maintaining this space is only one of the important constituents of working with people with borderline personality, and it is not enough by itself. Another critical element in the treatment is the requirement that the therapist face and deal with the deadly negativity that is an integral part of the personality structure of someone organized this way. Much is made, for example, of the way borderline people split up helpers and get them to fight with each other. One well-understood formulation (Kernberg 1975) attributes this behavior, at least in some significant measure, to the fact that borderline people have been unable to successfully traverse the developmental phases needed to integrate their experience of others as having elements of good and bad in their personality. That split is then enacted in the person's relationships with others, including the therapist.

It is less well understood that the borderline person is also enacting another experience. In that one the unendurable craving for attachment drives the person into a clinging, desperate, often parasitic connection to another. Finding herself or himself well inside the boundary system of the other person, the borderline person starts to panic, fearing complete annihilatory engulfment. In a panic the person starts to push away doing anything he or she can to get free. Like a drowning person, out of mind with fear, the borderline person will now do anything, even to the lifesaver who came to the rescue, to assure her or his own survival. This dance of merger, then paranoid fear and rage, followed by attack, followed by merger again, happens repeatedly as the person tries to have a different experience with the therapist than he or she had with a parent.

The patient's negativity often comes to awareness when she or he has this repetitive process brought to her or his attention, by the ap-

propriate and necessary boundary-making of the therapist. The patient's thrust to merge is thwarted, an attempt is made to subvert the therapist's autonomy using the same tactics which have been used on the patient. Failure to dominate and control the therapist threatens the patient with abandonment, and demonstrates the therapist's separateness. This activates the patient's sadistic, murderous rage, and the desperation to possess the soul of the therapist in the same way his or hers was possessed. In this state of desperate inflamed narcissistic and oral rage, and without an internal connection to benevolence, the patient can and will believe, and do, anything required to get what she or he needs. In this internal environment of unrestricted negativity there is no empathic awareness possible of the impact the person is having on another.

In this reality, where there is no sensibility for the innate goodness in people, hate, contempt, disdain, self-justifying abusiveness and exploitiveness run unconstrained, at least internally and unconsciously. Can the therapist stay in this space with the same openness to acknowledging the truth of the patient's experience, without the agenda to change her or him? Can the therapist endure assault after assault, hate, derogation, annihilation, disrespect, manipulation, contempt, superiority, and dismissiveness, and still bear witness to the patient's experience? If the therapist can make the choice to live consciously, purposely in that truth, then the patient has the possibility of doing so also (the techniques necessary to sustain the therapist in this context is for another paper).

Because of the constraints and limitations, and protection of the therapeutic arrangement, it is not easy to see the pervasiveness, the depth, and the ferocity of the negativity embodied and expressed by people with borderline personality. It is often seen much more clearly in the relationship between the borderline person and her or his dependants, spouse or partner, and children. Although sometimes, of course, it is such a constant pernicious aspect of the transference relationship that the therapist knows all too well the toxicity of the patient's interpersonal process.

In my case, until very recently, I confined the expression of the feelings of deadly hate, contempt, derision, and superiority to my im-

mediate family. I largely spared my therapists because of my fear of lacerating ridicule which was a feature of my family's interpersonal style, and because the threat of abandonment, were I to behave that way with the therapist, evoked the terror of being left by my father with my mother as a small child.

I raise this here because the prevailing view of people with borderline personality organization is that they present with acute and persistent hostility. In fact, the negativity may be very well concealed behind a psychopathic defensive organization, which also serves to disarm people in preparation for their being manipulated and exploited. It may be a serious failing in my first effective therapy, that the extent and severity of acted-out negativity was not addressed – even though the therapy saved my life, in no small measure because of my therapist's commitment to felt experience, wherever it took us.

I discovered the extent of my negativity in my relationship with my wife first, and my children after. My wife's refusal to be treated dismissively and derisively, and her ability and willingness to fight, forced me, over a very long time of defense and denial on my part, to face the truth of the destructiveness that is born out of the same processes which have destroyed me. The therapist facing this, lives with someone in the throes of excruciating pain, having been poisoned through and through, who then strikes others. It poses especially difficult problems for the therapist watching a patient acting out this process with a vulnerable dependant, like a child, who cannot make the same autonomous choice the therapist makes to stay with the person as they writhe and twist seeking a moment to attack.

Thus it becomes necessary for the therapist to seek out the negativity inevitably present in the borderline person, however it is concealed. It is not easy to do. When I began to understand the depth of my animosity and destructiveness through my interactions with my wife, I began also to seek to understand the manifestations of the poison in my attitudes and feelings to my children, my son in particular. I sought help from therapists and friends, to little avail. It is beyond the scope of this paper to investigate the reasons for the dearth of information on the intricacies of murderous hostility between fathers and our children. But I believe further study and con-

frontation with the truth of the matter, will lead to a recognition of the prevalence and the significant social effects of these interpersonal processes.

So it falls to the therapist to smell out, bring into the foreground, and, ultimately, feel the sting of the toxicity coursing through the veins of someone who has been threatened with annihilation. Someone who has been sadistically twisted, whose ability to feel pleasure, love, joy – the connection with benevolence which creates a buffer for, and an amelioration of the horrors in human life – has been destroyed.

The Therapist Lives on Purpose

In this context of despair, desperation, anguish, death and emptiness, and the toxic brew of negativity – hate, contempt, annihilatory coldness and devaluation, the therapist lives a life on purpose with her or his patient. It is this commitment to a life of felt experience, reality in other words, which the therapist offers to a patient, to whatever extent the patient chooses to live in that space. This living reality, nourished and supported in the therapeutic space of the psychotherapy encounter, wherein no one can be harmed (permanently damaged, that is), is what offers hope to someone like me, for whom often the pain is too much to bear.

Nothing would make that agony disappear – well, perhaps narcotics, but I have chosen not to go that route. Living my life on purpose has become the touchstone of my existence. Living-death, unreality, are all too common in this world. The conditions that engender them, the way people treat each other all too prevalent. I have decided, and decide every moment, not to live in that state when I can do otherwise. I fail, because I can do no more, or because I cling to my unfinished business, or because I have to memorialize the harm done me, or because I am in the throes of a perpetration. Every day I re-commit myself to living in reality. I stretch to feel the warmth of those around me even when it causes agony, even when I despise, envy, and want to ridicule them. I am gratified by my ability to help others live in reality,

and often to feel and do things which I cannot. I have become an expert in living in my immediate internal reality, and knowing when it does not correspond to outside reality. I have become a bit of an expert at the process of bringing the two states, my internal truth, so divergent from much of what is happening to me and around me right now, and that reality around me more into convergence at least in my capacity to recognize the truth. Psychotherapy is the crucible wherein I push the edge of this way of experiencing, it is the undiluted medium for the work. It happens everywhere else as well, of course.

For the therapist not organized as I am, who has a more grounded, organized, and cohesive self, the commitment is somewhat different, but no less crucial. That person has to seek and find ways to enter and reside in a version of reality and the world it would be far easier to avoid. In that space, with a borderline person, the therapist cannot expect, or need, the gratifications that come from working with patients organized differently. To enable the patient partner in the relationship to live on purpose, in the reality that is true to them, the therapist must make a similar decision to live in that reality with her or him. The therapist's struggle to apprehend, feel, and contain that reality becomes the infrastructure for work that confronts, examines, and even, in time, modifies the tragedy and trauma of a life lived in the darkness.

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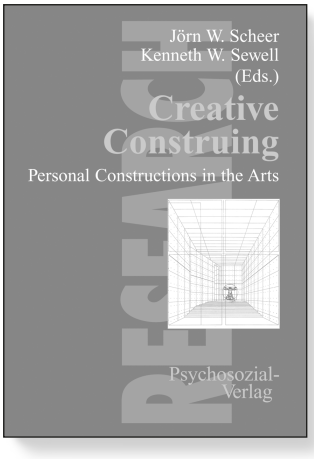

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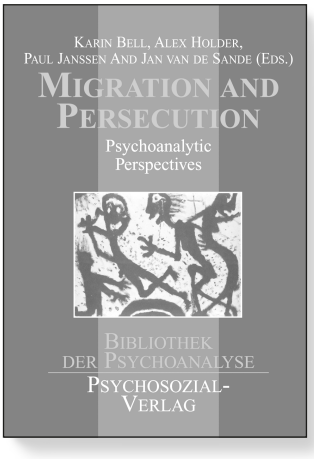

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