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Bioenergetic Analysis
2015 (25)

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Vincentia Schroeter, Margit Koemeda-Lutz, Maê Nascimento (Eds.)
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Contents

Reviewers for this issue were:
Margit Koemeda
Maê Nascimento
Vincentia Schroeter
Tarra Stariell

Letter from the Editor

Welcome to the 30th year and 25th volume of the publication of *Bioenergetic Analysis*, the clinical journal of the IIBA. Past editors invite you to read their tales of producing this product in the opening essay. In this letter I will encourage writing and reading for the IIBA journal, introduce a new change, summarize the articles in this volume, promote attendance at the next IIBA conference, and share my gratitude toward others.

Publishing an article:
If you have a research project, philosophical point of view, or new clinical perspective to add to the dialogue within Bioenergetics and toward the broader psychological community, the journal is a forum to express your ideas. Papers are accepted between June 1st to September 1st, then anonymously peer reviewed, and revised before the entire volume is sent to the publisher December 1st of each year.

Reading:
Maybe a clinician has a break between clients, picks up the journal and reads an article. This brings fresh ideas to the forefront of their brain and inspires them to pay attention to this theme in a way that provides a new lens and may contribute to the next clinical session in their office. I have been inspired by many an article, which renews my excitement and commitment to the work we do.

New Change:
As we continue to grow and diversify as a community, the journal also changes. The BOT has decided that the entire 2015 volume will be translated into Portuguese. Each year after that, a new language will be chosen and the journal will be translated into that language. This global expansion deepens the work among individuals and spreads knowledge to a wider community.

Summary of Articles:
Authors hail from Germany, Italy and the USA, providing a variety of interesting topics. In "Body and Body Psychotherapy in the Global Village", Helferich continues the dialogue with Nascimento's theme from her paper last year on engaging Bioenergetically with the present time in history. Heinrich-Clauer presents neurobiological findings on the somatic effects of resonance and provides Bioenergetic self-care techniques for therapists. Bedrosian shares a wealth of information comparing three styles and many techniques in working energetically with couples. Cardezza explores the emotion of shame and feeling ridiculous in relation to the physical aspects of Bioenergetic therapy. Finally, Fauser provides an in depth study of pre- and perinatal issues in Bioenergetic Analysis, complete with rich and disturbingly convincing case examples.

2015 IIBA Conference: "Fear of Love Fear of Life"
The next IIBA conference is on August 19–23, 2015, in beautiful Porto de Galinhas, Pernambuco, Brasil. It is really beautiful and the hotel is right on the beach.

Here is an ad from the conference committee inviting you to attend:

"Join us for the opportunity to reflect and dialogue about the origins and motives of our feelings of fear, which prevent us from living fully with joy, and prevent us from establishing safe and loving bonds. Come participate in this International Conference where there will be space for different views and experiences on the theme, integrating mind-body work as an agent of change in personal and family relationships, social issues, ecology, neuroscience and psychosomatics.

Enjoy the following benefits of attendance:

- Enjoy peer-to-peer networking and knowledge sharing.
- See beautiful Recife and Porto de Galinhas, Brazil.
- Learn what is happening in other parts of the world regarding BA.
- Explore what creative and innovative things your fellow bioenergetic therapists are doing.
- Find out how BA is evolving in other parts of the world, outside your society, country, and region.

Let yourself truly become part of the Global Community of the IIBA. Create new partnerships. This conference is in Brazil only once every 6 years, so don't miss out! Register now if you haven't already. On top of all of this we will have a great time dancing and enjoying meeting new friends!"

iibaconference.org/registration-fees/

Appreciations:

As you enjoy this volume, I would like to thank some of the helpers. First, thank you to all the authors, including past editors for their contributions of content. The trio of editors is back, so I had Margit Koemeda and Maê Nascimento sharing the job with me this year. Reviewers included the editors as well as Tarra Stariell. I would like to acknowledge those who translated abstracts. They were Slyvia Nunez, Fina Pla, Maria Rosaria Filoni, Guy Tonella, Louise Frechette, Violaine de Clerk, and Ulla Sebastian. I would like to send a special thank you to 7 year old, Lucianna Ying, who painted the fishes you see on the cover. I met her when I was invited to introduce Bioenergetics in Hong Kong. She is the daughter of a student attending the 5 day workshop, which I presented in June, 2014. As Bioenergetics newly expands into Asia, enjoy the photo of bright-faced Lucianna, the cover artist for this 25th volume of *Bioenergetic Analysis.*

Vincentia Schroeter, PhD
Escondido, Ca. USA
November 13th, 2014

Inside the Backroom

The Clinical Journal of Bioenergetic Analysis
5 Chief Editors Speak out
The 30 Year Perspective 1984–2014

Introduction

2015 is the year presenting this 25th volume of the clinical journal of *Bioenergetic Analysis*. 2015 also marks our 30th year of production of the journal.

To honor this 30th year here is the list of Chief Editors who took the helm over the years to provide a product that contained written material for the Bioenergetic community. Journals included the latest thinking in the field, the creative use of new and classic techniques, articles comparing Bioenergetics to other schools in psychotherapy and philosophy, research and examinations of topics within and beyond psychotherapy. Over the years various authors have taken themes of their interest and woven in new colors and shapes to contribute to the general zeitgeist of knowledge to inspire all of us in the Bioenergetic community.

Chief editors list:
1. Phil Helfaer: 1985–1990
2. Ed Svasta: 1991
3. Leslie Case: 1992–1993
4. John Conger: 1995
5. Miki Frank: 1996
6. John Conger: 1997–2004
7. Margit Koemeda: 2005–2007
8. Vincentia Schroeter: 2008-present

We have all had a team of editors, reviewers and proofreaders to help us with the annual task of putting together these volumes. Along with the authors, all these people have been essential to the process of completing the journals each year. I re-

quested notes from past chiefs and here are some of their messages sent for you to read about their time in the editing room.

An Exciting Time: First Issues of the Bioenergetic Journal (Philip M. Helfaer, Ph.D.)

I am looking at a large black and white photograph, which for me is imbued with warm memories. It is dated May 9, 1984, so it is not a digital photograph sent from a smart phone; it is from a conventional film camera. The photo shows two men, standing side by side, virtually shoulder to shoulder. A younger man on the left, slightly turned toward the older man, is holding a booklet in his hands and looks very excited and happy. He looks out at an audience. The older man, also looking very pleased and happy, regards the booklet. The younger man is a younger version of myself and the older man is Alexander Lowen, M.D., originator of bioenergetic analysis. The date indicates I would have been 50 years old, and Dr. Lowen would have been 74. The place the picture was taken was Liberty, New York, U.S.A., at the Grossinger resort. The occasion is the presentation of the very first issue, Volume 1, Number 1, of *Bioenergetic Analysis: The Clinical Journal of the International Institute for Bioenergetic Analysis*. Perhaps some readers of this journal will enjoy the story of how that occasion came to pass and how it almost did not come to pass.

Sometime in 1983, I received a letter, probably from Ed Svasta who was associate director of the institute at that time. It informed me that the executive committee (Ed, Len Hochman, Vivian Guze, Myron Koltuv, and Dr. Lowen) had agreed to offer me the opportunity to start a journal – as, they said, I had proposed doing. This was news to me. Dr. Lowen and I had talked about the idea of a journal; we both thought it would be a good idea. As I recall that was the extent of it. In any case, the executive committee invited me to come to New York to meet with them and tell them "my plans." I went down to New York. The committee talked about various other matters of business, and then discussed the idea of publishing a journal. They agreed I should take on the task of launching it. I requested a budget of $5000, a lot of money at the time, to hire a secretary and buy a computer. This request was granted. I returned home and started trying to figure out what to do next.

How did one create a professional journal from scratch for an organization that had never published a journal? I had no idea. At that time, there was no Internet available where you could learn about everything under the sun. My first act as an editor, then, was to purchase a book named *The Chicago Manual of Style*. It is a huge fat manual that was (and still is) one of the bibles of publishing. I studied it thoroughly.

Luckily, I discovered a congenial person living in our small town in Massachusetts who agreed to do the secretarial work. I purchased one of the first home computers, called a Kay Pro. You have to realize this was the very beginning of the information age and home computers. This Kay Pro was an impossibly complex thing that had to be programmed for every operation since it had no memory. I hired another young woman who was interested in learning it and she helped us through the first couple of issues. A few years later I purchased for myself the first Apple Macintosh computer, the one that put Apple on the map, and I learned how to use it.

These first issues of the journal were literally hand made. We had to do every step of publishing: type manuscripts, do "layouts" or "paste-ups" of every page, have a graphic designer do the covers, and of course I also did all the copy editing. For the first couple of issues we even took care of mailing out copies. We did all this in our home in Pepperell. Fortunately, we had a room downstairs we could devote to the journal.

I had to arrange for a printer. I found one of those unique individuals who find their way to small rural towns and develop a printing business. He lived in a large, drafty old farmhouse in Townsend, Massachusetts. He had an equally large, old, even draftier barn. The barn was filled with old-fashioned printing presses, those huge fascinating machines that could set type and print thousands of pages. I don't remember how many were in the first "run" of the journal – maybe 1500, maybe more, a lot of boxes in any case. I thought they came out beautifully.

I'm sure you'll believe me when I say, it was a lot of work. For that first issue, Velma, my wife, and I loaded several boxes of the journals into our car when we drove down to Grossinger's for the biennial conference. I was so excited about bringing the journal to the conference I wasn't sleeping.

I suppose it was the first full day of the conference. The New York Society was hosting the conference that year, and someone from that group was chairing the meeting. I approached him and asked for a five minute break in the program to introduce the journal. He refused. He said, "All I can say is that if you take a five minute break in the meeting, it will become known as the 'Phil Helfaer memorial break.'" I was nonplussed by this bizarre threat, but I knew that the matter was too important to be put off in that way and I went to Dr. Lowen. We went to the meeting together, he introduced me, and I introduced the journal.

I was heartened by the response of all present (or almost all). Everyone was really excited about it! On that occasion, we were offering copies for sale, for $5! I had announced that copies would be available for purchase at the close of the session. When the session closed everyone ran to the front reception area to buy a copy! It was a great moment!

After the conference, we had to deal with mailing copies to subscribers. We did this by hand for the first couple of issues. It was too much for one person. After the

second issue, I told the executive committee that we would have to find another way to produce and distribute. Dr. Lowen's long time secretary, Ruth MacKenzie agreed to take on that job.

For those first several issues, the completion of each one felt like a triumph against high odds. It was not easy to get material. Manuscripts had to be submitted in typed form. After I got my Macintosh, people could send floppy discs, but I don't recall when that became possible. Virtually none of the older therapists and trainers were in the habit of writing, and it was difficult to get enough material to fill an issue with qualified papers. I filled in the first few issues with quite a bit of material that Dr. Lowen had written previously in his quest to develop his work.

So that's the story of the beginnings of the journal of the IIBA. Establishing the journal meant a lot to me. I still feel a pride in that accomplishment and in those first six issues I edited.

I will end this story with the following. There are several papers of enduring value in the first six issues, a few of which are included in the recent reader. In particular, however, I commend to the current readers of this journal some of the papers by Alexander Lowen. These are especially, "A Case of Migraine," (Volume 1, Number 2), "A Psychosomatic Illness," (Volume 2, Number 1), and "Opening Address on Narcissism, Sexuality and Culture," (Volume3, Number 2). These papers beautifully illustrate and describe Dr. Lowen's focus on the energetic processes of the body, important vicissitudes of energetic process in the course of therapy including those relating to illness, the singular importance of the focus on sexuality, the capacity to 'see the person' as the most basic condition of therapy, and the sense of Dr. Lowen's attitude and feeling concerning the human, feelingful presence of the therapist as a real person in the therapeutic dyad.

IIBA Journal 1992 and 1993 (Leslie Case)

I was the second editor of our journal. I was surprised to be asked, as I had not published any books or articles at the time, and had no editorial experience. Nonetheless, I accepted, with excitement and trepidation, and permission from the Executive Committee for my sister (a writer/editor) to work with me.

It was a daunting experience to follow Phil Helfaer, a Reichian and Lowenian scholar, an original thinker, a writer, a passionate man, the creator and editor of our journal for six years.

It took me a while to find my own way. I created a new look for the cover, with a new name. The look was bold and colorful, with a mauve background. Majenta

surrounded the bioenergetic insignia. The journal was now called simply *The Journal*. The size of the J, however, was huge.

I did not have Editorial Consultants as Phil did. I liked the idea of going back and forth with the writer of each article, working together to make the article the very best it could be. Some writers loved these interactions; others felt that I was controlling their words and did not like it at all.

For the most part, *The Journal* had the same focus as in the past – communication within the bioenergetic community; disseminating its ideas, theories, and practices to others outside our arena. It continued to feature case studies and book reviews. I added a new section, "Short Items," for poems and anecdotes, brief essays, and miscellaneous entries; and a "Letters to the Editor" section.

I encouraged the membership to send me case studies of people they worked with, reviews of books that had meaning for them, creative submissions for the short items section; and to express their viewpoints about the journal in general and specific articles as well, to comment if an article touched or angered them. I hoped for a back and forth interchange with our entire membership.

The responses were encouraging: recognition that Phil Helfaer was a hard act to follow; appreciation for the inclusion of the soft colors, the feminine into bioenergetics to balance Phil's handsome, masculine presence; appreciation for the content and the graceful format; delighted disbelief that I included a poem in the first issue; and the one that made my day, "Beautiful. Exciting. Sexy." What I did not hear, but imagined: *The Journal* was "not professional enough." Although we were years away from reorganization within IIBA (Arles, 2000), there was a growing desire to increase our connectedness with other professional organizations; and a beautiful, exciting, sexy journal was absolutely not the way to get there!

John Conger, 1995 and 1997–2004

When I took over the editorship from the New York leadership, the journal appeared to publish within a fairly narrow range of authors. Lowen's secretary was typing out submissions and the printing price was high. I made a few basic changes so that the authors submitted completed work and got the journal printed at half the price. I also focused on writing from the broad international community. The tone of the journal was more informal and available so that the readership might include the students and not a select few. At the time I turned the leadership over, the need had changed in Europe for the journal to represent Bioenergetics as a serious scientific process. I was studying to be a psychoanalyst and was glad to pass the journal on to take its new position.

Margit Koemeda, 2005–2008

After one or two decades of expansion and creativity, during the eighties and nineties European health administrations tried to "professionalize" psychotherapy and it got increasingly difficult for bioenergetic analysis, which, according to APA standards, did not belong to the "evidence based" approaches. This is because we had no research, namely no RCT (randomized controlled trials) or other quantitative studies to remain among the acknowledged approaches.

The Swiss Society spent a lot of time and effort keeping track of the continuously evolving requirements and tried to stay connected to the evolving forces in the process of psychotherapeutic professionalization. Hugo Steinman and I were active in this process, until in 2002 when Hugo got elected as president of the IIBA. For the first time in the history of the IIBA a European had become president. Efforts to reorganize the Institute and install more democratic structures were undertaken.

During this time the consciousness that the IIBA membership belonged to different cultures and spoke different languages was growing. Since I had served on other editorial boards of scientific journals in German speaking countries, one day Hugo asked me if I would be willing to take on the editor's job for *Bioenergetic Analysis*.

In order to proliferate our body-oriented approach to a wider professional public, I thought we should have a publishing company for our journal, having contacted several of them for a book on Bioenergetic Analysis, which I had edited shortly before. The Psychosozial-Verlag in Gießen, Germany, finally agreed to publish *Bioenergetic Analysis* at a reasonable price. Barbara Bendel, our much appreciated IIBA administrator at that time agreed to mail volumes to our membership.

What I had underestimated was the difficulty of doing editorial work in a language that is not my first language. Fortunately, Vincentia Schroeter joined our editorial board from the beginning and helped with the translation of papers into English. Maê Nascimento from Brazil also joined our editorial board and she arranged to have our first joint issue translated into Portuguese. In this way the new editorial board represented at least three continents – Europe, North America and South America.

After three issues I was happy to pass on the chief editorship to Vincentia, as she is a native English speaker and does a wonderful job editing papers, which were originally written in other languages and then translated into English. Maê and I remained on the board (Maê with an intermission of several years, while she was serving on the IIBA BOT), and the three of us collaborate in a very constructive and pleasant way!

Musings on Chief Editors Job (Vincentia Schroeter, 2008–2015)

I reviewed my 8 years as editor in chief and here are some of my thoughts as I skimmed the volumes:

2008: The IIBA conference had been in Spain in 2007. This was my first trip to Spain, which was the homeland of my grandparents. In the Lowenian spirit of grounding, the cover photo on the journal is of my foot making its first step onto the land of my ancestors. I learned much from Margit as she helped me with the transition to chief editor. We changed our instructions to authors. For the first year all material was sent digitally, with no more need for paper copies. Margit and Maê were my valuable editing team, as I got my feet wet in my new job.

2009: Our founder, Alexander Lowen died October 28, 2008, just before this volume went to press, which made us all sad. For the first time we accepted papers from students in training in order to expose readers to written work from IIBA curriculum programs.

2010: The cover was a green tinted photo of Alexander Lowen and the volume contained memorial notes on his passing. A new addition sent from the Board of Trustees was to translate English abstracts of each published paper into 6 other languages for non-English speaking members.

2011: Along with professional papers, we included three book reviews and a creativity section that involved poetry, inspired by Bioenergetic concepts.

2012: Most papers were keynotes or articles from the 2011 IIBA conference in San Diego, California in the USA, which was a well-attended conference, with 32 countries represented.

2013: This year we suffered the deaths of prominent IIBA members, Frank Hladkey, Elaine Tucillo and David Campbell and memorialized them in this volume. Elaine's final paper is published in this edition.

2014: Many papers were originally presented at the 2013 IIBA conference in Sicily. Three articles were from Brazilian colleagues, including one classic paper on core energetics. Three papers were from the USA and one from Germany, providing proof that diverse voices are continuing to rise to be heard.

I was asked to comment on why we do this unpaid work:

Personally, although I am slow at it, I enjoy copy editing and proofreading every line of a paper. My goal is to make the article as clear as possible for the reader, while maintaining the original voice of the author. Sometimes I feel frustrated when I spend 10 or more hours proofreading one paper. Then I feel humble as I remember that these authors are often writing scholarly papers in English, which is often a second, third, or fourth language for some of them, while I can only write in English!

Summary

As you can read from these editor reports, the landscape has changed in the community over thirty years and with it the face of the journal over time. We remain open to new developments and modern thinking in the form of articles, as long as they are grounded in the theories and practice of Bioenergetic Analysis, as originally designed by our esteemed founder, Alexander Lowen.

Body and Body Psychotherapy in the Global Village

Christoph Helferich

Abstracts

English

The reality of the Global Village profoundly influences body psychotherapy, challenging fundamental received concepts such as "nature", "body" and "personal identity". This paper investigates these changes, particularly developing three points: a) the concepts of "body" and "nature" in the founding fathers of body psychotherapy; b) the challenge to these concepts by developments in advanced technology and virtual communication; c) the task of body psychotherapy today – namely – to raise awareness of the importance of both the external "nature" around us and our internal, bodily "nature", both of which can no longer be taken for granted, but must become the object of our choices and lifestyles. In the clinical considerations section the author presents a technique of "nurturing contact" that allows the patient's deep experience of his own bodily essence.

Key words: body psychotherapy, global village, nature, choice, nurturing contact

German

Die Wirklichkeit des Globalen Dorfes hat tiefe Auswirkungen auf die Körperpsychotherpie, da sie überlieferte Grundbegriffe wie "Natur", "Leib" oder "persönliche Identität" infrage stellt. Der Aufsatz geht diesen Auswirkungen nach, und zwar in drei Schritten: a) der Begriff des "Leibes" und der "Natur" bei den Gründungsvätern

der Körperpsychotherapie; b) die Infragestellung dieser Begriffe durch die Entwicklungen der modernen Technologie und der virtuellen Kommunikation; c) die Aufgabe der Körperpsychotherapie heute: Sensibilisierung für den Wert der uns umgebenden äußeren und unserer eigenen leiblichen Natur, einer Natur, die jedoch nicht mehr fraglos vorausgesetzt werden kann, sondern die gewählt und gelebt werden muss. In den klinischen Überlegungen wird die Technik des "nährenden Kontakts" vorgestellt, die dem Patienten eine tiefe Erfahrung seines Leibseins vermitteln kann.

French

La réalité de la globalisation influence profondément la thérapie psychocorporelle aujourd'hui, et remet en question nos concepts de base tels que la "nature", le "corps" et l'"identité". Cet article examine de près ces changements, et développe plus particulièrement les trois thèmes suivants: a) les concepts de "corps" et de "nature" chez les pères fondateurs de la psychothérapie corporelle; b) comment l'évolution de la technologie de pointe et de la communication virtuelle bouscule ces concepts et les remet en question; c) le fait qu'aujourd'hui, la tâche des thérapies psychocorporelles – à savoir- développer la conscience de l'importance de la "nature" tant à l'extérieur qu'à l'intérieur de nous, ne peut plus être considérée comme un fait acquis mais doit devenir l'objet de nos choix et nos modes de vie. Dans la partie clinique de l'article, l'auteur présente une technique de "contact nourrissant" qui permet aux patients de faire l'expérience profonde de leur nature intrinsèquement corporelle.

Spanish

La realidad de la Aldea Global influye profundamente en la psicoterapia corporal, desafiando conceptos fundamentales recibidos tales como "naturaleza", "cuerpo" , e "identidad personal". Este artículo investiga estos cambios, desarrollando tres puntos en particular: a) los conceptos de "cuerpo" y "naturaleza" en los padres fundadores de la psicoterapia corporal; b) el desafío de estos conceptos a causa del desarrollo en tecnología avanzada y comunicación virtual; c) la tarea de la psicoterapia corporal hoy-principalmente- incrementar la consciencia tanto de la "naturaleza" externa como de nuestra "naturaleza" corporal interna, ninguna de las dos puede darse por supuesta pero deben llegar a ser el objeto de nuestras elecciones y estilos de vida. En el apartado de consideraciones clínicas, el autor presenta una técnica de "contacto nutritivo" que permite al paciente experimentar la experiencia profunda de su própia esencia corporal.

Italian

La realtà del Villaggio Globale incide profondamente sulla psicoterapia corporea, mettendo in discussione tràditi concetti-base come "natura", "corpo" o "identità personale". La relazione indaga su questi cambiamenti, soffermandosi su tre punti: a) i concetti di "corpo" e "natura" nei padri fondatori della psicoterapia corporea; b) la messa in discussione di questi concetti attraverso gli sviluppi della tecnologia avanzata e della comunicazione virtuale; c) il compito della psicoterapia corporea oggi: sensibilizzare al valore di una "natura" esterna e interna, ovvero corporea, non più scontata, ma oggetto di scelte e di stili di vita. Nelle considerazioni cliniche l'autore presenta la tecnica del "contatto nutritivo" che aiuta il paziente a vivere a un livello profondo il suo "essere corpo".

Foreword

Finding Maê Nascimento's article on *The Present Dilemma of Psychotherapy* in the latest volume of *Bioenergetic Analysis* (Nascimento, 2014) was a pleasant surprise for me. As I had already written my present essay, I discovered that we share many ideas, finding there an *a posteriori* confirmation of a common ground in our thinking. One of these shared ideas is the necessity for us bioenergetic therapists to engage with the historical moment we are living in, or, as my colleague puts it: "the urge to face the great dimension of the radical cultural changes we are going through and their impact over people's personality and way of living" (Nascimento, 2014, p. 15). Moreover, I found surprising synergies in our clinical perspective, as the author proposes a model of energetic work that aims to "create a more introspective nature helping the connection with the energetic flow – and it does this without any kind of interference or suggestion coming from the therapist" (ibid., p. 29). This purpose agrees perfectly with the objectives of the techniques of *nurturing contact* presented below in my clinical considerations.

There are, however, also substantial differences between our contributions. Whereas Maê Nascimento focuses on changes in personality and lifestyle, the shift from "people towards the inside from the past" to "people towards the outside of the modern consuming society" (ibid., p. 20), I try to describe the overall process of the transformation of nature, included the human body, into an artifact. Also in general I am more cautious regarding the valuation of all these changes. I always try to bear in mind that our reference model, namely the person gifted with inner profundity, is the result of a rather recent historical evolution. As I pointed out elsewhere, this

evolution is intimately connected to the rise of Romanticism, symbolically starting with the hero of modern society, Daniel Defoe's *Robinson Crusoe* (Helferich, 2010). I will come back to these differences in my final considerations. As I said initially, however, I am very pleased that reflection on the "global" present has started within our bioenergetic community, and therefore consider Maê Nascimento's essay and mine as two complementary contributions of a common discourse.

Introduction

To contemplate the prevailing trends of our times and make conjectures about their possible future developments almost inevitably brings on a sense of unease and even anxiety – no one knows where this journey will end. We only know that we are on the road, travelling faster and faster, as though we were being whirled around in the great *Maelström*, the relentless vortex in Edgar Allan Poe's story of the same title. It is not by chance that one of today's most perspicacious sociological approaches is called *The Theory of Acceleration*; its fundamental assumption is that in modernity "there exists practically no sphere of life or society that has not been affected or transformed by the drive to acceleration" (Rosa, 2012, p. 285; see also Rosa 2005, engl. transl. 2013).

This process of acceleration requires a great effort at integration on the part of the individual so as to keep up with the pace of the times and face the vague sense of alienation that so easily creeps into the world we live in. Saying this, we already touch on some questions central to the role of psychotherapy in the Global Village, and particularly the much-discussed judgment of it made from the psychotherapeutic perspective. In this light, I should like to quote a famous passage in the New Testament (Mark 8, 36; King James version): *For what shall it profit a man, if he shall gain the whole world, and lose his own soul?* The Evangelist's warning encourages us to make a careful evaluation of the processes of communication and of knowledge peculiar to the Global Village.

We must weigh the possible advantages of the development of technology and information (primarily the broadening of the individual's freedom of communication and self-expression), but also the possible dangers and dark sides of the Global Village as concerns the identity of individuals, their perception of self and the world, and their experience of their own bodies. We must also keep in mind that the Global Village is only the tangible expression of an even deeper tendency, a tendency towards the appropriation, transformation and, we might say, digital "re-burning" of the entire natural world, including man.

Thus, it leads to a reflection on the hypothetical *loss of one's soul* conjured up by the Evangelist: with its sensitive instruments for the perception and self-perception of psychic processes, psychotherapy is the privileged guardian of the individual's intimate side. It is the task of psychotherapy, along with philosophy and sociology, to delve into, watch over and formulate theories about the repercussions of technological development on our personal and social life – on our identity in the broadest sense.

This task of discernment is especially pressing today in the field of body psychotherapy. Since it is explicitly interested in the somatic dimension of the patient, his/her "being body", body psychotherapy – more than other approaches – confronts our "being nature". This is because, as a felicitous definition puts it, "the body is the nature we are" (Böhme, 2003, p. 63). And it is precisely for this reason, for its intimate connection with the patient's bodily nature, that today body psychotherapy finds itself having to reconsider its basic assumptions, and so is in a particularly difficult situation, as if the proverbial rug under its feet had been taken away. Indeed, it would seem that recent developments in science and applied technology, the prevailing tendencies of our times as a whole, can be summed up in the idea, "Nature does not exist". Or more precisely, "What we once called 'nature' no longer exists".

The idea that "nature no longer exists" gives us an insight into how profoundly the Global Village affects body psychotherapy today. It affects its received fundamental theoretical premises and also its possible role in 21st century society. Below we investigate these changes, concentrating on three points:

A) The vision of "body" and of "nature" in the founding fathers of body psychotherapy, especially in Alexander Lowen.
B) The reopening of these questions, which has become necessary due to the development of technology and the new virtual reality.
C) The new task of body psychotherapy: to create awareness of the value of an external and internal "nature", no longer, however, to be taken for granted, but instead an object of choice and lifestyle.

A. "Body" and "Nature" in the Founding Fathers of Body Psychotherapy

The term "founding fathers" refers here to personalities such as David Boadella, Gerda Boyesen, John Pierrakos, Alexander Lowen and Malcolm Brown, who each in their own way and in a very personal fashion have interpreted and carried on the shared inheritance of Wilhelm Reich. As we know, though remaining within the field of psychotherapy in the strict sense, all their approaches significantly broaden

the traditional analytic setting, including explicitly and under many forms the patient's bodily experience while undergoing therapy. But, as many will ask, why should there be this broadening of the borders of the confirmed analytic setting? What reason is there to introduce into the therapeutic encounter experiences and techniques like direct contact between therapist and patient, techniques potentially confusing and in any case not easy to manage (Klopstech, 2000; Helferich, 2004; Buti Zaccagnini, 2010)?

In the end, the answers to these questions are to be found in a vision of man that is common to body psychotherapy. This vision involves the relationship between "nature" and "culture" in human beings, and more precisely the significance of the human body as a crossroads of these two dimensions. As Alexander Lowen writes, expressing this shared vision in an exemplary fashion:

> "The goal of bioenergetics is to help people regain their primary nature, which is the condition of being free, the state of being graceful and the quality of being beautiful. Freedom, grace and beauty are the natural attributes of every animal organism. [...] The primary nature of every human being is to be open to life and love. Being guarded, armored, distrustful and enclosed is second nature in our culture. It is the means we adopt to protect ourselves against being hurt, but when such attitudes become characterological or structured in the personality, they constitute a more severe hurt and create a greater crippling than the one originally suffered" (Lowen, 1975, p. 43–44).

As can be seen in this representative quotation, Lowen presupposes a conflicting dynamics between the "primary nature" of man and his "second nature", which is social or appertains to character. A series of opposites is drawn around this conflicting dynamic, such as the following:

- achievement– pleasure
- thinking – feeling (or)
- adult – child.

These opposites are grouped around the antipodes of "Ego" and "body" that underlie the "culture"- "nature" polarity (Lowen, 1970, p. 211).

Actually, these polarities rest on a common foundation, as the very term "bioenergy" suggests: "We work with the hypothesis that there is one fundamental energy in the human body whether it manifests itself in psychic phenomena or in somatic motion. This energy we call simply 'bioenergy'. Psychic processes as well as somatic processes are determined by the operation of this bioenergy. All living processes can be reduced to manifestations of this bioenergy" (Lowen, 1958, p. 16).

From this standpoint it is possible to conceptualize, as Wilhelm Reich already had done, the relationship between psychic/mental phenomena and somatic phenomena in man as "functional identity between mind and body". And it is faith in the vital energy of this corporeal-organismic foundation that guides our therapeutic work, understood as correction of the inevitable damage to the body and psyche of the individual that the cultural process involves: "Bioenergetics is a therapeutic technique to help a person get back together with his body and to help him enjoy to the fullest degree possible the life of the body" (Lowen, 1975, p. 43).

In a previous essay I identified as "romantic inheritance" this longing of body psychotherapy for the "natural wholeness" (Malcolm Brown) of man (Helferich, 2010). This is an attempt to reconcile, to heal the age-old scission (schism) between the Self and its *Leib*, its living organism. Here we cannot dwell any longer on this aspiration; we only want to make it clear that we in no way intend the adjective "romantic" in a negative sense. The modern individual, endowed with "interior profundity" (Charles Taylor), is largely a child of European Romanticism. Instead, what interests us here is the concept of "nature". Certainly, all the founding fathers of body psychotherapy are aware of the long evolutionary process that has characterized human history, and of the need for the process of education and socialization in which this history is repeated. And certainly they are all aware of the fact that the human body is a limit-concept between "nature" and "culture", an element of culturalized nature, just as it is an element of culture in natural guise.

Yet, in all these approaches the reference to "nature" seems strangely ingenuous. It is placed seamlessly within a philosophical tradition that from Aristotle's time has conceived nature as the form of being that has its own laws within itself. To distinguish this idea of nature from the human *téchne,* Aristotle cites a figurative example of the Sophist Antifonte: "If you buried a bed and the putrefaction became vigorous enough to produce a sprout, what would be produced would not be a bed, but a piece of wood" (Aristotle, 1967, p. 34 [193a]). "Nature", then, is seen as something primordial, distinct from and prior to cultural man, an autonomous sphere of being. In agreement with this premise, the human body is also thought of as an unexamined given that can be influenced by human action only within certain limits. In the writing of the founding fathers we find many references to the animal reign and to children, as well as the metaphor of the great "Mother Nature", which confirm this observation. What is more, this idea of nature also has a normative value as moral philosophy. It serves as a model for what is "natural" and "unnatural" and therefore does or does not have value. In the concept of "primary nature" in Lowen, it is possible to show how the meaning of nature as origin blends together with that of the nature-model.

B. Re-opening Questions Due to Developmental Technology and Virtual Reality: The Fading Away of Nature

We can therefore say that classic body psychotherapy is based on a received and as it were "stable" idea of nature, both as regards external nature and man's bodily nature. In fact, however, for some time now and particularly since the last century we have been witnessing a continual "shifting of borders" (Böhme, 2011, p. 5) between what is natural and what is artificial, between nature and culture. This is a process that ends up by making it more and more difficult to distinguish between these two spheres, at all levels. The first level is global and involves man's impact on nature: climate change, reduced biodiversity, the disappearance of forests, etc. It would seem that only volcanoes and earthquakes, as a result of movements of the earth's surface, are left as unhappy witnesses of nature's original activity. The second level takes us back to our daily lives, where we witness profound shifts in the borders between nature and *téchne,* a move towards the colonization by information systems of everything around us. This ongoing process was already defined in the early 1990s as "ubiquitous computing". Thus we have a vision of a world around us that is made intelligent by an interwoven system of mini-computers and interactive sensors ("ambient intelligence"). In his *Philosophy of Intelligent Worlds,* the philosopher Klaus Wiegerling summarizes this concept as follows,

> "Ubiquitous computing consists [...] in information-system equipment that permeates the entire mesosphere, which not only accompanies our lives, but will also change both our experience of the world and of ourselves, including the experience of our bodies. Technologies, and in particular media technologies, have always modified the way people experience the world and themselves. The new quality of the information vision of ubiquitous computing lies in the fact that the whole world, in a certain sense, comes to be permeated "informationally", so that every physical object, and not the least our body, can become a piece of information equipment, [...] that everything can become a means, an apparatus for connection, and its own informatics space" (Wiegerling, 2011, p. 14).

The perspective point of ubiquitous computing is a "smart" world, completely available to humans, who in turn are part of a technologically augmented reality. Among the various problems identified by Wiegerling, we indicate here only the fact that in this smart world the point of intersection between man and technology tends to become invisible, so that complex information systems can gradually substitute man as the subject of action. Another problem is the question of the world's "resistance" *(Widerständigkeit)*. In an environment that is technologically augmented and functionally standardized to meet determined needs, the world tends to lose its character

of resistance or oppositionality in respect to man. These experiences of the resistance of things and of the world in general are, however, indispensable for the constitution of our identity. To give an example, we need only consider that our children and grandchildren will never be able to have the experience previously considered to be archetypical, that of Hansel and Gretel who get lost in the woods and in the end find a way out: at every moment and wherever they may be, it will be possible to locate them.

C. New Task – Valuing External and Internal Nature

1. Nature Versus Construction

It is precisely at this point that we find the goal of the third great border shift: overcoming the resistance of nature as life, organism, animal body and human body. *"But you do not die because you are ill; you die because you live"*, writes Montaigne in one of his *Essays,* expressing what may be the hardest experience of the human condition, but is surely the most evident experience left of our cultural heritage (Montaigne, 1992, p. 1462). Today, on the contrary, medical technology has opened up for discussion the given conditions of everything we used to consider natural in man. As reproductive medicine, it can intervene artificially in our genetic make-up, and we must not forget that today only legal limits restrict the scope of these concrete possibilities. As transplant medicine, it can freely change and substitute organs and parts of our organism, on the basis of a "practiced Cartesianism" (Böhme, 2003, p. 168) regarding *homme machine.* The story of the French philosopher Jean-Luc Nancy in *The Intruder*, is a moving description of just such an experience: Nancy, suffering from progressive cardiac insufficiency, had agreed to live with the heart of another person, probably a woman much younger than he (Nancy, 2000). As with plastic surgery and pharmacology, medicine can modify both our outer and inner aspects. Through the widespread psycho-pharmacological practice of neuro-enhancement, people's moods can undergo psycho-physical improvement to meet their needs to achieve.

All these tendencies and realities of medical technology can be summed up in the concepts of *Biofact* and *Cyborg.* The *Cyborg* is so far only a vision, deriving from astronautics. It is a being that is a mix of living organism and cybernetic elements, meant to improve survival possibilities in space (for example, as regards the perception of dangerous radiation through implanted sensors). *Biofacts*, on the other hand, are

artificial objects made by man on an organic-biological foundation. Examples are food made from genetically modified plants, or the case of Dolly, the cloned sheep, probably the most famous *Biofact.* As it is impossible in these cases to separate what is natural from what is not, it is appropriate to speak of "secondary corporeality" (Wiegerling, 2011).

However, the term "secondary corporeality" already leads us to doubt whether and in what sense we can still speak about "nature":

> "If modernity has always been connoted by the intention to transform what is given into what is constructed, this project was enlarged to include man's body, which is the Nature we are, only in the 20th century. On various fronts man has begun his transformation into an artifact. This poses the question of what man should be held to be as given, and so as Nature. In light of this challenge, the question is posed for the first time whether and in what sense it is essential to man to be Nature" (Böhme, 2003, p. 152).

These troublesome questions may sound like a threat to body psychotherapy, in its aim to lead the patient back to identification with the lived experience of his concrete body, as Alexander Lowen writes in another representative passage, "Bioenergetics rests on the simple proposition that each person is his body. No person exists apart from the living body in which he has his existence and through which he expresses himself and relates to the world around him" (Lowen, 1975, p. 54).

2. Personal Identity in the Global Village

Besides the nature that surrounds us and that we are, the developments of computer technology have also transformed the whole field of human communication. Here, too, the physical body as concrete presence is fading away, if not already completely gone. As regards communication, it is difficult to speak of nature in the Global Village, for what is natural has always been collocated in space and time, while the Global Village represents our success in overcoming, or perhaps even canceling, these limits.

The metaphor of the Global Village was created back in the 1960s by the Canadian expert in mass media, Marshall McLuhan (1911–1980), who describes it in the following evocative terms,

> "Ours is a brand-new world of allatonceness. 'Time' has ceased, 'space' has vanished. We now live in a global village ... a simultaneous happening. [...] Information pours upon us,

> instantaneously and continuously. As soon as information is acquired, it is very rapidly replaced by still newer information. [...] The new electronic interdependence recreates the world in the image of the global village" (McLuhan & Fiore, 1967, p. 63 and 67).[1]

If this vision was at the time based only on the presence of traditional media like periodicals and television, it has certainly been perfectly fulfilled by the worldwide web, which has existed since 1991. In fact, the internet is not actually a medium in the classical sense. As its original name, *Interconnected Networks*, suggests, it represents a "hybrid medium", offering a general infrastructure that gives access to a great variety of visual, digital and audio information. While this simultaneity of media modes already goes beyond the traditional concept of media, the really revolutionary aspect of the internet lies in its "democratic" character, meaning its interactive potential (one-to many; one-to-one; many-to-many; many-to-one). In this sense, the presence of the internet has opened an enormous space of freedom for communication beyond any limit of time and of space, "in real time". It has created new spaces like the social networks and chatrooms, as well as virtual worlds like Second Life, which represent new forms of encounter and expression, both at the individual and collective levels. But in what sense does all this touch the topic under discussion?

To be as concise as possible, we can perhaps single out two central fields that interest both psychotherapy in general and body psychotherapy in particular: the question of reality and that of personal identity. Perhaps their common denominator lies precisely in a tendency towards the loosening or broadening of these concepts.

3. Reality and Personal Identity

Let us look first at the question of "reality". What is "virtual reality"? We may recall that the Latin term *virtus* ("power", "force") and then the medieval Latin term *virtuale* refer to something whose ontological state is less precisely definable than the term *realis*. While *realis* denominates a concrete, material reality, the *virtuale* has a changing quality, referring to something that "potentially" or "possibly" could be or happen.

This iridescent quality is made possible by the fact that the virtual reality we are speaking about exists inside a media space, or inside a reality that is in some way "enriched" by media. But we have to remember that the media, in sharp contrast with the

1 Due to a mistake in composition, the original title was The Medium is the Massage rather than the Message. McLuhan found this mistake enlightening and so decided not to correct it.

ingenuous name of *medium*, and so of mere mediators, have qualities that go further: not only do they have the power to select and transform reality according to their specific mode of presentation (for example, as photos, or children's stories), but they also have the power of constructing reality (by defining what is more "important" and so "really real" and what is less so). In the end, they also have the potential power to substitute reality. For example, for all of us there exists the danger of instinctively identifying the report of political events offered on television with "politics" in general. This obscure confusion between the medium and its contents, between world and medium, is already expressed by the above-mentioned Marshall McLuhan in his paradoxical formula, "The medium is the message". The following passage by Klaus Wiegerling sums up this complex superimposition:

> "The more complex is a society, the more important does media mediation become. In our society, being and appearance are so thoroughly mixed that it is almost impossible to speak of a reality independent of consciousness, clearly distinct from simulation and fiction. Our reality consists in a mixture of elements that are real in the strictest sense with simulative, fictional elements created with technical means. It has become, we may say, virtual, and so less connected to an outer, physically based world independent of consciousness than it is to an inner experience, which includes media productions" (Wiegerling, 2008, p. 230).

The reference to inner experience offers us the opportunity to move on to the question of personal identity. By now experts are convinced that assiduous presence online fosters a tendency to a so-called "multiple personality" in users. Let us try to understand in what sense.

In our context, this tendency is expressed above all in the relationship between the "online mode" and the "offline mode" in a user's life. We note *en passant* that the mere fact of distinguishing between "online" and "offline" modes of existence implies a huge change of the way we view our lives. What up to now we have simply called "life" – our one and only daily life – now coincides with the "offline mode" of existence, which is always compared to and seen in reference to the "online mode". More specifically, the question of multiple personality is linked to the online mode, in relation to factors like the average amount of time passed online each day, as well as to the age and personal maturity of the user.

But speaking more generally, we realize every day that our life takes place simultaneously on two parallel levels, the real-life level and the virtual one. Thus, we speak of a new social pattern called "networked individualism", and of the fact that we are more and more able to and do choose the partners of our communication freely and

outside the concrete ties of our life, of the *Lebenswelt* (Metzner-Szigeth, 2008). In the phenomenon of networked individualism, important trends of sociological change are converging with the extremely rapid development of information technology. Between society's eagerness and demand (demand pull) on the one hand and the offer of new sophisticated communication technology on the other (technology push), it sometimes seems hard to say which is the driving factor. It is easy to foresee that in the future our online life will become more and more important in respect to our real life. "Real life" will tend to be "elsewhere", in the great space of a simultaneous common presence. This is the space of a "free" communication, free also in the sense of being tendentially de-localized, because the body has no part in it. The body is the great absence.

As we know, the various realities of the internet, above all chatrooms and sophisticated virtual games like *Second Life* and *World of Warcraft,* provide room for multiple forms of constructing and presenting one's Self. We have already noted that these interactive forms open up wide spaces of creativity, freedom and play. But on the whole, internet reality works in many ways as a powerful scenario for a perspective presentation of one's own image, a form of "virtualization" of the Self. In the absence of a real Other, the user has the possibility of presenting himself and moving in many different forms, none of which are binding and which he is free to shed from one moment to the next. In this sense, the network has been called the sphere of "as-if", a sphere in which "any reference to things or happenings or real persons is purely casual".

We cannot continue to treat the question of multiple identity here; it is a phenomenon that will doubtlessly become ever more pervasive in the future. Nor can we dwell at length on other aspects of the Global Village that touch on our topic. Among these, there is above all the question of our perception of the world, as well as the problems of psychic integration of our experience. As far as perception is concerned, we might investigate further the growing importance of images and of the visual dimension in general, a dimension tendentially detached from the body and its concrete postures and sensations. It is not by chance that today image theory stirs such great interest in philosophy and communication sciences, so much so that over the last decade a new discipline has been created, called *Bildwissenschaft*, "science of the image" (Sachs-Hombach, 2009).

As regards psychic integration of experience, we can recall the above-mentioned "Theory of acceleration", which focuses on the growing difficulty of conceiving personal life today as an "organic unity" founded on an overall project for life over time. The lived experience of "resonance" with the world (Rosa, 2012, p. 9), even if it is not lasting, is based on successful psychic integration of our experience of the world.

For the inhabitants of the Global Village this integration is and will be especially arduous. As Klaus Wiegerling writes, "In the future the construction of identity will occur under more difficult conditions" (Wiegerling, 2008, p. 250).

4. The Nature in Front of Us – Choices and Lifestyle

Let us go back and pick up the thread of our argument. Starting from the concept of "body" and "nature" in the founding fathers of body psychotherapy, we have underscored the limits of their discourse in the conditions of the present, on two levels. First, there is a limit as regards changes in external nature and in the human body, i.e., the progressive technologization of both these spheres, which tendentially perverts the relationship with nature. Secondly, there is a limit as regards the world of the Global Village, a completely artificial reality that leads to numerous problems for the formation of a personal identity. Reviewing some of the key-words we have had occasion to use, such as ubiquitous computing, Biofact, virtual reality, online and offline modes of existence, and perspective identity, we become increasingly aware of the extreme complexity of the world we live in. It is as though diverse layers of meaning of "nature", "reality" and "identity" were living side by side in a sort of kaleidoscopic co-presence, participating in rapidly evolving processes. How can we get our bearings, how can we behave, how can we live in this situation?

A distinction made by the philosopher Gernot Böhme provides a useful contribution to our discussion of the concepts of "body" and "nature". Böhme presented this distinction in a speech given at the *Modena Festival of Philosophy* in September, 2011, dedicated to Nature. According to Böhme, in a technological civilization like ours, we can no longer take for granted "being body", "being nature" and "being part of a surrounding nature". It is as if this "old nature" for quite some time now had been "behind us". However, we have another nature "in front of us". More precisely, "Nature is in front of us like a task. [...] Nature is no longer simply what is given, but what is wanted" (Böhme, 2013/2014, p. 22). This means that we must ponder, decide and concretely realize on a daily basis whether and how we want to related to external nature and to the nature we are, what meaning we want to give them. These choices are expressed as a pragmatic attitude and merge in a lifestyle.

To give a concrete example, we need only consider that in the memory of humankind, though childbirth always took place within a cultural context, it was considered to be and to happen naturally. In the course of the 20th century, childbirth became the prerogative of new medical-technological know-how: birth-giving was moved from home to hospital, while the figure of the midwife, the traditional representative

of received knowledge, was pushed aside. By contrast, in recent decades childbirth has become the object of an informed choice that tends once again to limit medical aspects: today we can and must choose what kind of delivery to have, how and to what extent to make it again a "natural childbirth".

Another concrete example is found in the bioenergetic exercises conceived by husband and wife Leslie and Alexander Lowen in the 1950s and 1960s. By doing these exercises, we *choose* to explore ourselves as corporeal beings *(Leibwesen)*. We affirm, appreciate and accept being an organism, a part of the nature that surrounds us and that we ourselves are. Doing these exercises with a certain regularity, integrating them in our daily lives, we make this choice into a lifestyle. The image of Alexander Lowen as an old man who continues doing his exercises every day is a great example.

Psychotherapy in the Global Village is obliged to take into consideration the extreme complexity of this new reality, above all as concerns the identity of young people, the so-called "digital natives". For them, the presence of the computer as an integral part of the world is taken for granted just as cars and televisions were for the preceding generation of "digital immigrants". Indeed, it is just this tendentially destabilizing complexity that confirms the importance of psychotherapy. In the existential encounter with a concrete Other, the patient can and must experience the dignity and value of his/her own irreplaceable personality and of the irreplaceable personality of the Other and of all others.

Body psychotherapy also finds itself facing new challenges. It has already undergone a great change in respect to its beginnings, defining itself today as *somatic-relational* psychotherapy. Will it succeed in formulating and conceptually integrating the changes happening in today's technological world regarding the body and nature in general? Will it turn out to be "antiquated" or "out of date" in the face of this *smart* world?

Perhaps body psychotherapy's "critical humanism" (Schneider, 2012, p. 687), its specific and precious "untimeliness" (Nietzsche), lies precisely in its critical awareness of our "being nature". It would seem, therefore, that the importance of the body approach is even more tangible within our culture. The contemporary philosophers speak of "the growing loss of a unitary experience of life", of "alienation from our own body" (Wiegerling, 2011), and in general of "loss of the awareness of a coherent feeling of self or of life over time" (Rosa, 2011, p. 1058). These are phenomena that in his 1983 book on *Narcissism* Alexander Lowen, by then an old man, perspicaciously perceived as the growing "unreality of present time".

This is doubtlessly a very negative judgment. Yet one aspect of the complexity we have spoken of is that the reality of the Global Village – perhaps like the phenomenon of technology in general – also opens considerable spaces of freedom. Within this reality, in any case, we can identify two great tasks for body psychotherapy today: the

curative task of restoring the patient's experience to his own body and to root it in this body, and the *pedagogical* task of making him sensitive to the value of an external and personal-corporeal "nature" no longer to be taken for granted, but rather the object of choices and lifestyles.

D. Clinical Considerations

The curative task of restoring the patient's experience to and rooting it in his own body is a general objective of body psychotherapy that can be realized in manifold ways. Following the line of the previous discussion, in my clinical considerations I would like to focus on the question of time in psychotherapy. How can we, in a world of ongoing acceleration, bring the patient back to experience the biological rhythms of life? How can we bring him back to the "time of the body"?

1. Nurturing Contact

At this point, I would like to present the techniques of "nurturing contact" which are, in my experience, one valuable way of approaching these challenging objectives. These techniques have been elaborated in the *Organismic Psychotherapy* of Malcolm Brown (Brown, 1990), and therein represent the main tool for reaching deeper levels of our experience. At first sight, this kind of contact seems rather similar to the techniques we are familiar with in our established practice as bioenergetic therapists: while the patient lies supine or prone on the mattress, we work with contact, holding one or two hands on various parts of his body – on the forehead, under the neck, on the belly, in the area of the sacrum, on the knees, etc. But the difference from our usual way of using direct touch, the peculiarity of the nurturing contact lies in its duration. It is usually a soft, non-directive, long-term contact that provides the possibility for the patient to feel deeply. And that needs time. The contact may last 5, 10, 15 or even 20 minutes in the same part of the body, while the therapist stays with the patient in an attentively waiting, observing position.

In this unstructured, open "space of silence" (Nascimento, 2005), many things can happen. Feeling deeply, the patient may have regressive experiences, going back to primordial layers of the Self. The creative unconscious may produce powerful images, frightening or consoling, as I have described in referring to my own experience (Helferich, 2004a). The body may answer with manifold spontaneous organismic reactions from within, while experiencing all kinds of emotion. In certain cases,

"nothing" happens, the patient is busy thinking, or falls asleep. In other cases, he may experience a profound sense of peace and harmony as an effect of equilibration processes among various parts of the bodily Self. Sometimes, the body may express a need for direct interaction with the therapist, desiring more physical pressure or even a kind of struggle, for example. In these cases, "nurturing contact" becomes "catalytic contact", the other form of direct touch, which includes many kinds of interactive movement between patient and therapist.

As we can see, these techniques of non-directive, long-term contact aim at a deep integration and balancing of the embodied Soul. They operate by deliberately slowing down the rather quick processes of our consciousness and decelerating control systems of our mind, creating a different kind of receptivity, an "undifferentiated emptiness" or "diffused consciousness" (Brown, 2001). These deceleration processes facilitate alternative forms of energy activation, especially regarding our "second brain" (Michael Gershon), the visceral sphere, which may be conceived of as a bridge towards nonverbal, bodily-mediated layers of memory and feeling.

Regarding the therapist, the activation of such forms of bodily experience "from within" require two basic abilities. First of all, the therapist must develop the art of waiting. He has to learn to tolerate the uncertainty that comes from the patient's passivity and silence in a situation where he sometimes literally does not know what is going on with the patient. Waiting without actively doing anything easily creates anxiety, a sense of "feeling useless" or "doing nothing". These are countertransferential realities that deserve our respect. They require the therapist's ability to cope with his anxiety and to manage the timing of nurturing contact in each case, without forcing himself.

Secondly, in order to create an effective, nonverbal connection to the patient's inner life, the therapist has to develop a subtle receptivity through using his own bodily experience. This naturally includes continuous awareness of the bodily process of breathing of both patient and therapist, and towards the specific quality of contact, as may become evident in the temperature of his hands (e.g. warm – cold – changing).

Finally, we must consider still another, more objective prerequisite regarding the setting. Naturally, long-term contact is only possible within a therapeutic frame that provides time enough for this kind of deceleration. Therefore, a setting of one hour and a half or of two hours is more suitable, which is why I personally prefer sessions of one hour and a half whenever possible.

At this point, a general reflection regarding the temporal framework of our setting in body psychotherapy seems to be appropriate. Compared to all forms of purely verbal therapy, our approach is more complex. Moving on two levels, we usually integrate a verbal phase with an experiential part of the session. It seems, however, that since its beginnings body psychotherapy has adopted from psychoanalysis a setting

of forty-five or fifty minute sessions. But this temporal framework was created – and fits perfectly – for a purely verbal form of psychotherapy. Unfortunately, it has been adopted without considering the different temporal requirements of bodily experience. I do not want to say that providing excellent body psychotherapy within sessions of forty-five or fifty minutes is not possible. The realities of our daily work force us to do so, as this duration is the usual framework. We ought to admit, however, that many possible options of intervention are almost automatically excluded by the therapist when the time frame is so restricted.

2. Clinical Vignette

Alice, a 32-year-old client, is at a positive time of her life. In fact, notwithstanding certain difficulties regarding her career as a future psychotherapist, she has a good outlook on life and is planning to marry in the summer. Having been in therapy for more than three years with a frequency of one hourly session per week, she has successfully tackled many problems concerning self-confidence, female identity and her schizoid and oral character traits. Over the years, we have built up a good and trusting relationship, and I enjoy working with her.

During Easter vacation, she studied Lowen's *Depression and the Body*, which impressed her deeply. Therefore, in the present session she wants to start doing body work immediately, and I agree to this. We begin with some activating exercises, like grounding, bending over (aka forward bend; elephant), and arching (aka the bow). While she is arching, I ask her to find a sound, which expresses the over-all impact of Lowen's book on her. What she produces sounds like wailing. After that, I ask her to stand still for a while and to feel her body. She touches her neck and her shoulders, as if wanting to give herself a massage. In the end, she puts her hands on her belly. When asked how she would like to proceed, she says she wants to focus on her belly, and I invite her to lie down on a mattress in a supine position.

She agrees to receive contact from my hand on her belly. In the following phase of about ten minutes, she initially appears to be relaxed, and her breathing is regular and abdominal. After a while, however, she starts swallowing. Her breathing becomes more and more thoracic, her legs become agitated, and she opens and closes her hands, making faint sounds.

Some minutes later, she starts coughing violently, almost getting sick. Her whole body trembles and she starts to cry. After that, she caresses her eyes and face with her hands. By and by she gets calmer, turns slowly to the right and to the left, and in the end calms down completely and closes her eyes.

After a moment of silence, we start talking about what happened. She says it was a very intense and fearful experience, a feeling of being blocked and paralyzed that started from the hands and arms, as if her body was going to be petrified. By opening and closing her hands and moving her pelvis and legs, she tried to defend herself, but nonetheless she felt in danger of being petrified, of becoming white marble.

Unfortunately, we did not have enough time in that session to explore in detail exactly what it was that emerged; what it means to "become a stone"; what kind of recollections, images and emotions were associated with this. Therefore, I proposed to her that she draw a picture of the stone at home.

This clinical vignette demonstrates how a seemingly simple technique of nurturing contact, such as a hand on the belly can elicit profound bodily and psychic experiences, as this patient was sufficiently ready and open to let it happen. There is the problem of the time limit, too, but as there is a good therapeutic relationship, we would talk about the experience in the next session, follow-up and explore more deeply the meaning of her reaction.

3. Correspondences in Clinical Perspectives

As I mentioned above, I was pleasantly surprised to find similar ideas to my own considerations in Maê Nascimento's essay in the latest *International Journal (2014)*. This convergence regards the urgency of theoretically addressing the globalization process, as well as clinical considerations and propositions to counterbalance it.

Regarding the clinical aspect, the correspondences are quite evident to the attentive reader of "Two Body Touches for Restoring Connection to Inner Self" (Nascimento, 2014, p. 27–29). Even though the two kinds of touches are applied in a standing position (as opposed to the lying position usually used in nurturing contact), they essentially pursue the same goal, i. e. to "activate the energy through the autonomous nervous system and not through the bone structure or muscular levels. [...] It also activates the perineum and the Hara, facilitating an internal grounding and a deep plunging within oneself" (p. 28).

This is quite congruent with the concept of *horizontal grounding* in Organismic Psychotherapy, which aims at alleviating Ego-control by activating visceral energy flow (as in the tradition of Gerda Boyesen's work). The other noteworthy correspondence concerns the therapist's non-directive style, a stance that "gives room for the client's process without controlling it or directing it" (p. 29). This is exactly the attitude required by long-term nurturing contact: a subtle awareness of organismic processes going

on in the co-created field of relationship, as well as the deepest respect for the client's autonomous personal development, his *Selbstbewegung* (literally: "self-movement"), to quote an appropriate German expression. This profoundly humanistic orientation of the therapist, this humble stepping-back from himself out of respect for the patient, is mindful of the fluid yet powerful quality of "emptiness" in Zen philosophy.

Conclusion

After these clinical considerations, we return to our general discourse to draw a conclusion. I think we body psychotherapists ought to take the reality of the Global Village as a fact. We have to acknowledge that for quite a while we have been living simultaneously in two parallel worlds. There is a prevailing tendency to transform the traditional "real reality" of nature and body, as well as traditional "real communication", into a parallel artificially recreated or digitally mediated reality.

As we have already mentioned, the assessment of these developments is complex. We have to carefully weigh potentially negative tendencies, which might harm our bodily and personal identity, against the new spaces of freedom and choice we have at our disposal. In fact, we already have to continually choose what kind of "body", what kind of "nature", what kind of "human being" we want to be and all these choices have to find an expression in a corresponding lifestyle.

Psychotherapy, too, finds itself continually compelled to choose how far, and in which ways, to be involved in these ongoing changes, for example, regarding the question of to what extent digitally mediated communication can, should, or should not, take part in the therapeutic process. In this complex scenario, body psychotherapy becomes increasingly important. Highlighting the basic fact that "we are our body", body psychotherapy invites and challenges us to critically assess and counterbalance the prevailing trends of our time, the progressive evaporation of nature, body and direct forms of human relationships. In fact, the techniques of "nurturing contact" presented above in the clinical considerations are a bridge to the patient's experience of himself as the *organismic entirety* he is.

All in all, ours appears to be essentially a corrective, compensatory position in relation to the powerful combination of the dominant technological, economic and social trends of our time. In my opinion, however, this is precisely the most precious contribution of body psychotherapy's *critical* and *healing humanism* in our present time.

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Bioenergetic Self-Care for Therapists

Between Openness and Boundary Setting

Vita Heinrich-Clauer

Abstracts

English

In this paper I will present neurobiological findings on the somatic effects of resonance phenomena, empirical results on the respective occupational risks of therapists, and bioenergetic concepts and techniques regarding the subject of self-care. While I was thrilled to have described the phenomena of somatic resonance in the late 1990s and it's potential for work with embodied countertransference in the therapeutic process, the discovery of mirror neurons a short time later validated these exciting phenomena on the neurobiological level. Since then I have also immersed myself on the flip side of empathy. We as resonating therapists are in danger of losing our own living vibration, possibly even becoming sick. Bioenergetic exercises can, with a correspondingly modified non-clinical focus, be very helpful for the self-care of therapists. The illustrations (cartoons) hopefully bring some humor to the presentation of this important and hitherto neglected topic.

German

In diesem Beitrag stelle ich neurobiologische Erkenntnisse zu den somatischen Auswirkungen von Spiegelungsphänomenen, empirische Ergebnisse zu Berufsrisiken von Therapeuten sowie bioenergetische Konzepte und Techniken im Hinblick auf das Thema Selbstfürsorge dar. Während ich Ende der 90er Jahre begeistert die Phänomene der somatischen Resonanz und ihr Potential für die Arbeit mit der

verkörperten Gegenübertragung im therapeutischen Prozess beschrieben habe, die Entdeckung der Spiegelneurone kurze Zeit später diese spannenden Phänomene neurobiologisch validierte, beschäftigt mich seither auch die Kehrseite der Empathie. Wir sind als mitschwingende Therapeuten in Gefahr, unsere eigene lebendige Schwingung zu verlieren, eventuell sogar krank zu werden. Bioenergetische Übungen können – mit entsprechend verändertem nicht-klinischen Fokus – sehr hilfreich sein für die Selbstfürsorge von Therapeuten. Die Illustrationen (Cartoons) bringen hoffentlich etwas Humor in die Darstellung dieses wichtigen und bislang vernachlässigten Themas.

French

Dans cet article, je présenterai certaines découvertes en matière de neurobiologie en rapport avec le phénomène de résonance, des résultats empiriques relatifs aux risques occupationnels présents dans le travail de thérapeute, de même que des concepts et techniques en analyse bioénergétique en lien avec le thème de prendre soin de soi comme intervenant. Alors que j'étais très enthousiaste d'avoir décrit le phénomène de résonance somatique dès la fin des années quatre-vingt-dix de même que le potentiel que cette perspective ouvrait en ce qui a trait au contre-transfert corporel dans le processus thérapeutique, la découverte des neurones miroir peu de temps après venait valider ce phénomène fort intéressant au plan neurobiologique. Depuis, je me suis plongée dans l'étude de la face cachée de ce phénomène d'empathie. En tant que "résonateurs" nous, les thérapeutes, somme à risque de perdre notre propre vibration vitale, au point de tomber malade. Les exercices bioénergétiques – lorsque utilisés dans un but non clinique – peuvent s'avérer très utiles pour prendre soin de soi en tant que thérapeute. Les illustrations (caricatures) qui accompagnent le texte sauront apporter, je l'espère, un brin d'humour à la présentation de ce sujet à la fois négligé et important.

Spanish

En este ensayo presentaré los resultados neurobiológicos en los efectos somáticos del fenómeno de la resonancia, los resultados empíricos respecto a los riesgos laborales de los terapeutas, y los conceptos y técnicas bioenergéticas relacionadas con el tema del autocuidado. A pesar de mi entusiasmo al describir el fenómeno de la resonancia somática a finales del 1990 y la posibilidad de que funcionara al aplicarlo a la con-

tratransferencia personificada durante el proceso terapéutico, el descubrimiento de las neuronas de espejo un poco más tarde validó este fenómeno emocionante en el campo neurobiológico. Desde entonces también me he sumergido en el lado opuesto de la empatía. Como terapeutas resonantes corremos el riesgo de perder la energía en nuestra propia vibración, e incluso posiblemente enfermarnos. Los ejercicios Bioenergéticos pueden – con un enfoque no clínico modificado específicamente, ser muy útiles para el autocuidado de los terapeutas. Espero que las ilustraciones (dibujos animados) proporcionen un poco de humor a la presentación de este importante y hasta el momento descuidado tema.

Italian

In questo articolo presenterò i risultati neurobiologici degli effetti somatici dei fenomeni di risonanza, i risultati empirici sui rispettivi rischi professionali per i terapeuti e concetti e tecniche bioenergetici riguardanti il tema del'auto cura. Mentre ero entusiasta di aver descritto i fenomeni somatici di risonanza alla fine degli anni '90 e del loro potenziale per il lavoro con il controtransfert incarnato nel processo terapeutico, la scoperta dei neuroni specchio poco tempo dopo convalidava l'esistenza di questi interessanti fenomeni a livello neurobiologico. Da allora mi sono immersa sul contrario dell'empatia. Noi, come terapeuti che risuonano corriamo il rischio di perdere la nostra vibrazione vitale e forse anche di ammalarci. Gli esercizi bioenergetici possono, con un focus non clinico appositamente modificato, essere molto utili per l'auto-cura dei terapeuti. Le illustrazioni (fumetti), auspicabilmente, portano un po' di umorismo alla presentazione di questo importante e finora trascurato argomento.

1. Introduction

To be in living contact with our therapist body, our resonance skills and grounded presence are the basis for any successful work with patients. Our ability to vibrate (resonance) and set boundaries, from a bioenergetic perspective, are both connected to the breath and voice as well as muscle motility.

> "People, whose body is so rigid and paralyzed, that it hardly pulses or just pulses a little, lack empathy. If our body is alive, then we are sensitive to other people and their feelings and we also feel more love and pleasure" (cf. Lowen 1992, p. 388).

For 60 years, bioenergetic analysis – in the tradition of *Wilhelm Reich* and *Alexander Lowen* – has not only awarded us an analytical understanding but a very appropriate methodology as well. These methodologies have been increasingly examined and supported in recent years by findings from the neurosciences.

The therapeutic relationship is, a priori and independent of the actually used physical interventions, an embodied relationship (Reich spoke of the "functional identity of psyche and soma"). This means that our therapist-body represents – apart from technique – both the medium and the agent for the therapeutic process, and is therefore, in terms of self-care as well, the most important "instrument" to be cultivated.

The physical aspect of empathy, the "sympathetic vibration," is essential to the therapeutic process: yet, because of the intensity of this resonance, we are nevertheless at risk to develop a secondary traumatization if we do not dynamically take advantage of our own initiative and our ability to distance ourselves as an agent in the therapeutic process.

How can we sustain love and joy for our patients as well as for ourselves? The attempt to react empathetically with both body and soul to our patients has negative consequences for our emotional self-regulation if we get stuck being too receptive, externally motionless and without sufficient internal ability to set boundaries. Depending on what our patients bring to the sessions, we can become burdened and blocked in a variety of ways: we can experience, endure or act out fight or flight impulses in our relationship to our patients. When we are confronted with untold suffering, we can lapse into a state of shock. We can become ashamed, lose our sense of humor, freeze our heart-felt feelings, develop crazy fantasies, become frightened, afraid, annoyed, and lose touch with our loved ones at home and with our neighbors. Rarely is the efficacy of a therapy session measured by how it was for us – the therapist, for example how we felt afterwards or if laughter was allowed during the session.

In our work with patients, it is important to perform a balancing act between an emotional and physical openness (for relationship permeability, resonance and for the sake of our own health), as well as simultaneously create a protective boundary from any overflowing and damaging effects on us on the part of our patients.

In terms of bioenergetic self-care, we need – beyond the basic breathing techniques and grounding – a clear understanding of the effects of specific bioenergetic techniques, particularly those that help to energize us (instead of "discharging" us) and help improve our containment and our individual boundaries (cf. Klopstech 2011). We can find help in the bioenergetic differentiation between the concepts of "charge" and "discharge", as we have learned to do regarding the structural organization (early disturbance vs. oedipal) of patients. Bioenergetic self-care requires

that we modify these well-known bioenergetic techniques a little and direct our attention to charging/containing and boundary building (cf. Shapiro 2006, 2008) – or simply combining these familiar techniques with corresponding mental images and words to set our own boundaries.

2. Joys and *Sorrows* of Empathy – Neurobiological Perspectives[1]

To begin, here are a few words about the joyful aspects of empathy without which we as communicative beings probably would hardly be able to survive and without which psychotherapy could not succeed. Empathy was initially defined on the cognitive level as an "ability to participate in the feelings and thoughts of another person" (cf. Kriz 1985, Körner 1998). The discovery of mirror neurons neurobiologically confirmed our experience of *somatic resonance* (cf. Heinrich-Clauer 1999, 2011). Empathy is a physical event. The mirror neurons cannot be turned on or off; they are not subject to arbitrary control. Observation of the behavior of another person automatically activates the same premotoric cell assemblies that the observed behavior is based on (cf. Rizzolatti et al. 1999). "The transfer of emotional information is [...] intensified in resonating contexts" (Schore 2005, p. 403). It is a non-conscious, pre-reflexive mechanism used to uncover implicit intentions in the behavior of another person. It is not a mental process of identification (which tends to be more conscious). There is a brain in the gut that is involved in processing emotions and even works faster than the centers in the brain stem. Neuron cells exist in the heart (cf. Gershon, 1998; Siegel, 2011). Friendly eye contact, vocal differentiation and any contact within the context of a trusting relationship bring about a regulation of autonomic arousal as well as a regulation of the pain threshold. This is done by tonifying the ventral vagus and oxytocin secretion (cf. Porges, 2010; Moberg 2003).

This neurobiological evidence was very welcomed by all body psychotherapists regarding the implicit part of the therapeutic encounter. It corresponded to clinical experience that changing embodied relational statements (resonance) defined the therapeutic process and that the facial expression, gestures, posture, eye expressions, voice, breathing rhythms and body tone of the therapist and the patient influence each other (cf. Buti Zaccagnini 2011). Moreover, the psychotherapist uses her own

1 (cf. More information on the Integration of neurobiological concepts in Bioenergetic Analysis, see Klopstech 2005, 2011; Koemeda-Lutz 2012.)

somatosensory processes to perceive those of her patient and the psychotherapist is psychobiologically in tune with his patients and thus becomes the interactive regulator of the patient's regulatory disorders (Tonella 2011, p 99).

Findings from neurobiology allow us to assume that empathy is "a contact by the right hemisphere of the patient with the right hemisphere of the therapist", or as "a conversation between two limbic systems" (cf. Schore 2002, 2003, 2005; Lewis 2004, 2005). We can also say that empathy means "to feel the physical phenomena and sensations of the clients in our own body" (cf. Clauer 2003, p. 97) according to Harold Searles.[2]

"Therapy begins if the therapist feels what the patient is feeling" (paraphrased from Searles).[2]

Now on the sorrows of empathy: even 35 years ago Lowen had, in his own way, indicated that a therapeutic situation does not necessarily have to be a pleasurable one if our counterpart has problems expressing emotion and we are subjected to it.

2 For this and all following illustrations in this paper: © Vita Heinrich-Clauer, Graphics: Tanja Aranovych, Graz, www.tanjaaranovych.com

> "Conversation, to take another example, is one of the common pleasures of life, but not all conversation is pleasurable. The stutterer finds talking painful, and the listener is equally pained. Persons who are inhibited in expressing feeling are not good conversationalists. Nothing is more boring than to listen to a person talk in a monotone without feeling. We enjoy a conversation when there is a communication of feeling. We have pleasure in expressing our feelings, and we respond pleasurably to another person's expression of feeling. The voice, like the body, is a medium through which feeling flows, and when this flow occurs in an easy and rhythmic manner, it is a pleasure both to the speaker and listener" (Lowen 1975, p. 29/30).

What helps the empathic therapist in the picture to breathe and stay secure in her own rhythm? Certainly not sitting, holding her breath or going against the flow of tears leaking out! Sitting negatively affects metabolic activity. It is conducive to the health of the therapist if she wishes to move about – inside and outside the therapeutic situation. When we (moderately) move, oxygen exchange is in equilibrium. Our intercostal muscles and diaphragm relax and we breathe better. In the long run it may not be that healthy to sit on a chair, reflect the pain of our patients and, in a relatively breathless and motionless manner, only expose ourselves to their pathological relational patterns.

As a therapist I need to ground myself (to stay in contact with reality), have the ability to set boundaries and maintain a lot of emotional retention force (containment) for the patient's subconscious and intolerable feelings, but not in the sense of a motionless "container." A better comparison is that of a resonating body with a lively, moving and tonifying outer shell/membrane. Seen this way, my sigh and exhalation – accompanied by a sympathetic look – would already be the answer to the painfulness of a patient's experience, without having to utter a word. And my next inhalation as a therapist would represent a first action to help myself feel better. The larger the amplitude of my breath, the more likely I can achieve the full spectrum of emotional resonance and living expression – but the more likely do I feel my physical boundaries and the limits of the burden. Movement too could lead out of the shared depression. It is a requirement that the therapist not only endures the heated emotions of her patients both physically and emotionally, but remains lively in the process and is grounded enough to set boundaries when it exceeds her holding capacity.

In Bioenergetic Analysis we respond to our patients, regarding our interaction with and towards them, with our changing body positions, i. e. we make ourselves available in an interactive, cooperative way – and not simply mirror this from a seated position (cf. Heinrich-Clauer 2009, pp. 36ff.).

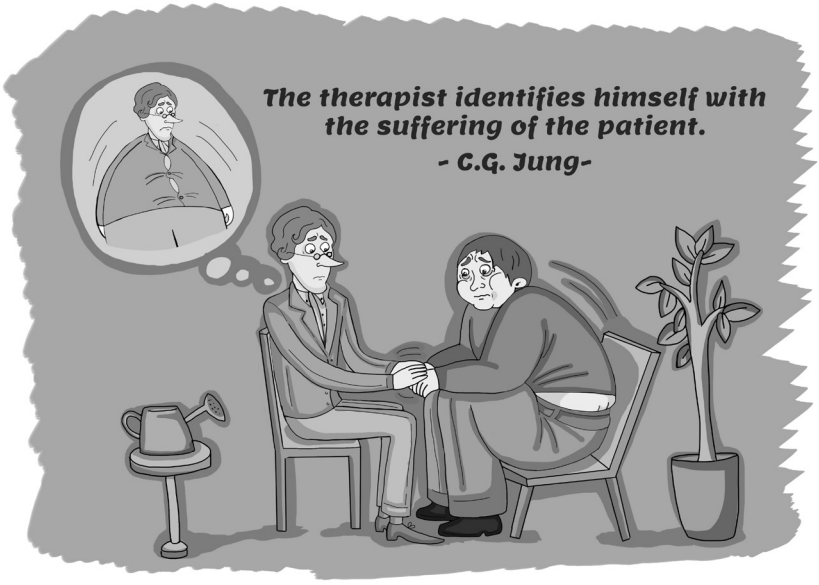
Some (MRI-based) neurobiological research results should now be mentioned

which appear extremely important regarding the non-conscious, not articulated painful influences – here, in the middle phase of the therapy – that may detrimentally influence a psychotherapist within the therapeutic relationship:

When we look at a person's face that shows a disgusted facial expression, then the same neuronal structures (anterior cingulum) are activated as when we feel aversion or disgust from smelling or inhaling something unpleasant (cf. Siegel, 2011).

Social and physical systems of pain perception and processing are connected. Insults and hurt feelings are experienced the same way as physical sensations of pain (Bauer 2011). Being excluded, neglected, degraded – hurts the heart like a knife (cf. Siegel, 2011).

In an empirical study of couples, called, *"Lovers share their pain"*, neurologists from University College in London discovered that a neurophysiologically measurable indication of empathy could be observed in one partner whenever the other experienced pain. If the partner knew that her partner was currently receiving an electric shock, then the same brain regions that control *emotional* responses to pain (e.g. sadness, arousal, fright) responded as if she had received the shock stimulus herself. Only that region of the brain which registers *physical* pain was stimulated when she received the electrical stimulus herself. The emotional processing of the partner was always stimulated even if the partner's face was not visible in the study,



"The therapist identifies himself with the suffering of the patient" (C. G. Jung).

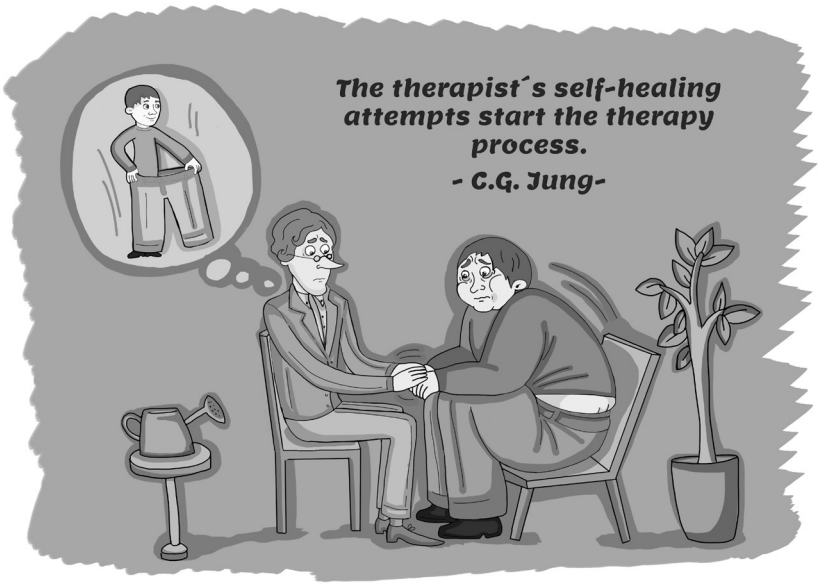
but only if the information was transmitted via display panels. The knowledge and mental picture about the partner's pain are enough to activate even those regions of the brain that control emotional responses to pain (cf. Science 2004, Vol. 303, p 1157).

Neurobiological research, in its research design, is still far from the kind of complexity that we would need in order to elucidate the process of unconscious interaction during a therapy session. The mirror neurons partially explain some of these observations, but not the whole complexity of the relational events and somatic resonance, such as sensory perceptions of cold/heat, heaviness/lightness, contraction/expansion, etc.

C. G. Jung and his concept of "infection" already had a constructive and process-oriented understanding of the right-brained resonance between patient and therapist (cf. Jung 2011 paraphrased): "The therapist infects himself with the suffering of the patient."

With this assumption, Jung was not explicitly exploring physical mirroring and resonance, but had expressed something like a relational perspective of countertransference.

The first reaction of the therapist may be shock at the patient's symptoms, as in, "Oh my goodness, there's no way he should be that fat." (or), "For God's sake, there's no way I want to have a body like that!" The spine of the therapist stiffens accordingly as in the previous illustration. His face (eyes, forehead, mouth) conveys that he does



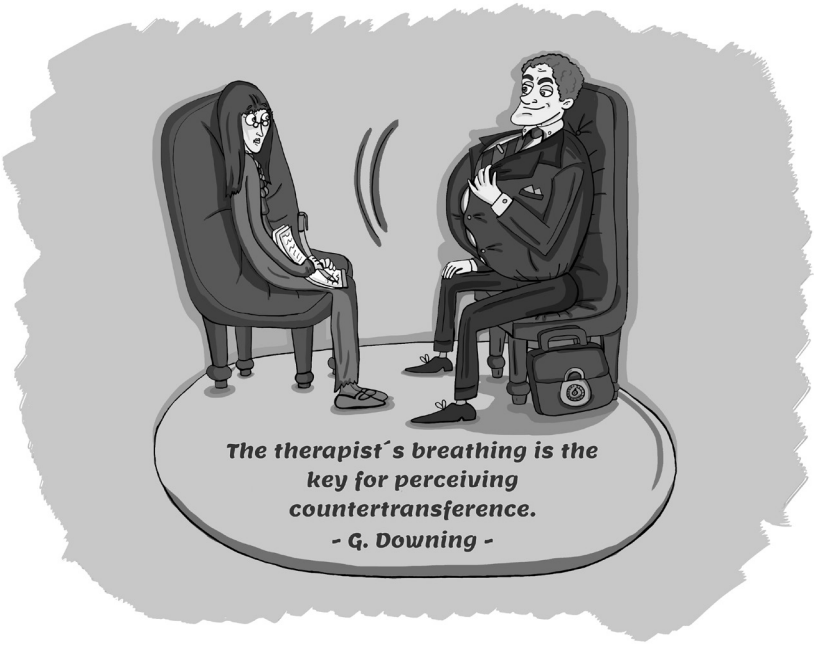
"The therapist's self-healing attempts start the therapy process" (C. G. Jung).

not want to eat. At the same time, his first reaction has already trapped him via contact with the hands, looking, and feeling. The therapist does not consciously admit it, but his body recognizes the imprisonment of his reaction to the patient.

How are we influenced by our depressive, exasperated, anguished, or disparaging patients? And how do we overcome these "infections"? How can we protect ourselves from the harmful influences of patients when we are simultaneously trying to feel as open as possible? One way out is the work with the embodied countertransference as a catalyst for the scenes and techniques available to us.

The mental image of a solution then emerges out of the self-defensive posture against this "infection": "The self-healing attempts of therapists promote the therapy process" (paraphrased C. G. Jung 2011).

With this vision of the slender patient, he mentally gives it back to him and will certainly look for ways *not* to understand why the patient can be so fat. On the path to the liberating vision of the more slender, more agile patient, the therapist will need to develop many physical initiatives to extract herself from the infection. The infection as such, however, can also be included in the interaction with the patient on the concrete physical level.



"The therapist's breathing is the key for perceiving countertransference" (G. Downing).

This concept differs from concepts which primarily think of therapists as "containers" for the feelings of their patients in order to "hold" their not-held, not bearable, not consciously perceived feelings for them. If this holding takes on too much of a quality of "enduring" and too little respiration and pulsation are present, then the effects tend to be harmful to the soul and body of the therapist and, of course, detrimental to the therapy process. Our resonance animates the therapeutic process if we make it available, and can be used as a catalyst and generator for new patterns of physical movement, new means of experience and expression by patients so that the process can be more playful and flowing (cf. Heinrich 1997, 1999, 2001; Clauer 2003; Heinrich-Clauer 2014). The therapist's breathing is the central key to perceiving these (see Downing, 1996, pp. 322f.). It is possible to put that which was felt during contact into descriptive words and carefully communicate this or perhaps reflect it non-verbally.

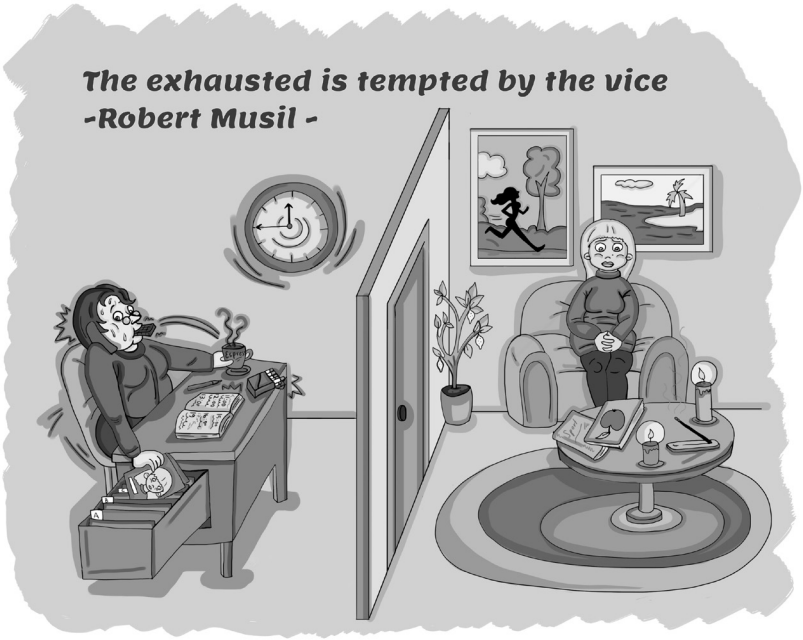
A patient without awareness of his fear and need for love can cause the therapist to hold her breath and become terrified even by his physical expansion and dominance alone. In this case, a resuscitation of the therapist would be possible from the indication of her awareness to hold her breath and become terrified, together with a question directed towards the patient, asking if he had experienced this kind of inner attitude from his past. If the patient exhibits *no amnesia* from his own traumatic experiences, then these are often reported without emotion or with a smile so that I, as a therapist, experience somatic resonance phenomena (such as loss of ground contact, freeze, fright, reduced breathing, nausea, etc.) and in this way receive references to past emotional events. Once the patients are activated and enlivened we too have a chance to feel more alive.

3. Occupational Risks in Psychotherapy

If we feel obliged to maintain an empathic attitude and dare not perform any dynamic, bioenergetic interventions for our own safety and for our own well-being during the therapy process and in the presence of the patient, then this attitude can be dangerous.

3.1 Psychological Risks: Suppression of Anger, Depression, Burnout

> "To resist harmful influences, is also a question of vitality: the exhausted is tempted by the vice" (Robert Musil in *The Man without Qualities*).



"The exhausted is tempted by the vice" (Musil).

This therapist has obviously lost her ability to set herself boundaries, ground herself and demonstrate self-control in her contact with her patients. Spatial-temporal boundaries seem necessary as well. This kind of a dissolution of boundaries and lack of resilience can manifest itself in such symptoms as a difficulty to meet deadlines, fatigue, a lack of energy, a feeling of being flooded by the issues of the patient, thinking about the stories of the patients at home, or our patients controlling the course of the session.

The classic burnout symptoms mentioned in the relevant literature are (cf. Fengler 1994):

- Emotional exhaustion – depression (low energy levels)
- Low personal potential (sense of futility, inefficiency)
- Depersonalization and loss of empathy (cynical attitude towards patients)

The following aspects are considered to promote burnout in professional and private life:

- Imbalance between effort and reward
- High demands with minimal influence

- Endangered work-life balance
- Narcissistic regulation at risk: great need for recognition combined with a low possibility of reward

Besides financial remuneration, we need a sense of self-efficacy and "reward" from our work. Until the first improvements of the often stubborn and violent symptoms – or even positive life changes – can come to fruition in patients, our psychotherapeutic work is often an exercise in patience. Working with resistance and negativity in the relationship between therapist and patient, which is required during psychodynamic and bioenergetic therapy, often lets us fall into despair rather than feel successful, especially in the middle phase of a long-term psychotherapy.

Thus, the psychotherapeutic work per se already meets some of the above mentioned criteria for burnout-promoting contextual conditions. Add to that "patient-client confidentiality", which is the obligation to protect the patient and to keep silent about the contents of the therapy to the outside world. This requirement conflicts with our need to be seen in our social environment and be recognized for our work. The occupational hazard of our profession has hardly been explored on a systematic level, but has received increasing attention lately (see the many articles and training courses advertised in trade journals in recent years) and was discussed in a German study on the quality of life of psychotherapists.

Among the occupational group of medical doctors, both psychiatrists and anesthesiologists have the highest suicide rate. Comparatively high rates of suicide have also been observed with psychologists. This professional occupation spent with people who denigrate, deny, are addicts, have destructive relationships, see life negatively, show symptoms of depression, hatred, anger, fear, and perversion, can be very distressing and reduce our quality of life. In borderline patients, we sometimes experience a constant questioning and threat to our limits and integrity.

The constant emotional overload – from narcissistic motives – can make one sick and cause symptoms of tension, stress, exhaustion, fatigue, sleep disorders, burn-out, and tobacco or drug abuse. The relationship with our partner, children, friends and family may suffer because our willingness to open up to the interests of other persons is reduced in our private lives. In general, any joie de vivre, confidence, and fun can be dampened. In addition to symptoms of depression, we can also develop aggressive feelings towards our patients, including disinterest, a cynical or ironic distance, objectification of the contact, hostility, impatience, anger, and boredom.

The patient simply becomes an object for counseling or therapy, whereby the technique that comes into question for this "case" is considered solely for professional reasons with no real empathy and loving attitude. The unconscious hostile counter-

transference reactions can lead to sadistic, power-oriented dealings with patients. These can be triggered not only by this distance and rejection of the patient but by their clinging, co-dependent and whining behavior as well (see Reimer, Jurkat et al 2005; Deutsches Ärzteblatt 11, 2003; Niedersächsisches Ärzteblatt 7, 2003).

From our perspective, in terms of the self-care of therapists, it is crucial that we acquire a temporal-spatial distance from our patients.

A positive image of distance in the relationship (individuation and separation) and autonomy (independence in the relationship) helps to limit any feelings of guilt we may have. Bioenergetic exercises for at home (in the interim) can be considered as *transitional objects* for the patient and help to maintain the therapeutic relationship.

> "The physical exercises for grounding also allow the patient to develop himself positively regardless of the presence of a therapist. In doing so, on a developmental psychological level, these exercises build on the inexhaustible patience and joy exhibited by children to promote psychomotorical progress. Here we find the psychomotorical equivalents to the 'ways out of fear and symbiosis'" (Kast 1982) (see Oelmann 1996, p. 131f.).

Furthermore,

> "When the symbiotic maelstrom is particularly large in the therapeutic relationship, encouragement to perform the exercises at home definitely promotes an autonomous detachment of the client from the therapist. The client can develop a feeling of how he can take steps towards personal growth independent from his contact with the therapist, even without her direct presence" (cf. ibid., p. 135).

We cannot fail to mention that it may be advisable for us therapists not only to lead these exercises or to provide recommendations on these to our patients, but to take this kind of transitional object with us to use for ourselves in our own spare time!

In this context I would like to point out research findings from infant research, which show that parents only respond 20–30% of the time truly empathically or properly tuned to the infant. But securely attached children have parents (assuming they themselves are secure and well-tuned) who within two seconds at the most give their children freedom and space. The children regulate this interaction as well as themselves and both children and parents can release the tension (Tronick 1989). These implicit, non-verbal, two-second dyadic regulation systems operate throughout an entire life cycle. For the therapy situation, this means that we can allow ourselves a relaxed attitude if we can trust that we do not need to develop successful interventions

100% of the time to positively influence the self-regulation system of our patients. Less frequent phases of attentive and coordinated contact are enough to place these patients in a position to bring both their and our inner agitation back into balance through interaction.

"Holiday plans of the therapist should be talked about in a timely manner."

A timely announcement makes it easier to be responsible to our own need for some rest and recovery within a relationship. Timely arrangements value our connection to the patient. Only if I deny the bonding quality of the therapeutic relationship – or don't even see it as a relationship, but as a working relationship determined by the technique – do I come up with the idea of considering divisions and distances between sessions as irrelevant.

Since the early 1950s, it has been known from psychosomatic research and the works of Alexander (cf. Alexander 1977) that particularly suppressed impulses of self-assertion or repressed hostile impulses have direct physiological effects and are the cause of somatic symptom formation. Since then, a variety of such psychosomatic connections have been proven on an empirical level. Worth mentioning in this context are the works of the emotion researcher Harald Traue. These show that

the suppression of emotional reactions, to neglect expressive behavior when communicating during simultaneous physiological arousal, which adversely influences the autonomous nervous system and the immune system, leads to psychosomatic symptoms. Whereas the expression of anger – especially when we show it to a person who has caused this trouble, lowers blood pressure and strengthens the immune system (cf. Traue et al 2005; Sonntag, 2003, p. 48ff.). In this context, we as bioenergetic therapists wholeheartedly agree that the use of our active, expressive and emotionally-releasing interventions in patients can now be seen as having been empirically validated (Lowen 1978).

So far, all of these findings and empirical evidence have been made in reference to patients. It has not yet been addressed that these findings apply to us therapists just as much. It is not healthy to sit on a chair and expose ourselves either with constant concern or emotional distance and detachment (none of these two attitudes can be considered as healthy in the long term) in a relatively motionless and expressionless way to the listlessness, anger and suffering, the depression or latent degradation of our patients!

For more than ten years, we have known about the neuroplasticity and nerve cell formation in the hippocampus, and the adaptability and learning ability of the brain. In the same way, we should not forget – in the fervor to create MRI-based "neurological maps" that display "locations" and their connecting paths – that this is rather a description of neurobiological and neurophysiological processes instead. It is mostly about reduced adaptability, about dysregulation – and not about "life-long" damage (van der Kolk, 2010, p 11). Luckily the idea of neuroplasticity is valid for life and for us psychotherapists as well because otherwise we too would also have to fear for our mind-body unity. If we turn to the painful experiences of our patients, which touch the limits of survivability, throughout our long professional lives while only experiencing their clarification and vitalization after a very long ordeal – or sometimes not at all, we may live at risk.

3.2 Narcissistic Temptation

In order to be immune to narcissistic temptations and the misuse of an emotionally dominating position towards the patient, emotional stability and inner independence are an essential prerequisite. Because of our own stressful life situations, our need for contact and longing for recognition, we as therapists can become in danger of violating the personal boundaries and autonomy-related needs of our patients (see Schmidbauer 1999). In both the English and German literature on psychother-

apists, reference is always made to the "wounded healer." This archetypal image is based on the idea that a healer must have been hurt herself in order to know how healing can succeed. At the same time, it is often alluded that therapists have often experienced trauma themselves and thus need help themselves, which is why their therapeutic job performance is impaired. However, there are indications that one's own problematic experiences in fact improve one's ability to feel empathy and thus enhance the professionalism of therapists as well (Goldmann 2007).

Alexander Lowen has always talked about the fact that we cannot help our patients progress more than we ourselves have gained insight into our own past and have arrived at the solution of our own character-specific blockages: "The therapist cannot take the patient any further on the way to self-discovery and self-fulfillment than he has been himself" (Lowen 1993, p 8).

"The therapist cannot take the patient any further on the way to self-discovery and self-fulfillment than he has been himself" (Lowen).

Most psychotherapeutic training programs are "case-oriented" and primarily convey methodological competence. The danger here is that a narcissistic position is thereby

encouraged by focusing exclusively on the methodological issues and their supervision – the physical reality of the therapists in the repercussions of that reality on the process is neglected. Our own biographically conditioned vulnerabilities selectively shape our resonance ability and influence the selection and modus of our interventions. Accordingly, the relationship offered by the therapist is always of a subjective nature – and not an objective one merely determined by the "case" or the chosen methodology. We hope to have learned a trained, differentiating, less conflictual and less defensive perception of body signals (based on the embodied competence of the therapist).

The principle narcissistic issues, besides the depressive issues, certainly possess the greatest invitation of becoming virulent in the therapist herself within the therapeutic relationship – due to the asymmetric setting as well as some expectations on the part of patients. The therapist, thus, may possibly talk more about herself in order to obtain admiration or apply strong acting physical techniques (cf. Downing 1996, pp. 340f; Shapiro 2000).

Unconscious motives for the compensated narcissistic stance of therapists may – as with all other structures – lie in their general search for recognition, love, self-efficacy, etc. However, a particular motif here is also the therapist's search for admiration, superiority, ceding her own inner diminutive self to the patient, the shame of being human and incomplete, the lack of a secure footing (lower part of the body) and emphasizing the image of herself.

However, accepting Lowen's assignment to want to help patients "move forward" may already imply a narcissistic omnipotence fantasy as well!

Work on the self-regulation and self-monitoring of the patient – with the ultimate goal of his autonomy – per se, means that it is not we who "do" it. Rather, we trust in the body's self-healing powers and view ourselves as companions or catalysts. Especially the narcissistic seduction contained within the concept of "doing" should be particularly recognized as a threat in terms of a more directive technique like Bioenergetic Analysis.

4. Devotion to the Therapist Body: "Instrument Care"

The recommendations for psychotherapists to do something for their own health and well-being, avoid burn-out, joylessness and listlessness, are mainly focused on activities outside of the therapy sessions, such as the suggestion for self-therapy, supervision, peer supervision, sports, engage in wellness, yoga, singing, dancing, praying, meditating, or going on vacation. This distinction between physical activity *before and after the therapy sessions*, but sitting still during the sessions, fortunately is not

part of Bioenergetic Analysis – and is also seldom in other forms of physical psychotherapy. Bioenergetic self-care is much more than subjecting yourself to self-analysis or case-oriented supervision. It means "instrument care", to revive yourself, to sustain your vibration, and always looking to stay grounded in order to prevent a depression or emotional detachment as a result of your workload. In doing so, the bioenergetic focus lies in our ability to ground ourselves (grounding), our breathing, our energy flow, as well as our limitations and emotional retention force (containment) – before, during and after a therapy session. Many exciting findings from neuro-immune and neuro-physiological research document, step by step, what we have already known for a long time from clinical experience – that our body has enough regulatory systems to recover from stress if we give it the chance to do so (cf. Ehlert/Känel 2010; Schubert 2011).

4.1 Exercise, Breathing, Grounding

In epidemiological sports psychology research, a construct is currently being intensively discussed which calls itself "Sedantariness" ("sedentary lifestyle"). The results of these studies on "Sedantariness" revealed that people who do not engage in any sports activity at all, but only sit down a small amount of time during the day, lower their risk of premature death more than people who are even moderately physically active, but still sit the majority of the day. This speaks against any seated psychotherapy work!

"The sedentary lifestyle proves to be a significant risk factor especially for the incidence of metabolic diseases such as type 2 diabetes mellitus and coronary disease." Furthermore: "Sedantariness," according to current research, "is a behavioral health risk that occurs relatively independent of physical inactivity" (Fuchs & Schlicht 2012, p. 7).

There is also empirical evidence from studies on patients with chronic disease (arthritis, cancer, diabetes, cardiovascular) regarding the relationship between physical activity and well-being which stated that pure motoric training programs were significantly more effective than exclusive or complementary motivational/educational programs (cf. ibid., p. 42).

By switching between phases of contraction and relaxation during physical activity, our muscles set free a type of neurotransmitter in the body called "endorphins." Endorphins cause pleasant sensations, a kind of natural "high," and can act as a mild analgesic – reducing pain in the body. Certain physical activities and pain experiences (e.g. the "runners high" or sports – such as climbing and paragliding, which are associated with flow-like experiences) can cause endorphins to be released, causing a feeling

of happiness. This effect has now been medically confirmed albeit it is experienced very differently on an individual level.

To return to the plane of physical awareness, expression and body control, these results show, for example, that limiting the time allotted for speaking in therapy need not be a mechanistic, directive and contact-avoiding technique, as it is often emphasized by some analytical critics. Instead, doing so can at least improve the well-being and sensomotoric relationship of patients with psychosomatic disorders. That is, it may be advantageous for us therapists as well to simply motorically "work off" (not simply using verbal-affirmations or the imagination) the onerous experiences of our work with patients that are stored in our body! We as therapists of Bioenergetic Analysis enjoy the advantage of having flexible settings. As in other humanistic and physical psychotherapeutic methods, we can be physically active in a variety of ways during our work with patients. *Breathing* exercises and those that promote the *flow of energy*, which we may perform together with the patients, also enhances our self-perception and the motility of the muscles within this relationship. Likewise, our retention force and our ability to distance ourselves can grow with our ability to ground ourselves and practice deep breathing.

The reality-based principle of *grounding* (Lowen 1976) that is innate to Bioenergetic Analysis focuses our attention on the lower half of the body, on concrete grounding, on being rooted in the here and now, which thus leads you away from an illusory self-concept (misjudgment and excessive demands). Grounding exercises stimulate our body awareness on the sensorimotor and proprioceptive levels (cf. Clauer, 2009; Siegel 2011). We can be sure of our own stance and stand point – both concretely and figuratively. The proprioceptive cells in our feet, hands, and face for example, provide us, together with the vestibular organ in our ears, with the information about our standing in the world as well as via our bones, muscles, tendons and ligaments (cf. Clauer 2009).

Self-Care Exercises for Therapists 1: Grounding
(CAUTION: These exercises are provided for Bioenergetic therapists trained in the proper use of each one. Only use if you easily follow the directions and are clear in proper execution of each exercise. Ed.)

➢ Stand balancing your weight on one leg, while rolling the bottom of the foot of your other leg onto a small ball. You can hold onto a chair for better balance if needed. Use little rubber balls for foot (plantar) massage with an emphasis on the outer edges and the heel. This emphasizes the outer contour of the legs, hips and back, which changes self-perception from a

receptive to an active mode. Control the pressure by how much weight you apply to each side. Exhale while pressing down to your foot. Find a sound for expressing your pain. Switch feet.

- Pose like a runner at the starting line of a foot race: One leg in front of the other, knees bent, heels on the floor, and hands leaning down on either side of the front foot. Lean on the balls of both feet, as if ready to sprint forward. This exercise loosens the gluteal muscles and stretches the Achilles tendon. It promotes the feeling of being able to run away.
- Go into a forward bend, aka bendover, aka "Elephant": hands and feet on the floor; head is relaxed, hips are high, weight mostly in legs. In this position make grimaces to the floor. Shake your head and think of unpleasant patients; make a "brrrrrr..." vocal sound.
- While in the elephant position, think of annoying patients who mistreat you. Use words like "Get lost!". Say your words with strong affect.
- Move your hips from left to right, saying: "I value my sexuality, even if you do not value yours" (while thinking of sexually inhibited patients).
- Sit on your knees and lower legs, then place your head onto the (carpeted) floor. (aka the pose of the child in yoga). Next slowly and carefully roll your skull and forehead onto the carpet, using your flat hands by your face for leverage and balance. Rolling your head (skull and forehead) on the ground expands your field of vision, releases any blockages in the neck, base of the skull and the eye muscles. Use it to temporarily "forget the sight of the patient".

4.2 Vocal Expression

Confirmation about the healthy effects of activating the body and vocal expression is provided by a study from the Frankfurt Institute for Music Education, entitled: "Singing promotes the immune system! Listening to music, however, does not!"

Researchers from the University of Frankfurt measured the blood values (immunoglobulin A and cortisol) of singers from an amateur choir before and after rehearsals of Mozart's Requiem. Their blood values, regarded as an indicator of the body's immune system, increased after singing. Their subjective mood also changed for the better. A week later, the same study proved that listening to the same Requiem

did not positively influence blood values at all (cf.. NOZ 01.17.04, report about Prof. Hans Guenther Bastian from the Frankfurt Institute for Music Education).[3]

In Bioenergetic Analysis, we emphasize the ability of the *body and the voice to express themselves*. We regard the releasing power of vocal expressions of fear, sadness, or anger per se as therapeutically effective – just like the vibration of the muscles (neurogenic tremor). Expressive work with the voice is – in contrast to coordinated singing or silent mindfulness and Yoga exercises – a magnificent permission to be our true self. The shrill squeals, deep sighs, vehement cries, animal roaring, profound sobs, loud voluminous laughter now receive a space and we can massage our voice from within, tonify ourselves, relieve ourselves from any stress and reach out to our social environment with our emotions. We turn our attention to vocal timbre (the emotional coloring), melody (prosody), volume, and the ability to make ourselves noticeable in our surroundings. In this respect, Bioenergetic Analysis is very different from other purely therapeutic body techniques like Yoga (except Laughter Yoga), Tai Chi, Chi Gong, Shiatsu, osteopathy, meditation, focusing, etc. or even purely verbal methods that work with the principles of mindfulness and imagination. To my knowledge, no other psychotherapeutic method works explicitly with the voice. Even psychodrama and Gestalt therapy does not grant the voice the same status as we do in Bioenergetic Analysis.

Self-Care Exercises for Therapists 2: Vocal Expression (Discharge)

➢ Go down on your hands and knees and move your back alternatively into concave ("cow") position and convex ("cat") position. Use this Yoga "cow-cat" exercise with fear being inhaled in the cow-position and relief exhaled in the cat position. Imagine a difficult and scary patient while you look at the ceiling and inhale with a "hhii." Next, imagine that he has exited through your door while you are arching your back like a cat, letting go and exhaling with an "Aah." You may experience a discharge of anxiety with the exaggerated, amplified sound of fear (permission to be afraid) and control over your repugnance and fear by switching between fear and relief. The upper and lower parts of your body become integrated through the wave motion (trust through pelvic breathing) and dissolution

3 Cortisol – a hormone which, for example, has catabolic effects and a dampening effect on the immune system, is widely used in medicine to suppress over-reactions in the body and inhibit inflammation. In this respect, the increased cortisol value after singing can be seen as a significant sign of the body's responsiveness in favor of improved immunity. Immunoglobulin A (IgA) is an antibody that occurs mainly in the external body fluids, where it forms an important defensive barrier against pathogens.

of the rigidity held in fear (eyes, mouth, neck, throat, diaphragm.) This paradox often makes room for a lighter and even humorous mood. (The same exercise can also be performed standing where you imagine seeing the face of an unpopular patient on the ceiling.)

- ➢ Try starting laughing while in a standing position. First arch your back (aka arch aka bow) and then bend over (aka forward bend, aka elephant). Laughing is the easiest, most enjoyable and spontanous way to deepen your breathing (explanation of exercises cf. Shapiro 2008, p. 79).
- ➢ Imagine you are an idiotic therapist. Stick out your tongue left or right in turns and laugh with joyful, absolutely stupid excitement (ibid., p. 69).

Case Study Self-Care

In a self-awareness group, a colleague in training reported about her own insomnia. Out of fear of her first consultation sessions, she could not sleep for two nights and was plagued by doubts about her abilities. She could not sleep once she arrived here in the seminar house (where training occurred) either. In a first body diagnosis of her body posture while standing up, her raised, tense shoulders and the anxious expression in her eyes became apparent. She reports about the "Frozen Shoulder" symptom. In her body-oriented family constellation of the relevant biographical scene, there emerged a picture of her three older brothers bearing down on her shoulders and pushing down on her. They would often frighten and torture her with their antics: she remembers how she went to the outhouse in the dark across the yard when she was 4 years old and, as she sat there alone, how the brothers had turned off the light. She was terrified and screamed. Her parents had not noticed the dirty trick and her plight. Today, as an adult, she reports not being able to scream and feeling imprisoned in her own body when she feels overburdened by excessive demands. While working on this scene, she dares to raise her voice and gradually calls out "Stop it!" with increasing volume until she emits an explosive scream that fills the room. This relaxes her shoulder muscles and her fear-filled eyes as well. The following night she is able to sleep well in the seminar house. Back home, she regularly practices screaming during her trips in the car to her counselling work and reports that she is able to sleep again.

4.3 Touching and Soothing

Skin contact lowers blood pressure, promotes the interaction of the adrenaline-system ("fight-flight-freeze") to release the hormone oxytocin – the hormone of peace and love (cf. Uvnäs-Moberg 2003). When physical contact is experienced in a safe manner within a relationship, this will, in terms of neuroception, stimulate the "intelligent" ventral vagus (VVC) most likely via the oxytocin mechanism and, along with facial expressions and emotional exchange, prosocial behavior as well (cf. Porges 2010; Clauer, 2013, p 152f.).

In my opinion, the difference between Bioenergetic Analysis (and other body psycho-therapies that work with relationships) and pure body therapies, such as massage, physiotherapy, osteopathy, Yoga, etc., is that it is defined by relationship-building, rhythmically coordinated gestures, or physical contact connected to relationship images, that stimulate other responses via the vagus than mere mechanical contact from a strange person. This specificity of a trustful physical contact within a trusting human relationship has not been adequately studied in neurobiological, ethologically oriented research.

By touching our patients, practicing different hands-on techniques and types of contact (such as sitting back to back, pressing our hands and feet against each other, holding them, "dancing" with them), we are touched by them and thus encounter a feedback effect. This means that our VVC is stimulated during our bioenergetic work.

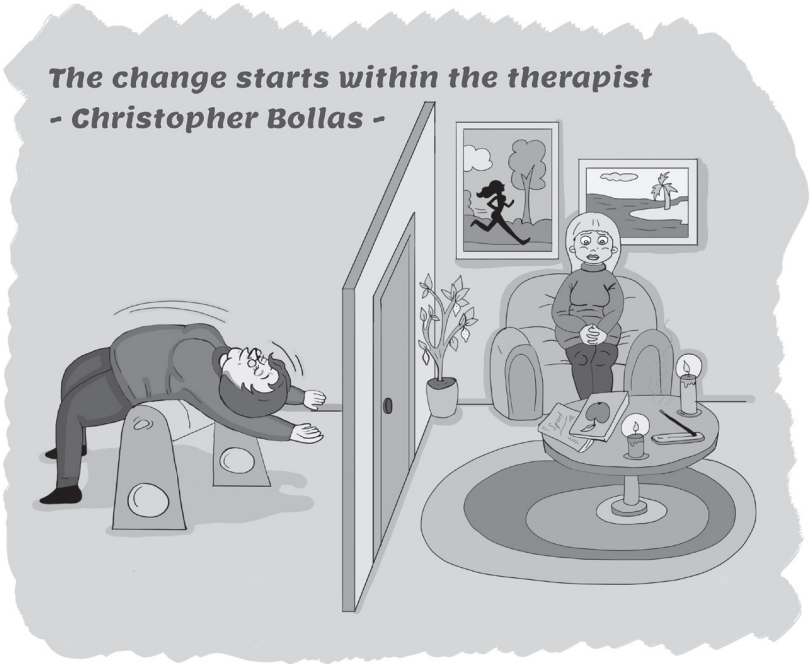
Physical contact is salubrious and absolutely necessary for psychotherapists! Especially when working with an abstinent touch when physically contacting our patients, it is all the more necessary that we ourselves are sufficiently hugged in our own private lives and lovingly maintain a fulfilling sex life.

Self-Care Exercises for Therapists 3:
Body Contact Partner Exercises for at Home

- Lie supine (face up) on the back of your partner who is lying prone (face down) on a mattress. Use this for safe partner grounding. Relax and breathe slowly.
- Sit across from your partner and, place your feet on your partner's feet to support each other in grounding.
- Go into the Bow (aka "Arch") position. Have your arms above the elbows held by your partner to get a slow expanding stretch in your the chest muscles (aka "open wings"). Lean forward as your partner pulls your arms back slowly and carefully.

- Next, have your partner tap your back with hands while you are bent over in the elephant position.
- Next, as you drop your head, have your partner give you a neck massage, while you are in the elephant position.
- Stand back to back with your partner. Both of you start pushing the other across the room with all the strength you have in your pelvis/buttocks. Offer some resistance to your partner using your voice as well. Imagine a place where you want your partner to get to. Next, turn around and stand across from each other. To feel your boundaries, place your hands on your partner's hip bones and slowly push them across the room, while they offer some resistance as they walk backwards across the room.

4.4 Resilience and Vitality as a Physical Concept



"The change starts within the therapist" (paraphrased from Christopher Bollas 1989).

Surely, this statement is similar to that expressed by C. G. Jung – regarding emotional and mental infection and the corresponding inner self-healing attempts by the therapist. In Bioenergetic Analysis, we have a bodily understanding of the "infection" and the "self-healing attempts": "The personality of an individual cannot change as long as no corresponding change in his physical dynamics takes place" (cf. Lowen,1993, p 8).

Of course this also applies to us therapists. Our special responsibility is primarily to only apply those interventions that we have also experienced and learned ourselves (cf. Pechtl 1980, p. 196 and cf. Schroeter/Thomson 2011) and, I would like to add, only those that we are ourselves are willing to continue to practice.

"It is therefore essential in my eyes to know the different areas of your own body space in the form of emotional vibrational ability in perception and physical activity, emotional expressiveness or blockage" (cf. Oelmann 2009, p 66).

The strength *to set boundaries* is a skill that is not primarily directed against others but is available for yourself: a joyful "No" to a transgression of your boundaries is an important task!

Depression beckons the exhausted therapist, since breathing is often reduced or a reduced respiration is a result of the attempt not to feel so much and to protect himself from the patient's feelings. The ability to set a boundary not only depends on the awareness of your own muscular strength but largely on your ability to breathe deeply. As a result, the body develops resiliency and toning, as the thoracic spine straightens up when inhaling. This way we send nonverbal signals that demonstrate that we are in full possession of our strength and that we do give ourselves inner space. The more clearly do we then non-verbally show our counterpart this personal space and the limits of our contact. Others have less of a chance to penetrate us when we fill ourselves sufficiently (with breath). When our speech is full of breath our voice communicates that we are sure of ourselves. This self-conviction acts as a contact boundary. This does not even require any sort of confrontation or struggle even. Sometimes merely a deep sigh or a direct statement are enough to say that it is too much for us.

We can develop this contact boundary by employing bioenergetic *exercises for our breath and our voice* for our daily "hygiene."

Self-Care Exercises for Therapists 4:
Vocal Expression, Charging and Boundary-Building

➢ As you exhale, emit a strong "hah!" sound in different variations (loud-quiet, short-long). We may use internal images or imagine scaring someone (perhaps a patient). We can keep other people at bay with our voice. Or we can simply project the sound to the nearest wall or send it to the ceiling (which relaxes the diaphragm).

- Experiment with consonants that give a sense of boundaries and incisiveness, such as: "... SSSShh ..." – "Pppah" – "KKah" – "Ttth" (emitted loudly).
- Imagine a domineering patient. Stretch your arm out, pointing your index finger in your imagination towards the person, proclaiming: "You need to do it the way I want it!" Or: "I will have the last word!"
- Lying on your belly on a mattress – tense the muscles in your back, arms and legs to their maximum, tone up your voice, draw it in and hold, exclaiming: "I caaaaaann!" Stop at the top (peak) of self-control! This energizes, invigorates and warms you. It promotes a feeling of self-efficacy. It involves toning the muscles instead of stretching and releasing. This feels containing rather than discharging (cf. Shapiro 2006).

Exercises for grounding and expressive work with aggressive impulses can help us to not retain the representative anger and indignation in us that may result from our therapeutic contact. Bioenergetic techniques, like hitting something with a tennis racket, kicking the mattress while lying down, using the teething ring and growling, etc., can help us in this regard. By releasing the muscles in our abdomen, back and legs, combined with vocal expression, we make contact with our own emotionality and take our protest seriously in order to invigorate ourselves again.

By directing our attention to the hidden aggressive charge behind an exhaustion depression and by permitting an energizing of our anger within a safe framework – instead of simply regulating ourselves down via soothing, regressive and avoidance-related activities – we act invigoratingly, move out of our resignation and organize our emotional movement patterns anew. This positive orientation or appreciation of our aggressive impulses – even those of resentment – gives us a chance to remain in contact with ourselves and others in a constructive manner. Here Bioenergetic Analysis has an aspect of self-care that cannot be appreciated enough, which is also consistent with the results from emotion research (cf. Koemeda 2006).

Self-Care Exercises for Therapists 5: Resistance

- Tap your sternum stimulating the thymus gland, proclaiming: "Me first!" (reduces altruistic mode).
- Stretch your arms upwards and then turn to the side imagining being able to feel the air's resistance and pushing against it.

- Stand in the doorway pressing against the resistance of the wood with extended palms when exhaling.
- Press palms of your hands against each other (cf. Shapiro 2008, 2009).
- Lie on your back pushing the air with your legs while exhaling, toes towards your face, heels towards the ceiling. Imagine pushing someone away.
- Lie on your back kicking your legs into the air yelling: "Beat it!"(think of last weeks patients) – while letting your buttocks bounce on the floor.
- Assume the elephant position, leaning into the wall or a cube.
- Push against the cube with your neck and upper back while exhaling and exclaiming: "Nooooo!" with a rising voice.
- Stamp your feet, saying: "I do not want to please you!". Next, thrust jaw out and place hands in a defensive position. Push your elbows behind your back, yelling: "Beat it!" (Imagine your most annoying patients.)
- Exercise self-control during the classic bioenergetic exercises, which are not used here to discharge stress but to contain your strength: kick a cube or lie down and kick on a mat 10 times and hit down hard with your arms 10 times. Do stop before getting exhausted! Stop when you feel you are in control of your anger.
- Go over the Breathing stool (not as trained into the surrender position but holding your head up looking straight forward!). Push your lower jaw forward and thrust your pelvis forward while exhaling.

I regard this next statement by Stanley Keleman (2008) as an indication of the health-maintaining function of "rigid" bioenergetic procedures in the therapeutic process. The statement was certainly meant in terms of patients. However, from a self-caring perspective, it applies just as well to us therapists. Rigid therapists (according to the character structure analysis of Lowen) do not allow any heart-felt feelings for their patients. Instead, a sober and factual, non-erotic approach prevails in matters of love and sexuality. They also have more "structure" (emotional control) than so-called pre-oedipal characters. The fact that the "empathic dilemma" (mutual consternation and collusion) may be limited in their therapeutic encounter – with its focus on cooperation and ritualized exercises – may be regarded as a positive aspect of the rigid therapist. Repetitions and directive, ritualized bioenergetic techniques and exercises based on tangible objects and technical aids represent a protection for us therapists in the context of our risk of being flooded with emotions!

"Better some rigidity than being flooded" (Stanley Keleman).

Work, however, is no problem for the rigid character. To save the rigid therapist from an exclusively technique-based orientation, playful activity and an opening of her heart would be important (Shapiro 1993, 2008, 2009)!

Summary

This article has argued the importance of the empathic and resonating body of psychotherapists. It focuses on the value of using the motility of the body itself in self-care for body-psychotherapists. Bioenergetic exercises are provided to help the therapist recover from the effects of negative experiences with difficult patients. Many exercises are included for grounding and expression of negativity and containment (setting boundaries) to enhance the ongoing health of the practicing therapist.

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The "Energetics" of Couples Therapy

Garet Bedrosian

Abstracts

English

This paper addresses the energetic communication between couples that sometimes derails their connection. Through the integration of Bioenergetic Analysis (BA) and various relationship modalities such as Imago Relationship Theory (IRT) and Emotionally Focused Couples Therapy (EFT) I offer insights and interventions, which may address these nonverbal, energetic disruptions between couples. Examples of sessions with two couples are given using a combination of theories. The paper concludes with themed bodywork techniques for couples addressing issues such as power struggles, negativity, cooperation, connecting/containing and supporting/receiving.

Key words: Bioenergetics, Imago Relationship Theory, Energy, Bodywork Techniques for Couples

German

Dieser Aufsatz befasst sich mit der energetischen Kommunikation zwischen Paaren, die manchmal entgleist. Durch die Integration der Bioenergetischen Analyse (BA) mit verschiedenen Beziehungstherapien wie die Imago Relationship Theory (IRT) und die Emotionsfokussierte Paartherapie (EFT) biete ich Einblicke und Interventionen, die diese nonverbalen, energetischen Störungen zwischen Paaren ansprechen.

Beispiele aus Sitzungen mit zwei Paaren verdeutlichen die Kombination dieser Theorien. Der Artikel schließt mit körperorientierten Paartechniken zu den Themen Machtkämpfe, Negativität, Kooperation, Verbinden/Halten und Unterstützen/Empfangen.

French

Cet article traite de la communication énergétique des couples et de leurs relations pouvant parfois dérailler. En utilisant diverses approches intégrées à l'analyse bioénergétique telles que la Thérapie Relationnelle Imago et la Thérapie de Couple Axée sur l'Emotion, je leur offre une certaine compréhension ainsi que des interventions centrées sur leurs perturbations énergétiques, non verbales. J'illustre ceci en donnant deux exemples de séances de travail avec deux couples combinant ces diverses approches. Puis, pour conclure, des techniques thématiques de travail corporel sont décrites, s'adressant aux couples et traitant des problématiques telles que les luttes de pouvoir, la négativité, la coopération, entrer en contact/contenir et donner du support/recevoir.

Spanish

Este documento aborda la comunicación entre las parejas que a veces hace descarrilar la conexión energética. A través de la integración del análisis bioenergético (BA) y diversas modalidades de relación como la Teoría de Relación Imago (IRT) y la Terapia de Enfoque Emocional de Parejas (EFT), ofrezco conocimientos e intervenciones que abordan el tema de las interrupciones energéticas no verbales entre las parejas. También aporto ejemplos de sesiones con dos parejas en las que pongo en práctica una combinación de dichas teorías. El documento concluye con técnicas que centran en el cuerpo para parejas que presentan problemas relacionados con la lucha por el poder, negatividad, cooperación, y cómo conectar/contener y apoyar/recibir.

Italian

Questo saggio affronta il tema della comunicazione energetica nelle coppie che a volte fa deragliare la relazione. Attraverso l'integrazione dell'Analisi Bioenergetica (BA) con varie modalità relazionali, come la Imago Relationship Theory (IRT) e la

Emotionally Focused Couples Therapy (EFT) offro approfondimenti e interventi che possono affrontare tali rotture non verbali ed energetiche nelle coppie. Sono proposti esempi di sedute con due coppie, utilizzando una combinazione di teorie. L'articolo si conclude con tecniche corporee per le coppie che si confrontano con problemi di lotte di potere, negatività, di cooperazione, di collegamento/contenimento e di dare e ricevere sostegno.

1. Introduction

I am fascinated by the dynamics of romantic relationships. I'm interested in what attracts one person to another; what makes the relationship successful; what causes tension or frustration; why and how love dissolves; how conflict can inform or strengthen rather than weaken a connection; and how someone's history affects the success or failure of their love life.

Since working bioenergetically with couples was not an emphasis in my training I turned to the field of relationship therapy. The body of work on relationship therapy is immense.

Some of the more popular theories in the US at this time each offer valuable insight into how to create successful relationships. I would like to name a few. John & Julie Gottman created The Gottman Institute, which is a laboratory for the study of and teaching about successful relationships. Gay and Kathleen Hendricks created The Hendricks Institute, which teaches Conscious Living and Loving. Sue Johnson's International Centre for Excellence in Emotionally Focused Therapy (EFT) also offers valuable information about attachment issues influencing adult relationships and how to enhance, repair and keep relationships healthy. PACT (A Psychological Approach to Couple Therapy) was developed by Stan Tatkin. Harville Hendrix and Helen LaKelly Hunt co-founded Imago Relationship Theory (IRT).

Bioenergetic Analysis (BA), Imago Relationship Therapy (IRT) and Emotionally Focused Therapy (EFT) share a common theoretical tenet, which correlates childhood attachment and developmental experiences with adult character traits and relationship styles making them a natural fit (Lowen, 1975; Hendrix, 1988; Johnson, 2008; Scharff & Scharff, 1991). Not only do individuals store the wounds of their childhoods in the muscles and cells of their bodies as theorized by Bioenergetic Analysis, but they also develop an unconscious template of love that informs their partner selection and relational styles as espoused by Imago Relationship Theory and Emotionally Focused Couples Therapy. I will introduce each of these modalities in more detail in this section.

1.1. Bioenergetic Analysis

BA offers a unique understanding of the lifelong affects of early relational wounding and how those wounds affect the individual's ability to connect with the people and the world around them. BA facilitates a releasing of emotional, mental and somatic defensive patterns so one can be more heart-fully available to connect and love.

The "couplehood" connection in Bioenergetic Analysis happens between the client and therapist and through that relationship the client reclaims their ability to become vulnerable in relation to another. In his collection of papers called Relational Somatic Psychotherapy, Bob Hilton writes extensively about the relational healing which occurs when the client is able to emotionally and somatically break down and repair within the safe and consistent relationship with the therapist (Hilton, 2007).

I have experienced that tremendous healing in my therapeutic relationship with Bob Hilton and it has had a profound affect on my life and relationships. His grounded presence and astute ability to notice, support and challenge my relational wounds and defensive patterns has transformed me from a terrified, dissociated girl into a dynamic, relational woman yet, there is another dynamic that is triggered within a primary romantic relationship that confounds that healing.

I know I am not alone. Couples I know personally and professionally have shared that confounding experience. Romantic partnerships seem to trigger core wounds and defenses regardless of the depth of individual healing. Of course one's individual healing can inform and possibly ease those disruptions yet does not eliminate their presence in romantic relationships. Since I am trained in both modalities, combining BA with Relational Therapy made sense. Couples inevitably encounter unconscious, relational tensions and are more likely to find lasting resolution if they experience a shared energetic healing as offered through BA.

1.2. Relationship Theories

John Gottman writes extensively about successful relationships and says that even successful couples argue, disagree, get frustrated and hurt one another. Their success is determined by a five to one ratio of positive to negative incidences as well as to the degree of love and respect exchanged (Gottman, 1994). A couple's ability to maintain that ratio requires connection and trust. When each partner has experienced a grounded, embodied healing, remaining present to trust and connection are more likely.

According to the Imago theory, (Hendrix, 1988) partners are unconsciously chosen because they energetically match family of origin dynamics and create possibilities for

healing of the emotional wounds left by those dynamics. This unconscious template triggers an attraction to someone with similar developmental wounds but who defends themself in a dissimilar way. For example, one may defend against early heartbreak or misattunement by becoming more aggressive while the other defends by withdrawing. The purpose of this union is to heal and reclaim energetic holes or missing parts, as they are called in Imago theory. These are the parts of one's self which were suppressed to survive or be loved in one's family.

In time these unconscious, energetic attractors trigger or threaten the blissful union.

Because they are unconscious and integrated so thoroughly into the body and ego structure, the threat can unknowingly get transferred onto the romantic partner. Making those dynamics known on a visceral level helps the couple develop more awareness and allows for more conscious choice in the ways they interact and connect.

1.3. Literature Review

I am aware that there are many Bioenergetic therapists who work with couples but I reviewed the past 20 years of IIBA journals in researching for this paper and found no articles on this topic. Anne Evans (1995, vol 6) wrote about healing sexuality within a relationship and David Finlay (2010, vol 20) wrote about intimacy, but there were no other articles that I could find about how to apply BA to couples therapy. At the 2011 IIBA conference in San Diego, Barbara Davis, Vita and Jörg Clauer and I each presented workshops about working with couples but their work has not been published in English. I hope they will submit their articles to the journal so we may all learn from their work. In this paper, I would like to offer my perspective.

I am a certified Imago relationship therapist and workshop presenter so this is the theory about which I am most familiar and have experience integrating with Bioenergetic Analysis as an approach to working with couples. Therefore Imago will be more prevalent in this paper. The following is an introduction to clinicians in combining the three methods of BA, IRT, and EFT.

1.4. Why Combine the Three Methods: Introduction for Clinicians

When you observe couples and watch them interact and react to some trigger you did not experience, you may wonder what you are missing as the dynamics build and change. The nonverbal energetic exchange between partners is akin to a siren song: alluring, irresistible, yet destructive. If you are not in the relationship it is likely that

you cannot hear it, but they hear it beckoning from an unconscious place. When they do, they become compelled to engage with one another as if they are fighting for their deepest desires or maybe even their lives.

Sue Johnson (2008) addressed this phenomenon in her book, *Hold Me Tight*,

> "The powerful emotions that came up in my couples' sessions were anything but irrational. They made perfect sense. Partners acted like they were fighting for their lives in therapy because they were doing just that. Isolation and potential loss of loving connection is coded by the human brain into a primal panic response" (p. 46).

IRT and EFT offer a structure as well as communication tools to help couples navigate those turbulent waters and consciously respond rather than unconsciously react to the siren call. Merging relationship therapies with BA is a unique approach to couples therapy. This integration is a perfect marriage--please excuse the intentional reference!

Bioenergetic therapists are trained to observe and help make conscious the nonverbal exchange of energy between partners. EFT therapists help couples articulate their attachment wounds, triggers and needs through topically focused conversations (Johnson, 2008). Imago relationship therapists are trained to facilitate intentional dialogues that are explicit communication styles within a safe relational container so that unconscious and sometimes threatening material can be discussed and healed non-reactively within the romantic relationship where it is more likely to be triggered (Hendrix, 1988).

2. Theoretical Constructs

I will specifically focus on the following 3 theoretical constructs, which support the integration of these modalities:

2.1. Adult personalities and relationship styles are influenced by childhood experiences.
2.2. Healing occurs within the context of a relationship.
2.3. Unconscious transference and projections quickly derail connection.

2.1. Adult Personalities and Relationship Styles Are Influenced by Childhood Experiences

BA, IRT and EFT are developmentally based theories and correlate the connection between childhood experiences with adult character traits and relationship styles.

One of the fundamental premises of BA is that people protect themselves from their childhood wounds on a somatic level as well as on a mental/emotional level. These defensive contractions restrict the life energy of the organism and compromise the connection with another. Since these wounds are embedded in the cells and muscles of the body, the developmental stage and chronicity of the wounding determine the characteristics of those contractions and adaptations as well as relational styles.

Alexander Lowen (1972) identifies the restriction of life energy on a somatic level as character armoring.

> "Armoring refers to the total pattern of chronic muscular tensions in the body. They are defined as an armor because they serve to protect an individual against painful and threatening emotional experiences. They shield him from dangerous impulses within his own personality as well as from attacks by others" (p. 13).

Lowen named 5 character adaptations according to the stage of development in which the wounding occurred. They span from infancy to approximately 5 or 6 years of age. The 5 character types are Schizoid, Oral, Masochistic, Narcissistic and Rigid. Each has identifiable somatic, emotional and mental stances that need to be addressed and healed for the adult to be free enough to love on all levels. Until those armored stances are healed there are challenges to achieving connection encased in each character structure. I will not elaborate on each character structure in this paper except to say that the younger the wounding, the deeper the contractions and therefore reaching for contact can be more challenging. To learn more you can read Alexander Lowen's book, *Bioenergetics.*

The IRT philosophy is also based on a developmental model. The premise is that each stage of development has specific relational needs, which affect a child's ability to function fully in the world. If they are not adequately met or attuned to by their caretakers they become split off from themselves and create a lost or denied self with characteristic beliefs and patterns of behavior to protect themselves from harm or intrusion (Hendrix, 1988). According to Winnicott, if developmental needs are not met, emotional development stops, and those unmet needs cause a wounding that affects the person's life and especially their relationships into adulthood (Greenberg, 1983).

Sue Johnson (2008) states that couples need to understand one another's attachment wounds to understand the demands, criticisms and withdrawals in their relationships. She says,

> "Attachment needs and the powerful emotions that accompany them often arise suddenly. They catapult the conversation from mundane matters to the issue of security and

> survival. If we are feeling basically safe and connected to our partner, the key moment is just like a brief cool breeze on a sunny day. If we are not so sure of our connection, it starts a negative spiral of insecurity that chills the relationship. Bowlby gave us a general guide to when our attachment alarm goes off. It happens, he said when we feel suddenly uncertain or vulnerable in the world or when we perceive a negative shift in our sense of connection to a loved one, when we sense a threat or danger to the relationship. The threats we sense can come from the outside world and from our own inner cosmos. They can be true or imaginary. It's our perception that counts, not the reality" (p. 36).

There are effective Imago dialogues and EFT conversations designed to help couples navigate these negative spirals of unconscious insecurity. The conversations are structured to direct attention to unmet childhood needs rather than shaming, blaming or criticizing one's partner for a perceived offense. With more intentional conversations there is less likelihood of acting out and re-wounding one another and more possibility of getting those needs met. Incorporating full bodied awareness and energetic healing through BA experiential exercises helps partners understand how these developmental wounds have affected their emotions and beliefs about themselves and in relation to others. This can support the type of self-regulation needed through body awareness to remain present for that type of intentional communication.

2.2. Healing Occurs Within the Context of a Relationship

Choosing someone who cannot meet your needs sounds absurd but when understood through the lens of IRT it helps explain some of the relational struggles. After many years of study, husband and wife team Harville Hendrix and Helen LaKelly Hunt, cofounders of Imago Relationship Theory, say in their newest book, *Making Marriage Simple* (2013), "Incompatibility is grounds for marriage" (p. 24). In this context marriage encompasses any committed partnership.

IRT states that individuals learn their unconscious templates of love in their families of origin. All the positive and negative experiences and characteristics of their parents or primary caretakers form their energetic love-map. Not only do they possess those traits but they will only choose and fall in love with someone who also possesses those traits. They choose their *Imago* or *mirror image* and, according to Hendrix and Hunt (1988), they will not fall in love with anyone else. In other words, if an adult experienced neglect in their childhood they would be attracted to someone who would trigger the experience of neglect and then they will unconsciously react to the threat.

In *Getting the Love You Want* (1988), Harville explains it this way,

> "Our old brain ... is trying to re-create the environment of childhood ... You fell in love because your old brain had your partner confused with your parents. Your old brain believed that it had finally found the ideal candidate to make up for the psychological and emotional damage you experienced in childhood" (p. 14).

To heal childhood misattunements, wounds, and broken hearts, one needs to be with someone who is willing to stretch and grow their ability to provide what the other needs and vice versa. Hendrix believes that each partner possesses what the other needs to grow into their fullest, most alive self.

Being with someone who meets their needs too easily would either bore them because they are familiar with the energy of the power struggle or the opposite challenge occurs, which relates to feeling overwhelmed by intimacy. Many people say they want closeness and intimacy, but being vulnerable can be frightening so they consciously or unconsciously sabotage it. The beliefs, behaviors and bodily contractions created in childhood for protection against disappointment, overwhelm or pain typically resurface in the romantic relationships when an emotional threat is triggered.

Alexander Lowen wrote extensively about the emotional, mental and somatic wounding created by the child's relationship with their primary caretakers. In *Love and Orgasm*, he wrote, "The love of an infant for his mother is the prototype of all later love relationships ..." (p. 66). Although his techniques were designed to heal that early wounding, his approach did not emphasize the healing potential of the therapeutic relationship. As BA has evolved in the last twenty plus years Bob Hilton and many others have integrated more relational models such as Object-Relations and Attachment theories into their philosophy of somatic healing.

Harville Hendrix has also acknowledged his reliance on Object-Relations Theory in creating IRT as a model for treating couples. Over the years I have heard both Bob (Hilton) and Harville say (Multiple Conference Lectures), "We are born into relationship. We are wounded in relationship. We need to heal in relationship." In their paper, *Object Relations in Psychoanalytic Theory,* Stephen Mitchell and Jay Greenberg assimilate theories from Fairbairn, Winnicott, Guntrip and Kohut. They write that Object-Relations theory is generally based on the stance that from birth the infant has a core energetic drive toward contact and relationship with another. If that drive has been repressed the authentic and spontaneous self seeks full expression which can only be achieved through a safe relationship with another (Mitchell, Greenberg).

In his paper entitled, *The Importance of Relationship in Bioenergetic Analysis*, Bob Hilton talks about the client/therapist relationship as a relationship in which the client restores their ability to love.

> "... one way of expressing love and through it allowing the client to release a narcissistic position is to surrender our agendas and theories and follow the client's needs. In other words, we do not need to be right. Another way is the willingness on our part as therapists to allow ourselves to be moved by the clients experience. [...] When this kind of loving mutuality is achieved with our clients, a spontaneous bodily movement begins in them. This movement is the expression of the real body/self that is reaching back toward the environment for contact" (p. 98).

Sue Johnson (2008) writes that when she asks couples about their problems she hears blaming of the other. When she asks therapists what are the basic problems they think couples face she hears that the couples are caught in power struggles and need to learn how to better communicate, but she also believes:

> "... couples have disconnected emotionally; they don't feel emotionally safe with each other. What couples and therapists too often do not see is that most fights are really protests over emotional disconnection. ... The anger, the criticism, the demands, are really cries to their lovers, calls to stir their hearts, to draw their mates back in emotionally and re-establish a sense of safe connection" (p. 30).

As Bioenergetic therapists we can support and welcome that reach for connection through a number of physical interventions including touching and being touched. If the relationship is safe enough, the client can risk the terror they must face in allowing themselves to be vulnerable. We must also risk our vulnerability and face our desires and limitations to loving and being loved. As therapists we have hopefully worked through our own wounds and have enough support in our lives to remain clear and focused on our client's needs and provide them with a healing experience. If we fail in some way, being available for the repair can also be healing.

Although BA is a relational therapy and despite the incredible healing possible in individual therapy, a partner in a loving relationship can still trigger a regression into those original childhood wounds. The regression may not be as consuming or detrimental as it would have been had the individual healing not occurred but there is still another level of healing that is necessary but sometimes thwarted between committed, romantic partners.

Typically, both partners are triggered into regression at the same time so they are often unable to create emotional safety for one another in the same way as in a therapeutic relationship. The couple's therapist can create the safety in which to hold the relationship and support each partner as they risk and face their own terror while reaching for more contact and connection with their partner. Although IRT's

Intentional Dialogue is a valuable communication tool, sometimes verbal communication cannot derail long held unconscious defenses. The body remains in high alert and somatically defended.

As mentioned earlier non-verbal BA interventions can accentuate an unconscious, sabotaging dynamic, create a safe container in which to express anger, hurt and disappointment as well as provide a physical experience of support and affection desperately desired. This type of visceral experience with a loving partner is profound. There is a primal connection and experience that touches into the core of the heartbreak and uncoils the cellular holding. Complementing the physical intervention with an Intentional Dialogue or an EFT conversation can then intellectually ground the experience.

To be healthy and happy, the individual must release the mental, emotional and somatic holding to allow energy to flow freely through them as well as between them and others. In these psychotherapeutic models the healing of developmental wounds in a safe relationship is essential to having an energetically dynamic life and connection.

2.3. Unconscious Transference and Projections Quickly Derail Connection

I have heard many IRT therapists repeat this quip when referring to projections in relationships, "You will either pick them, provoke them or project onto them." In other words, you will either pick someone to wound you in a similar way to the way you felt wounded in your family of origin, provoke them to wound you in that way or project that their behaviors are meant to wound you in the same way.

Romantic relationships often begin with an idealized experience of the other. That idealization consists of unconscious projections about the love object being the one who will love, appreciate, support and fulfill all needs ... finally and forever more!

When a transgression is perceived, infantile fears of abandonment or rejection trigger defensive reactions. That survival reaction might be aggressive, seductive or rejecting but it's intention is to get another to meet a real or perceived need and, a need that triggers this type of defense usually originates in childhood.

In a *Getting the Love You Want* workshop facilitator training, Maya Kollman, a master IRT trainer shared an Imago saying, "If it's hysterical, it's historical". In other words, a reaction that carries big energy often has a historical root. The partner receiving the reaction experiences it as excessive, threatening and out of proportion to the incident so reacts from their reciprocal defensive style. Harville says our partners are wounded in a similar developmental phase but defended in an opposite way. Consequently neither is functioning within the present reality. Both

are regressed and reacting to a historical wound causing their adult connection to be derailed. When this becomes a chronic style of relating there is little room for love. Liz Greene, PhD in her article about projections in relationships wrote, "Sadly, once one or the other or both people become engaged in this dance of illusion, there is little room left for the real people to exist and enjoy authentic acceptance and love" (wealthyandloved.com, blog post).

This "dance" is often unconscious yet the threat feels very real in the moment. Romantic partners reflect both our wounded selves as well as our most loving selves. Harville Hendrix says that our romantic partners are our mirrors. Becoming conscious about our projections is a challenging, scary and painful process for most, so holding another responsible is a primitive defense against feeling that pain.

Sue Johnson has written about how childhood attachment wounds trigger this type of regressive response. She has developed a series of questions designed to make what has been unconscious more conscious thus enabling couples to frame their reactions more accurately. Hendrix has developed intentional dialogues with a specific structure that is designed to engage the cerebral cortex and frontal lobe and hold the couple in a safe, contained, conscious, mature place.

The Imago dialogue process creates safety and structure. Each person has the opportunity to talk about his or her experience in the relationship and how it resembles their childhood hurt and the defenses they adapted to protect themselves from that hurt. The partner repeats what they are hearing, empathizes with the pain their partner experienced in childhood and lets their partner know how defending against a similar pain in their relationship makes sense. When the speaker feels satisfied they switch roles.

The process is intended to eliminate projections because these projections quickly move from the triggering event to the childhood wound and to ways of defending that wound that ultimately sabotage their ability to give and receive love as an adult. As a result of this structured communication the speaker has the opportunity to become more vulnerable when they remove the projected beliefs and then they can trust that their partner is genuinely interested in listening. The listener has an opportunity to become more empathic and understanding of the other's experiences in the relationship when they do not have to defend against an attack. Both EFT and IRT processes enable healing yet do not address the somatic resistance and holding.

Introducing BA to enhance individual body awareness strengthens the effectiveness of these interactions. Creating a relevant, experiential, sometimes non-verbal intervention enables them to embody the spiraling stuckness created by their own projections and transferential dynamics as well as enhance the somatic healing when they follow their energetic movements.

According to BA, family of origin wounds are absorbed into the body, emotions and mental beliefs at such a young age that distinguishing the armored self from the authentic self is difficult without intervention. Because the wounding happens so young some regressive beliefs and emotional triggers are to be expected until there is enough healing for someone to grasp what is happening in the moment and remain present and rational.

Until that time, partners need to be loved and accepted despite their regressions. So when couples cannot remain safe for one another the therapist can create a non-verbal, experiential intervention to support both partners to drop their intellectual defenses and somatically explore their energetic movements toward and away from one another. If the therapist can hold a safe frame during that visceral experience it can reveal primal as well as present needs and defenses and promote safe exploration toward a new, more authentic way of being that incorporates and heals the whole person including the body.

Our authentic nature is to be whole so when our projections are made conscious we can integrate them back into our sense of self. When one can re-own those parts that trigger shame, self-doubt or self-hatred and still experience love from another then there is a chance for sincere, full-bodied and whole-hearted love. In his article, *The Importance of Being Liked: The Therapist's Dilemma,* Bob Hilton writes, "Someone has to contact us in our shame in order to build a bridge back to our true self where we can thrive and be free" (p. 266). Integrating the theories of Bioenergetic Analysis and relational psychotherapies in my therapeutic practice has been amazing and rewarding. Here are some examples.

3. Case Example 1: Somatic Defense Breakthrough

I worked with a highly intelligent, professional couple who were perpetually triggering one another. Sometimes they triggered each other through words or tone but at other times it was completely nonverbal. The eye rolls and crossed arms were easy to spot and address but sometimes their communication unconsciously triggered and drew them into the turbulent waters of the siren call.

They were in the midst of another conflict about who did what to whom when I noticed an almost imperceptible stiffening in his neck as the male partner ever so slightly lifted his chin and appeared to be looking down his nose at her. She, unconsciously and energetically transformed into a distraught little girl no longer able to compose herself.

I asked them to become quiet and physically still to create an awareness of what

was happening in the moment. Neither could identify their energetic or physical transformation. I then had them exaggerate any tensions or lack of energy they felt and to become curious about the exaggerated pose.

He surprisingly identified this "looking down his nose" stance as his father's. This was the way his father expressed his disapproval toward him when he was a child. He hated it and had no idea he was using it with his wife. I asked her if she knew this look and through an outburst of tears she said that she knew it well as it triggered a "never good enough" feeling.

He very sincerely apologized and she melted into a tearful pool of relief, which she later identified as finally being seen and heard. He spontaneously reached out to hold her and she sank into his arms. His unconscious, defensive stance relaxed as he allowed his empathy to flow for his wife whom he realized was experiencing the same pain he (as a boy) knew so well. Not being good enough, of course was a belief and agony she carried with her from childhood and into which she was so easily triggered.

Neither of them felt good (adequate) enough for their parents but his pain was defended behind a "better than" stance while hers was expressed in longing that could never be met. They fell in love with one another to help heal these wounds of inadequacy. It's the same wound expressed in an opposite way.

Each of them has to move more toward vulnerability and risk the fear of being rejected, which is the struggle all face in love to one degree or another. Defensive structures are insidious and surrendering to intimacy is challenging. *They were trapped in a verbal sparring match so exploring the somatic expressions of their primal defenses allowed them to drop into vulnerability.* When a romantic partner requires an authentic expression of love and empathy in order to heal, their partner also has the opportunity to become more fully alive.

4. Case Example 2: Finding the Conflict in the Body

Another couple with whom I worked was entangled in insecurities with one another. Each blamed the other and neither was able to claim their contribution to the danger zone. Their energies were pushing and pulling at the same time.

I asked that they stand with the palms of their hands flat against one another and to experiment with pushing and pulling. One would push and the other would resist or one would move their hands back and the other would follow.

I then had them experiment with not cooperating with one another's movements. As one moved back, the other would either push harder or not follow at all or if

one moved forward the other would block the movement or move back without any contact.

Very quickly they went from laughing and enjoying the playfulness of this exercise to having a somatic experience of the emotional struggle in their relationship. Their bodies lost the vibrancy and spontaneity expressed in the first round of this experiment. It became more sobering and emotional for them. The embodiment of their relational dynamics took them to the their painful loss of connection. This allowed a deeper awareness of their defensive patterns, which prevented them from attaining the intimacy they desire.

Each was able to take responsibility for their contribution to the conflict. Through her tears, the woman said that this is exactly what she feels in their relationship. The man immediately moved toward her in an expression of compassion and empathy. As he held her he was genuinely remorseful about his unconscious tendency to withdraw his energy from her. Of course she had tried to tell him but he couldn't hear it when her communication sounded critical, shaming or blaming. This exercise gave him a felt sense of his own struggle to remain in contact with himself as well as with his wife rather than protect himself by withdrawing. She was able to recognize how her anger and criticism was an attempt to protect her from heartbreak, but only served to push her husband away.

This somatic experience of a less defended and more vulnerable communication enabled the healing of childhood wounds thus creating the opportunity for a mature, adult loving relationship.

5. Clinical Summary

Experiencing the energetic transformation in couples work is completely satisfying. I witness it in my private practice and in the *Getting the Love You Want* couples workshops that I lead. Each partner discovers the mysteries and gifts of their relationship's frustration as the missing pieces fall into place. They understand how and why they chose one another and how the relational struggles are opportunities to heal and grow into a deeper love.

Blending these two fields of study, relational therapies and Bioenergetics Analysis, creates a fuller, richer picture of human development. When unable to trust the relationships with childhood caregivers, individuals characteristically defend their expressions of love as well as their receptivity to love. However, defending against authentic expression creates a multitude of physical, emotional and relational problems. Humans are born fully alive, joyful, and connected and want to reclaim that birthright. This disconnect from the true or authentic self can cause a tug-of-war within

relationships. Individuals long for the give and take of love, yet unconsciously defend against it due to the possibility of heartbreak. The unconscious energetic expression of that tug-of-war is fascinating. Accompanying someone through the obstacles to their unique life expression is honoring and humbling. Remaining grounded through the turbulent waters of the siren's call for a couple can stretch the therapist as well as the couple to a higher level of attunement.

6. Addendum: Body Interventions with Couples

On the next few pages I would like to share couples exercises I created with Diana Guest, MFT, CBT. Together we presented a variation of this workshop at the International Bioenergetic Conference in Spain as well as at the United States Association of Body Psychotherapists Conference in Colorado. I have presented a different variation of this workshop at an International Imago Relationship Conference as well as at the IIBA conference in San Diego.

The following are examples of exercises we have used with couples. We would not recommend using all of these exercises with any one couple. One cannot just overlay these exercises on the couple. They may not be applicable in their original form. The intervention must be organic and relational for that couple. They must therapeutically address the dynamics for the couple present while also considering their personal and relational history. For example, you may not do some of these if there is a sexual abuse issue, domestic violence history, etc.

6.1. A Suggested Beginning to a Session

Have the couple sit facing each other. Have them close their eyes and go inside, get grounded in themselves and then move their awareness to the relationship between them and instruct them to notice how they feel at that time. When they appear or report feeling present and grounded tell them to complete each of the following sentence stems silently with their eyes closed first. Then have them open their eyes and one person at a time share each sentence with their partner. The partner will repeat each sentence as they hear it.

1. As I enter the relationship space I am aware of experiencing ...
2. How I would like our relationship to be at the end of this session is ...
3. What I can do to help make that happen is ...
4. Something I appreciate about you is ...

After this initial ritual the couple can discuss an issue in their relationship. One of the following body interventions may enlighten them to *character structure, transference, and/or projections to illuminate* the unconscious dynamics in their relationship.

6.2. Power Struggle Interventions

- *Go away:* Have the couple stand and face one other. Partner A starts by doing a pushing movement with hands (with or without contact depending on the couple).
- *Relational Ambivalence:* This exercise begins as the previous exercise but as ambivalence is recognized or felt have the ambivalent partner move into pushing with one hand while saying, "go away" or "leave me alone" and alternately, with the other hand reaching and pulling their partner toward them while saying, "don't leave me." Have the other partner mirror these alternate expressions. (Example: A husband was ambivalent about intimacy and so he had a pattern of pushing his wife away. I had him physically experiment with the push/pull dynamic so he could embody his defensive pattern and make a more conscious decision about whether this is how he wanted to behave. In this example, he expressed empathy for what it might feel like for her, which allowed her to sink into her sorrow and to own her critical, defensive style and also make a different choice in her behavior.)
- *Towel Pull, My Way:* Have the couple play tug of war with a towel, each holding onto opposite ends, while expressing the different sides of their power struggle, which may just be saying, "My Way." Couples often see the futility of this and drop into a more authentic place.
- *Turning Your Back:* Partners are face to face. As one begins to talk the other turns their back and walks away. Process feelings that arise.
- *Control Exercise:* Have partner A stand and face partner B. Partner A starts moving arms in various directions. Have Partner B try to control the arm movements of A. Then have partner A take the hands of partner B and say "move with me, I'll keep you safe". (example: A wife literally jumped up and wrapped her legs around her husband to try to control his arm movements. When we moved to the second part he took her hands and said, "move with me, I'll keep you safe." She said she could feel her body relax. He said he felt more like a partner and there was more room for him in the relationship) Then they began a dialogue about the experience. This exercise allowed them to experience an embodied sense of their power struggle.

- *Feet to Feet Push-Up:* (this provides a container for negativity) Have partners lie on the floor on their stomachs as if doing a push-up. The bottom of partner A's feet is in contact with the bottom of partner B's feet. As they move into a push-up while in this position, have them talk about a frustration.
- *Shoulder to Shoulder Push:* While on hands and knees have partners face each other. Partner A puts the soft part of their right shoulder against the soft part of partner B's right shoulder. You may also use left to left shoulder. Have them push against each other. Use your clinical judgment about whether to have the couple talk or make sound.

6.3. Negativity Interventions

(These exercises should be used prudently. Expressing negativity to a partner in this fashion may cause deeper wounding. Also be aware of previous abuse issues with each couple while using these exercises.)

- Before beginning this exercise have the couple determine a safety word such as "red." This means stop the exercise immediately. The person receiving determines the intensity of the contact. Have partner A hang over in a forward bend. Using the side of their fists have partner B rhythmically hit A's back, legs, and buttocks. (Instruct them not to hit A's spine or kidney area.)
- Put a tall cube between the couple and have partner A hit it with a tennis racket or hands while looking at partner B. Partner B holds a pillow as a protective barrier and also imagines a safe place before beginning this exercise. (Explain to the couple before they begin the 90/10% rule: This means the frustrations being expressed are 90% about the person expressing and 10% about the person witnessing or receiving.)
- Partner A twists a towel while letting anger come through their eyes, sounds or words directed toward Partner B.

6.4. Cooperative Exercises

(Verbal communication is very important in these exercises)

- *Tree pose (as in yoga):* Partners stand side by side facing the same direction with inside arms around each other's waist. Each does the same tree pose by bending their outside leg and putting their foot on the inside of their straight leg, leaning out with the knee and forming a triangle with this leg. Then they take their out-

side arms up over their head and clasp the hand of the other or place their palms together with their partner. Take a minute to breathe together in this position.

- *Back to back:* Partners sit back to back with knees bent and feet on the floor in front of them. They sit as erect as they can and with their buttocks pressing toward one another. They interlock arms at the elbow. Now with each applying pressure toward the other's back, have them stand using only their legs. This exercise is to demonstrate interdependency.
- *Face to face:* Partners stand face to face and grab each other's wrists. With feet hip width apart, move feet closer to partner and lean back. Now bend knees and go down to sitting position on floor. Now reverse movement to standing position.

6.5. Connecting/Containing Exercises

- *Breathing:* Sit face to face with partner A mirroring partner B's breathing for 1–3 minutes. Do this exercise with eyes open and/or with eyes closed (depending on the couple). Reverse and have B mirror A.
- *Spoon tuning:* Partner A lies on his/her side with knees bent. Partner B lies behind partner A, fitting the front of their body against A's backside. B puts arm around A (Spooning position). Partner B mirrors A's breathing. (Reverse.)
- *Writing Love Messages on Partner's Back:* Partner A draws individual letters to spell a message on Partner B's back. Partner B receives and verifies the message.

6.6. Supportive/Receiving Exercises

- *Giving and Taking Directions of Support:* Partner A sits comfortably on the floor and partner B sits between A's legs with his/her back to A's front. Partner B then instructs A how s/he would like to be supported or held.
- *Human Barrel exercise:* Partner A is on his/her hands and knees in the crawling position. Partner B stands at the feet of A and bends backwards, slowly lowering him/herself so that B's lower back is supported by A's buttocks. B may place his/her hands on A's back for support as he/she continues to bend backwards until they are back to back. Depending on the couple's physical capabilities, A can move into the convex and concave ("cat/cow") movement. To get out of this exercise, A slowly sits back onto his/her feet using his/her arms as support, thereby lifting B. They end the exercise by sitting back to back. This exercise requires continual dialogue between the couple to be sure they are each safe and supported.

- *Forearm support:* A extends his/her forearms forward, palms facing down, elbows slightly bent. B faces A and in a gentle hold supports A's arms by placing his/her forearms under A's forearms with palms up.
- *Holding Exercise:* (So the holding partner can remain emotionally warm, do not use exercise to discuss the relationship. Because of the regressive potential inform couples that this exercise should never lead to a sexual experience.) Partner A as the holder, sits with back support against a wall, sofa, etc. Partner B stands facing A on their right side. B then sits on their feet or cross-legged beside A, right hip to right hip. With arms folded on their chest, B lies on his/her side across the front of A, head nestled with an ear to A's heart. A is to support the full weight of B's body. This is to replicate an infantile position for B. B may then speak about childhood memories, while A listens. A may mirror but does not ask questions. A's hands need to remain still. There is no patting or rubbing.

7. Conclusion

I hope this paper inspires others in their work. As a Bioenergetic therapist my hope is that it inspires other Bioenergetic therapists to use what we already know about working with individuals and apply it to working with couples, while also adding the structured dialogical component. I also hope it inspires other Bioenergetic therapists working with couples to share their knowledge with the broader community.

I also offer workshops on the energetics of relationships to the Imago community and am always rewarded with interest and fascination on the somatic elements, so my intention is to develop other workshops and learning opportunities about Bioenergetics for that group.

Being trained in both Imago Relationship Therapy and Bioenergetic Analysis has allowed me to experience and facilitate a deeper level of discovery about romantic relationships. I trust the process and believe the authentic and energetic need to love and be loved will lead to healing, vulnerability and intimacy.

In order to have intimacy one has to have safety and as David Finlay (2010) says,

> "(Intimacy) is a state where we can feel understood, safe, physically strong and capable, able to empathize and help others. Through intimacy our fears can be tamed. Intimacy as a way of harmony may be our best chance of finding our way home on levels ranging from the cellular to the soul, personally and interpersonally, perhaps even nationally and internationally" (p. 31).

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The Importance of Integrating Pre- and Perinatal Issues into Bioenergetic Analysis

Wera Fauser

Abstracts

English

This article deals with the importance of integrating pre- and perinatal issues into Bioenergetic Analysis (BA), since our individual story begins long before we can look into our mother's eyes. The pre- and perinatal period creates our first foundation, our first grounding and our first attachment in this world and the way we experienced our time in the womb and our leaving this first abode and what happened in these earliest moments and days can strongly affect our entire later life. After an introduction, a short historical survey and a chart depicting for body-oriented therapy relevant stages of prenatal development, I will describe examples of pre-and perinatal trauma. For some of these examples clinical vignettes are presented that should emphasize that the consideration of these earliest themes are not to be neglected especially in body-oriented therapeutic methods like Bioenergetic Analysis.

Key words: prenatal development, pre-and perinatal trauma, early attachment, therapeutic procedure

German

Dieser Artikel handelt von der Bedeutung, prä- und perinatale Themen in die Bioenergetische Analyse (BA) zu integrieren, da unsere individuelle Geschichte schon lange vor dem ersten Blick in die Augen unserer Mutter beginnt. Die prä- und peri-

natale Periode stellt unser frühestes Fundament, unser erstes Grounding und unsere erste Bindungserfahrung in der Welt dar und die Art und Weise, wie wir die Zeit in utero erlebten, wie wir unsere erste Behausung verließen und was in den ersten Momenten und Tagen post partum mit uns geschah, kann unser ganzes späteres Leben stark beeinflussen. Nach einer Einführung, einem kurzen historischen Überblick und einer Tabelle der für die Körpertherapie relevanten pränatalen Entwicklungsstadien werde ich Beispiele für prä- und perinatale Traumen aufzeigen und zu einigen davon Fallbeispiele präsentieren, die unterstreichen sollen, dass eine Betrachtung dieser frühesten Themen besonders in körperorientierten Methoden wie der BA nicht vernachlässigt werden sollte.

French

Cet article traite de l'importance d'intégrer en analyse bioénergétique (AB) les problématiques prénatales et périnatales puisque notre histoire individuelle commence bien avant que nous puissions regarder dans les yeux de notre mère. Les périodes prénatales et périnatales créent nos toutes premières fondations, notre premier enracinement et notre premier attachement au sein de ce monde. Ce que nous vivons dans l'utérus et ce que nous éprouvons en quittant cette première demeure, ce qu'il se passe durant ces tous premiers moments et ces tous premiers jours, peut nous affecter profondément, et ce, pour le reste de notre vie. A la suite de l'introduction, d'une brève étude historique puis d'un tableau décrivant les étapes pertinentes du développement prénatal à l'intention des thérapeutes psychocorporels, je donnerai quelques exemples de traumas pré et périnataux. Des vignettes cliniques illustratives montreront combien nous devons prendre en compte et ne pas négliger ces thèmes, notamment en thérapie psychocorporelle telle que l'analyse bioénergétique.

Spanish

Este artículo aborda la importancia de integrar los problemas pre-perinatales y perinatales en el análisis bioenergético (BA), dado que nuestra historia individual comienza mucho antes de que podamos mirar a los ojos de nuestra madre. El período pre-perinatal y perinatal establece nuestra primera fundación, nuestra primera experiencia de arraigamiento, nuestra primera experiencia de apego en el mundo y la manera en la que experimentamos el tiempo que pasamos en el útero, así como la

partida de esta primera morada y lo que tuvo lugar durante esos momentos y los días anteriores. Todos estos factores pueden afectar inmensamente el resto de nuestra vida. Después de una introducción, una breve encuesta histórica y un gráfico que representa la terapia de orientación corporal de las etapas relevantes del desarrollo prenatal, describiré ejemplos acerca del trauma pre-perinatal y perinatal. También introduciré viñetas clínicas con ejemplos relevantes que enfatizan la importancia de tomar en consideración y no descuidar los temas pre-perinatales y perinatales, especialmente cuando se trata de métodos terapéuticos orientados al cuerpo tal como el análisis bioenergético.

Italian

Questo articolo riguarda l'importanza di integrare le problematiche pre e perinatali nell'Analisi Bioenergetica (BA), dal momento che la nostra storia individuale inizia molto prima di quando possiamo guardare nostra madre negli occhi. Il periodo pre e perinatale crea le nostre prime fondamenta, il nostro primo grounding e il nostro primo attaccamento in questo mondo e, il modo in cui abbiamo vissuto nel grembo materno, il nostro lasciare questa prima dimora e quello che è accaduto nei primi momenti e giorni, possono influenzare fortemente tutta la nostra vita successiva. Dopo una introduzione che comprende una breve indagine storica e un grafico che raffigura le fasi rilevanti dello sviluppo prenatale per la terapia ad orientamento corporeo, porto degli esempi di traumi pre e perinatali. A partire da queste vignette cliniche risulta evidente che i temi precoci non non devono essere trascurati soprattutto dai metodi terapeutici ad orientamento corporeo come l'Analisi Bioenergetica.

Introduction

"I am inside a cave with a torch in my hand. I feel very good and think what a funny experience this is. Then I am walking along a dark channel when suddenly my torch starts to flicker and I feel panic that it may lose all its energy and leave me in the darkness. Will it last until I can manage to get out of here? I doubt it. I am sure that nobody will ever find me in there. I wake up shivering and in total fear of dying." (Birth-dream of a client, a wanted child with a Blue-Baby-Syndrome, born with the umbilical cord three times around his neck. A priest had already given him an emergency baptism, because his survival was so unlikely.)

Whereas until the late eighties the embryo and foetus were seen as a mere accumulation of cells without any sensitivity, and newborns and babies up to four to six months were operated on without being narcotized, more and more the realization that the unborn and just born baby is equipped with an independent, elementary emotional life and receptivity and a rudimentary memory has become more accepted in the medical and therapeutic world.

The fact that the unborn and newborn has been able to experience the life in the womb and his birth particularly via body-sensations and physical awareness (Dowling 1991, Emerson 2000, Janus 2000, 2013) is gradually playing a more important role especially in bodily-oriented psychotherapy. It is from our first prenatal and perinatal experiences and impressions that we all derive our fundamental attitudes, our deepest conclusions and convictions about life on earth and about what we might expect from those who take care of us.

Never again in life will we be that vulnerable and dependent on just one person than during that early time. Without our mother we cannot survive the first three quarters of our prenatal months, whereas after birth others can take over the role of the mother and can at least help us to stay alive. Our first abode was absolutely the only place in the world where we could ground ourselves, where we could grow in a hopefully secure and welcoming atmosphere, and the way we could settle there as well as the way we left this abode, has shaped our existence and is engraved in our brain and our body.

If this intra-uterine bonding and grounding or the extra-uterine attachment during the first few weeks and months have been severely disturbed, and in case our birth had taken place under traumatic circumstances, it will have the deepest effects on the entire psychic and physical development of the child (Bauer 2011, Nathanielsz 1999, Schore 1994, Verny 1995). Will the baby be strong, resilient and self-confident or rather weak and not provided with much ability to tolerate stress? Will it be able to keep its temper or will it be nervous, hyper-active or in constant alarm? How will it be capable of concentrating and sleeping peacefully? How much basic trust will it have? How much deeply rooted mistrust? What kind of a character will it form? What kind of diseases might it get later?

This earliest period of our life can also be responsible for the development of mental disorders or psychosomatic diseases (Janus 2013, Nathanielsz 1999, Schore 1994).

The most decisive and most damageable time certainly is the period of the so-called *"foetal programming"* during the first 12 intra-uterine weeks when the organs are being developed and the earliest withdrawal-reflexes come into being (Blomberg 2012, Dowling 1991, Emerson 2000, Nathanielsz 1999).

As undisturbed, relaxed and at ease the unborn had been allowed to live, and the

more powerfully it can enter the earth with no birth complications and of course provided that it has afterwards been cared for and raised in a relatively optimal way, determines how relaxed he can be in his future life.

Fundamental answers cannot be found solely by considering the genes and the experiences days and weeks after birth but by literally going back "to the dark wonderland of womb life" (Verny 2013) and to the roots of pre- and perinatal experiences to find the basic melody of our life. Therefore, this article will focus on these issues and leave aside the obviously also very important and character-forming months and first years after birth. Due to limitations of space only some of the mentioned issues can be described in detail.

1. Historical Introduction

The psychoanalyst *Otto Rank* was the first to acknowledge already in 1924 that the relationship between mother and child begins long before the child is born and that pre-and perinatal memories were true memories. One of his main statements referring to this matter says that prenatal feelings and experiences and the ones during birth could essentially influence the dynamic between therapist and client (Verny 2013, in Janus 2013).

Both Otto Rank and *Gustav Gruber* investigated this subject and described it systematically.

Otto Rank attached more importance to the intra-uterine issues and the birth experiences than to the oedipal complex which in 1926 led to a breach between him and *Freud*, who was not willing to revise or expand his psychoanalytical concept.

Otto Rank could imagine the time in the womb as the very beginning of the mother and child relationship and is considered as the precursor of Ego-Psychology.

In the thirties the Hungarian psychoanalyst *Sándor Ferenczi* realized the importance of the preverbal time in the womb and in the first year after birth and was occupied with the issue of the rejected unborn and baby (*The Unwelcome Child and His Death Drive*, 1929). Not knowing anything about birth-trauma he valued this procedure as an event of omnipotence.

All of the analysts mentioned above, as well as *Nándor Fodor* in the fifties, who also had been interested in this subject and emphasized the traumatic aspects, did not meet with a positive response and remained outsiders.

Alfred Adler rather looked at the aspects of feelings of inferiority and power-

lessness during this period. He was the first psychoanalyst who did not idealize the intra-uterine phase.

In *C. G. Jung*'s archetypes one can also find references to prenatal themes.

Like Freud, *Wilhelm Reich*, had been more concerned with postnatal drive concepts and *Alexander Lowen* followed Reich in this tradition.

During the last three decades research on and the preoccupation with these issues of early life, initiated by classical psychoanalysts, has been taken over by more body-oriented therapists and physicians. Referring to pioneers like *Arthur Janov* (*Early Imprinting*, 1984) and *Stanislav Grof* (*Topography of the Unknown*, 1983), it was *Terence Dowling* and *Alfred Tomatis*, who developed new approaches to help their clients or patients to dive into the pre- and perinatal period of their life. In the eighties Tomatis was the first to re-enact traumatic womb and traumatic birth experiences and he used the mother's voice on tape or in reality as a remedy. Also one of the most important scientists and therapists, *William Emerson*, has been working with children and adults on this theme for more than 30 years now (Schindler 2011, p. 8).

Meanwhile pre- and perinatal issues and early trauma are gradually being considered within the bioenergetic world. For the exciting journey back to the very roots, Bioenergetic Analysis with its definite body-orientation within the frame of a secure and hopefully step-by-step, trustful and warm therapeutic relationship and with its elaborate know-how concerning trauma in general, actually seems to be especially suitable for this task.

Fortunately neurobiological research nowadays affirms the necessity of a physical approach to preverbal subjects. Neuronal network-patterns are prenatally determined by the genetic disposition, but as the neurobiological findings prove, they depend in their evolvement on the experiences within this habitat (Bauer, 2011). *"Prenatal traumata are burned into the brainstem, like Bruce Perry (2005, p. 18) formulated and this prenatal trauma sets the limits for future brain development"* (Schindler 2011, p. 55). These early patterns form strong connections particularly if negative or traumatic experiences have been made which lead to fixed convictions because the foetus or newborn draws all conclusions from his narrow little primary world (Gerald Hüther: *Die Macht der inneren Bilder*, 2008).

Unfortunately, it is normally completely unconscious that this overshadowed world outlook stems from the very beginning of our life and is therefore, of course, too simplified. Moreover one can hardly change it by pure verbal therapy and mere mental insight. Modern brain research has proved that we tend to perceive and repeat what is already known to us and the new and unknown is rather turned off in the brain. Once our first coping strategies are learned we will stick to them and prevent ourselves from learning and trying new solutions.

2. Important Stages of Prenatal Development

Time	Division	Size (ca.)	Characterization
1st day	Early Development	0,1 mm	Conception, Fertilization
day 4–5			Free Blastocyst
day 5–6			Adhesion of the blastocyst on the uterus's mucous membrane. Nidation. At present **the basic plan of body and brain is female**.
3rd week		0,2–2 mm	**Three-leaved embryonic disc**, beginning of the **spine**-development, (primal vortex), **a small brain is functioning after only 20 days. The stem-brain develops first and grows quickly**. Shortly afterwards the heart begins to beat. Nervous cells are spreading all over the body. Skin and brain spring up from the same cell layer (ectoderm). A part of the nervous cells is being locked up in the emerging brain, another part floats in the abdomen and forms the **intestinal brain**. The **unmyelinated dorsal vagus (DVC)** is developing. This enteric system functions almost independently from the central nervous system (Porges, 2011).
4th week	Embryonic Period	2–5 mm	A yolk bag produces stem-cells of leucocytes and erythrocytes, **arm- and leg-buds** can be recognized, **the umbilical cord** is created. The embryo is swimming in the amnionic cavity.
5th–8th week		–40 mm	**Organogenesis** From week 6 on, the sense of touch is the 1st sense to be developed before seeing and hearing is possible. Shortly afterwards the **embryo is able to hear** the mother's (or twin's) blood circulation and intestinal noises. From week 6 on: **muscles emerge, first active movements. Muscle training stimulates the creation and linking of nervous cells.** From week 7 on, the muscles distribute Dopamines and Endorphins. **Emotions can now be suppressed by contracting the muscles, which weakens the perception**. From week 7 on the gonads of future boys produce Testosterone. **Fingers** and **hands** come into being before the feet develop. Eyelids are shut now. **The Babkin-reflex** (Blomberg, p. 115) starts to develop. If later in pregnancy it touched the palms of the hands it might bend the head forward, open the mouth and make sucking movements **to train for later breast-feeding**. This reflex continues for 3–4 months after birth. In case the newborn does not suck properly, the palms of the baby can be massaged to stimulate the Babkin-Reflex. **The fear-paralysis-reflex** as a stress-reaction is now being established as a very early retreat-reflex. If the pregnant mother experiences a lot of stress in the first months or the unborn child is threatened, it might stay in a **state of freezing and immobility** for most of the time (DVC, Porges, 2011).Or in a **state of constant stress** and adrenalin and cortisol (SNS) is poured out (Blomberg, p. 109).

3rd month	Foetal period	–9 cm	Legs and arms grow. Taste-buds can be seen in week 10. In week 11 **the Plantar-reflex** develops as an early grasping reflex and **trains the movement of the toes to be able to cling on to someone**. Like the Babkin-Reflex, another grasping reflex, it also supports the later breast-feeding. From week 12 on the **sex is recognizable** and identifiable. The organs come into being. First reflex actions and reactions occur after being touched (Abortion, abortion attempts, Amniocentesis in week 16/17). **The Moro-reflex** starts to develop and should be fully formed in week 30 (Blomberg, p. 113f.). It is also triggered by loud unpleasant noises, quarrels, fighting, disagreeable or threatening touches like being boxed or hit from the outside. The yolk bag disappears since liver and spleen function now. They produce their own blood corpuscles and can detoxify the blood now without having to send it all back to the mother. From week 14 on, thumb-sucking is practiced. The grasp-reflex is now beginning to be developed.
4th month		–16 cm	**Bones** are perceptible, **joints** are created. Swallowing reflex and sucking reflex. A separate closed blood circulation system allows some more self-regulation. The whole **5 million eggs are developed in the female foetus**. From week 16 on **noises and sounds** from the outside world can be perceived.
5th month		–25 cm	Hair growth: Fur-like Lanugo-hair covers face and body. Mothers can now feel the movements of the foetus. The beginning of the **myelination**. **Until the end of month 6 all neurons (100 billions) are built. Especially the part for perception is completely active**. Parts of the limbic system are now developed and are networking. The **amygdala** is fully functioning now (LeDoux 2002). From week 24 a rapid increase of **myelinated vagal fibers** (**Ventral Vagal Complex**, VVC, Porges, p. 122). After birth the linking of the neurons continues in all parts of the brain. **The synaptogenesis of the cortex only begins after birth. Postnatally it takes 6 - 8 months until the orbitofrontal cortex functions fully** (Herman 2010, p. 90). In week 18 **the asymmetric tonic neck-reflex** (ATNR) starts to develop. When the foetus turns the head to one side, the arm and leg are stretched to the same side whereas at the other side of the body the arm and the leg bend. This releases kicking movements and is a **training for the birth-process** (Blomberg, p. 114). **The ears are now completed, the ability to hear is entirely formed.**
7th–8th month		–35 cm	Via hiccup in the last three prenatal months **the diaphragm** is trained. In month 7, specialization is already completed. From now on the embryo only puts on weight. Communication between mother and unborn functions via **right hemispheres** (A. Schore). The eyes are open, lungs work but are still immature. The foetus is viable.

38th–40th week			Birth: *"The human infant is not born with a completely functioning myelinated vagal system. The mammalian vagus is only partially myelinated at birth and continues to develop during the first few months postpartum"* (Porges, p. 122). If there are no medical interferences the foetus defines the exact time of leaving the womb and pushes itself off the contracted stable wall of the uterus **by the toes. In fish-like, involuntary movements it starts the journey.** (The more the unborn had to protect itself, the less mobile and vigorous it is during the birth-process.)

3. Examples of Circumstances Causing Prenatal Trauma

"... the amygdala is fully functioning in the second half of the prenatal period, and if the unborn baby perceives through sensory activity a situation threatening survival, this will be stored in his amygdala. Moreover, if the mother perceives a threatening situation, the amygdala nuclei of the unborn baby will also register the perceptional context along with the mother's physiological response" (LeDoux, in: Janus, *Die pränatale Dimension in der Psychotherapie*, 2013, p. 160).

- Abortion-attempts
- Longer duration of strong ambivalence and feelings and thoughts of rejection
- Chronic anxiety and stress
- Severe depression
- Premature uterine contractions (the earlier, the more frequent, the more life-threatening they are)
- Longer use of tocolytics (meds to suppress premature labor)
- Violence and quarrel in the partnership or in the close surrounding, (e.g. screaming, being boxed, kicked, pushed)
- Natural catastrophies, accidents, shootings, terror, war
- Separation of the parents
- Medical problems like Gestosis, Eklampsia, Preklampsia, etc.
- In-utero death of a twin
- Lack of food
- Abuse of alcohol, medicine, nicotine, drugs (Frank Lake, The Toxic Womb Syndrome)

3.1. Abortion-Attempts

Abortion-attempts are always very traumatic experiences and result in the deepest form of schizoid frozenness. In panic the heart begins to beat fast, then the tachycardia ceases, the embryo shies away, and in a fear-paralysis-reflex falls into total numbness by activating the dorsal vagal complex (Porges, p. 292). The embryo stays there and has to defend against the danger from the outside, against its own panic and the fear of being attacked again or of being caught when finally coming out.

Possible consequences:

- deep-rooted coldness
- severe depression
- feelings of profound worthlessness
- reduced vitality and weak perception of the body
- feelings of not belonging to this world
- psychoses, paranoia
- strong feelings of mistrust, unsociableness, even Autism (Dowling 1997)
- hospitalized movements
- uncontrollable fits of aggression
- chronic pain-syndrome
- feelings of being threatened in human closeness (Lowen, *The Betrayal of the Body*).

3.1.1. Case 1

"A sky-scraper stands in the middle of a torrent. I live on the first floor and can only get there by boat. I think: For god's sake that's where I should live, I need to escape at once. The torrent gets worse, it will sweep me away. How can I ever manage to reach the shore?"

"Someone hands me a little lifeless child with terrible strangulation marks on the throat and, horrified, I think by myself: How can people do this to a child?"

A woman of 50 years, a mid-wife herself, had been in therapy with me for almost 6 years.

She came because of her hypertension, her repeating nightmares, her severe depression and her being incapable of working. In her marriage with her much older husband she felt "hemmed" in as if she felt hindered to breathe. She was the 6th child of seven, with two miscarriages right before her. It was not certain whether the mother had on purpose induced abortion with them. But during therapy she found out that this was

certainly the case. From the start she remembered her dreams clearly and gradually it became obvious and was later coldly confessed by her mother that she had tried to get rid of her several times by using knitting needles. What the mother did not know at that time was that she had expected twins and when one embryo left, she stopped further efforts. My client later experienced herself in utero as being a frozen foetus in an awful conflict: She was afraid to stay and afraid of coming out.

Actually she was born 3 weeks too early via an emergency-cesarean with the umbilical cord twofold around her neck. Her mother often told her that her birth was the most dramatic one of all of her births, because she suddenly had started to bleed and for a long time this bleeding could not be stopped. When born, my client was blue and unable to breathe. Both mother and child were in mortal danger and were separated from each other. The doctor and nurses grabbed the newborn by the feet, held her underneath cold water and kept hitting her on her back and her buttocks until she finally cried, which she did more or less for the following three days and nights. Fortunately her grandmother sometimes turned up and carried her around because her mother could not care for her.

When the baby was three months old, her mother arranged an operation for her, because my client's spider naevus (lesion) at her throat annoyed her. This operation was not completely successful and had to be repeated at the age of six months. Both operations were undertaken without any narcotics. From then on she was described as a very quiet and well-behaved baby and child.

When she was older she tried in vain to win her mother's love by helping her as much as she could. Fortunately her warm, accepting father, an architect like her husband, was, besides the grandmother, a compensation and without the two of them she *"... might have died very soon"*.

3.1.2. Case 2

"I crawl up a steep hill to a tower on the top. Inside is a hole and I climb down, head first along a narrow channel until I come to a little cave. Suddenly a knight attacks me from the right hand side with a lance, then another one with a lance from the left hand side. I press myself against the wall and try to hide."

"I can see myself in an igloo standing in an artic landscape. I'm all alone with no-one to turn to. It is terribly cold and I have no idea how to survive in such coldness."

In 1986 at the age of 32 a very pale, haggard psychologist *"full of fear, hate and rage"* came into my office looking more dead than alive. The above dreams he called his

"standard dreams of my childhood" with no idea what they meant. During therapy he realized and felt deeply that, *"already there had I lost all hope, all optimism, all joy and trust in life"*.

He had been living in almost total isolation thus far, with only one student-friend and regular visits to his family. He had never had any close contact with women and it took all his courage to come to me now, because he *"could not stand life anymore and was considering suicide."*

His parents had been very poor and lived together with the mother's mother in one flat.

He was the first child and the mother was very ambivalent about her pregnancy. Since the grandmother and the unemployed father who had a drinking problem and later became an alcoholic, were definitely against a baby, she and her mother had tried for several times to get rid of him by using knitting needles. When they did not succeed, his grandmother finally said: *"Let us stop, somehow we will manage to get the baby through."*

During his birth his mother fell into a coma and stayed there for three weeks. Every four hours the nurses took him to her and thus he was at least breast-fed for a while, even though she did not notice him and it felt very embarrassing to him. His mother needed months to fully recover and his grandmother cared for him most of the time.

When he grew older he became a very beautiful child and his mother started to cuddle him, which ended abruptly when his brother, who was four years younger, was born. The economic situation had improved and they lived in their own flat now.

In recurring dreams he was haunted by war-scenes and murderers chasing him. At the beginning of therapy his only safe place was a space-shuttle far away in the universe with at least a direct talking-line to me. In 1990, after 4 years of therapy he left because he had finally got married and his wife and he expected a child. He returned 10 years later, just separated and stayed a few months to get over it. In the beginning of 2013 he showed up again, because he and his girlfriend, a warm sociable teacher, planned to live together after five years of acquaintance.

3.2. Chronic Anxiety and Stress

"In comparison to most of the other mammals the placental contact between mother and child is especially strong. Hormones, medications and toxic substances need only a few seconds until they flow through the mother's blood circulation into the placenta. For a

short time the placenta can even function as a buffer against them, but if the distribution continues they reach the unborn" (Terence Dowling, seminar 2006).

In cases of chronic anxiety and stress the unborn is flooded with a lot of maternal stress hormones like adrenalin, cortisol and noradrenalin, which all stimulate the sympathetic nervous system and generate tachycardia. *"In a tense environment the blood of the foetus rather flows to the muscles and the brain-stem to supply those parts of the body that are necessary for a life-saving reflex-behaviour. Owing to this protection reaction less blood flows to the intestines and the stress-hormones also suppress the function of the basal forebrain"* (Lipton 2007, p. 174). For a while the child can regulate itself but if the situation continues the child suffers under constant stress and the exhausted stress-system can cause infections, since the immune system is weakened (Bauer 2011, p. 47, p. 117). This can later lead to various diseases like colitis ulcerosa or Crohns Disease. Usually these babies, thus made insecure, are very anxious and clinging and tend to cry a lot.

3.2.1. Case 3

A professor at the age of 57 came to see me after 700 hours of psychoanalysis, because some of his most annoying symptoms like burn-out, hypertension, chronic sinusitis, bronchitis and the inability to feel well when alone had not changed. The analysis had concentrated on the early parental divorce and on his violent stepfather. He had gained a lot of understanding for himself, but still felt that he could not relax and feel comfortable in his own body.

He was the first child of a mother who had tried to chain her weak, latent homophile husband, a gifted painter, to her. When it became clear that he would never really love her and be a responsible father she regretted the pregnancy, and was in constant worry that she might not manage to raise a child all by herself. He was born two weeks late via an emergency-caesarean and was covered with infantile eczema and furuncles (boils). His mother refused to hold him or nurse him and only every now and then gave him his bottle. Whereas, she left the clinic within two weeks he stayed there and was finally put into a dark small room *"to die"* where his father found him two weeks later. He took him to a university hospital where he was treated with antibiotics for five months. His mother had gone back to work and never visited him and his father came rarely.

After he had realized that his symptoms had a lot to do with the suppressed feelings of the unborn and newborn, the symptoms gradually vanished and he started to be more considerate with himself by doing sports, eating less food as well as more

wholesome food and working less. He is now in the middle of a dramatic journey back to his earliest injuries and his deep desperation and frozenness.

3.2.2. Case 4

A woman in her late thirties, a doctor and therapist herself, was sent by a colleague, who felt that she needed body-oriented therapy and not merely talking therapy. Literally, since she had moved into the house of her current husband, (where he had lived with his first wife who had left him against his will) she had developed a grave colitis (Crohns Disease) with sporadic heavy bleeding. Shortly before I first saw her she had been in hospital and the doctors now advised an operation to remove the infected parts, which scared her a lot. She described herself as being under stress very easily; even the packing of her luggage to go on holiday stressed her awfully.

She was the second child of a young, insecure mother who had lost her son two years ago during birth because of an iatrogenic mistake. During her second pregnancy, being still traumatized by the loss of her beloved son, she felt a lot of panic that she might also lose this child. The mother later confessed that she was afraid of loving my client and building a strong prenatal connection to her as a protection for herself.

In many dreams and prenatal exercises my client remembered this period as a time of *"complete loneliness"* and her body as being stiff and immobile. Being born she met a very sad and exhausted mother who for three weeks put her away in a children's home at the age of three months, because the parents found that they needed to go on holiday. When the parents fetched her *"she was a completely different baby, very thin and fragile"* since she had not really wanted to eat and additionally had suffered from diarrhea.

Daring to gradually feel the connection between stress and her stressful and sad beginning of her life helped her to recover without needing any operation so far. And even though she is not yet totally cured the bleeding has completely stopped.

On the deepest level of her prenatal time she found the parallel between her mother and her husband. For both of them she was *"the wrong person"* and her mother *"would have definitely preferred if her son had survived instead of me."* And her husband would have liked to still be with his first wife. After trying couplse therapy she finally moved out and is now divorced. This is a step the unborn could not take!

3.3. Lack of Food During Pregnancy

The growth and the development of the child can be lastingly affected by the lack of food during pregnancy. It can be seen as the deepest form of orality. In case this

lack occurs during the first three months of the pregnancy, the development of the organs could be influenced and they could be irrevocably undersized (Nathanielsz 1999).

Consequences:

1. The liver cannot regulate the cholesterol level sufficiently, which can cause chronic hypertension and arteriosclerosis.
2. The pancreas does not produce enough insulin to assimilate normal amounts of blood glucose. Diabetes is likely to be developed.
3. A general risk to suffer from overweight and cardiac and circulatory troubles in later years.

3.4. Alcohol Abuse: An Intoxicopathy

Besides nicotine, alcohol belongs to the most damaging poisons during pregnancy. Each year about 10,000 babies in Germany are born with physical or mental damage. 2,000 of them suffer from severe and irrevocable defects. The pregnant mother's consumption of alcohol is far more often the cause of physical or mental harm in children than genetic diseases. Even small amounts of alcohol in the first three months of pregnancy can drastically damage the development of the embryo's optic nerve by reduction of the vitamin A level. Furthermore intoxication can lead to hypertension and renal insufficiencies. In severe cases, (which we usually do not see in our private practice) it results in deformities of the face (Downing, seminar, 2006).

In the second trimester of pregnancy alcohol can disturb the building of the nerve-cells whereas in the third trimester it can destroy the already existing neurons. In comparison to nicotine abuse enough blood reaches the unborn, but the blood is intoxicated so that the child has to protect itself and its liver must carry out heavy labour.

Physical Protective Measures: With the help of the contraction of the psoas muscles the unborn adducts its little legs to pinch off the groin. Thus the heartbeat is reduced and the child waits in a protective position until the level of the alcohol decreases and the dilution of the poison, (all of which must be processed through the developing liver of the foetus), starts. Gradually the heartbeat comes back to normal again.

3.5. Nicotine Abuse: A Deprivation-Syndrome

Nicotine is one of the most damaging poisons constricting the development of the body and the brain. Even a relatively small dose of this poison (about 6 cigarettes a

day) is enough to vitiate the growth and the brain development. Postnatal hyperactivity is seen in this connection (Dowling, 1997).

If the pregnant mother had been smoking or was forced to chronically smoke passively the risk of having a still-birth or a preterm birth or a caesarean rises. The newborn babies are usually lighter, smaller and have a diminished circumference of the head. More often they suffer from allergies, asthma or infections, more frequently they later become addicted to tobacco and/or overweight, and can show developmental retardations and problems concerning learning and their behaviour (Dowling, 1997).

The unborn inevitably has to "smoke" with the mother causing the following results:

- Shortly afterwards the concentration of nicotine increases in the blood of the mother and the unborn.
- The supply with oxygen and nutrients deteriorates.
- The nicotine causes stress in both organisms and the blood pressure rises which leads to tachycardia and the veins and arteries get tighter and thus impede the blood circulation. The blood first supplies the brain that is essential for survival and flows away from the abdomen and the extremities, which get cooler and less supplied with blood.
- Even the mother's wish to smoke provokes tachycardia in the unborn.
- The carbon monoxide creates an oxygen deficiency that can lead to a so-called "false suffocation" and the organism is in a state of alarm and distributes a lot of adrenalin.

Physical Protective Measures: The unborn can better protect itself from the poison in comparison to alcohol, the anoxia, however, is very threatening. By an accelerated heart beat the baby pushes the blood out of his own blood circulation back to the placenta and thereby it has to do excessive work that can tense or even enlarge the heart. This can later result in the feeling of "I have to work to survive" (See Case 5).

3.5.1. Case 5

The 46 year-old teacher, born in Lithuania, came to me because of burnout, constant stress and her bad contact to her only daughter. Her mother worked as a medical doctor and midwife in a clinic. Twelve times she herself had successfully completed abortions via a suction apparatus when she finally *("I have no idea why")* decided to keep my client alive. Relentlessly, she smoked *"2–3 packages of cigarettes every day"* and on weekends she liked to drink heavily. My client was born with an enlarged heart and hepatitis and a *"very tense body"*. She used to cry for hours and only the grandmother could calm her down. For months in therapy I had to appease her be-

cause she was in a state of chronic hyperarousal and stress. She could hardly be still for a while and relax and as a mother she used to be very demanding, impatient and even aggressive toward her own daughter. It took us a rather long time to realize how early these patterns had been installed and how difficult it was to change them.

4. Examples of Perinatal Trauma

"Birth is the greatest challenge to human survival … (it) … disrupts the fetus's dependency on maternal physiology and expels the fetus from this secure environment" (Porges, p. 83).

- Premature birth
- Umbilical cord around the neck with anoxia
- Cyanosis, Blue-baby-Syndrome (or other reasons)
- Cesarean Section
- Breech delivery
- Suction cup delivery
- Forceps delivery
- Precipitate delivery
- Placenta praevia
- The use of ebolics during birth
- Postnatal separation without any bonding because of an amniotic liquid aspiration or other medical problems of the mother or the baby

4.1. Cesarean

Primary cesarean: 5 to 10% and planned before birth because of a medical indication and without any uterine contractions. Usually done under a general anesthesia or less often under a peridural anesthesia. (At first the mother is 'gone' and shortly afterwards the unborn is also numbed.)

Secondary cesarean: Unplanned and suddenly necessary because of complications during the birth process. More often the child here can experience uterine contractions for a while. Usually done under peridural anesthesia.

Wished cesarean: Planned on an appointed time without medical reasons and without any labour pains. Tendency increasing.

In the USA caesareans are the most frequent operations and the rate lies between 25–50 % depending on the specific clinic (Emerson, 2013, p. 90).

For the mother the big belly wound means pain and a long scar and the risk to get a thrombosis and embolism and for the child it can also have grave effects, such as the following:

Respiratory problems: Since there is no body-massage as during a normal birth to press the amniotic liquor and/or the meconium out of the child's lungs it can come to an amniotic liquor and meconium aspiration, which often results in lung infections and breathing problems. A Swiss study showed that *"a cesarean increases the risk for asthma in comparison to a normal delivery about 80% ... and that the rates for cesareans and asthma are rising in parallel in the last decades" (*RNZ Wissenschaft, p. 15, December 2008).

Missing physical experiences: The numbed mother cannot encourage the baby. The first very important full body massage and the experiences of one's physical boundaries of a vaginal birth are omitted. Furthermore, the child is bereaved of the experience of being active and effective and it cannot co-determine the time of the leaving. Involuntarily, mechanically and often too early he is quickly taken out of his warm abode.

Nursing problems: This frequently occurs since the milk is produced one day later than normally and the mother is weaker and more strained.

Bonding disturbances: The intoxicated mother needs longer to recover and be really there for the baby. Sometimes, due to medical complications, a separation is necessary.

4.1.1. Case 6

"Nazi soldiers abruptly and violently open the door of my room. They give me no time to get dressed or pack anything. They grab me firmly, I have to leave at once."

Three years ago a young teacher, suffering from allergies, chronic sinusitis and severe asthma combined with fits of panic, came to see me. Like her older sister she was born via a planned cesarean together with the third daughter, her twin-sister. Unfortunately she had swallowed too much amniotic liquid and meconium and had difficulties breathing. Whereas her mother stayed with the other twin, she had been taken to a special hospital and had to stay there for two weeks. Her mother never visited her and she developed pneumonia. During therapy she realized the relationship between her early suffering and her actual disease and the panic. She lost her fear of dying and after undergoing several respiratory infections is now almost completely healthy. Since then she never again had any life-threatening asthma attacks.

During the therapeutic process she became aware of the fact and expressed it with wonder that, *"my inner child had not yet realized that it was already born without any birth-massage and without a loving touch afterwards."*

4.2. Breech Delivery

The baby does not glide with the head but with the pelvis down towards the birth channel, while the legs are folded up and cover the body and the head. The baby thus finds itself in a very difficult situation. The more it tries to fidget and follow the natural need of the legs to move and to push against the uterus wall the worse it gets and the baby experiences helplessness and impotence. If there soon is competent help this might not be necessarily traumatizing, but if this is not the case the little head and the vertebra are submitted to high pressure and a strong drag force. Frequently the baby gets stuck and anesthesia has to be given to the mother and she loses the contact with her baby.

Typical later consequences: Feelings of anxiety and impotence, drug abuse, back pain, spine disk problems, blockage of the sacroiliac joints. The pelvis area is often very tense which can cause cystitis and myoma. The following is a case involving breech delivery.

4.2.1. Case 7

"I'm sitting in a wheelchair and I desperately want to be able to walk, but no matter how hard I try I cannot move my legs. Usually I wake up in panic."

One reason to come into body-oriented therapy was this repeating dream of a forty-two year old nursery-school teacher. Besides that she mentioned that she could not go to sleep without having drunk 6–8 bottles of beer, that she was afraid of the darkness, but also afraid when it was too bright and that she could not go and visit her mother in the hospital, because of panic attacks approaching the building. She could not explain her symptoms, since she was a loved child and had a rather good relationship with her parents.

When working deeper with her dreams it turned out that the person in the wheelchair was not yet born. When she asked her mother she told her that she was a breech delivery and had been stuck in the birth channel for almost an hour (and) three doctors, and three nurses had pressed and pushed against her belly and the mother's pain had been so unbearable that to her greatest relief she finally had received laughing gas and did not remember anything else.

Gradually and after a lot of preparatory bioenergetic work with her legs, she needed several healing re-experiences of her birth until the panic lessened. After two and a half years of therapy she left me and had no more inclination to drink alcohol to ease the pain of the baby (she had been) as the laughing gas once did.

4.3. Suction Cup Delivery

The most frequent vaginal-operative delivery is when the unborn gets stuck in the birth canal, the heart rate decreases or the mother cannot press. By generating a vacuum the baby is pulled out with the suction cup tight around his skull. Sometimes this works very well within a relatively short time with little risk for the mother and the child, but in difficult cases complications can be quite serious.

Possible consequences for the baby:

- Swelling and/or strong deformations of the head
- Hematomae and injuries of the skin
- Kiss-Syndrome (Atlas-Axis induced asymmetry)
- Panic with tachycardia and mortal fear

4.3.1. Case 8

A very beautiful 34 year old single woman came to me with the feeling *"I am ugly, I am not okay, I have nothing to say, nothing to determine, I am afraid of closeness and I would need my own slow tempo but never have it. I feel completely numb in my body."* Her mother had had eye-tuberculosis as an adolescent and when she gave birth to her first son, my client's 3 years older brother, the scars in her eyes burst and she had been blind for several weeks after delivery. She was very afraid to receive a second child, but her husband persuaded her and with constant worries she became pregnant again. During the second birth she was not allowed to press at all because of her eyes and my client was dragged out via a suction cup. *"In total shock and way too early"* as she found out later in therapy, she entered the world. Her freezing state that could have been released by a loving comforting mother was even aggravated because her cool and unempathic mother refused to hold her, because her *"head was elongated and strewn with blue-green hematomae and swellings."* The nurses took her away for several days, because the mother could not bear the sight of her.

5. Therapeutic Procedure

Stabilization

"The injuries can only be healed in the same way they were primarily generated: In the relationship with another human being" (Herman 2010, p. 90).

- Verbal anamnesis (recollection) including the time of the mother's pregnancy and the birth, without dramatizing, just registering
- Physical anamnesis
- Establishing contact and building a trustful relationship in a safe, warm and welcoming atmosphere
- Mental reinforcement
- Help for self-help and learning of techniques to calm the amygdala
- Grounding in mother earth and one's own body
- Introducing physical relaxing and self-strengthening exercises
- Focus on the resources and inner healing power and self-regulation
- Encouragement of working on one's resilience
- Gradually enhancing the breathing
- Working with the right distance and closeness and – if allowed – with touch and holding
- Grounding in the therapist's body, especially when the standing position does not feel right or seems impossible and there is yet no pleasant and secure place to find in oneself
- Mindfulness based stress-reduction, sensitive awareness exercises
- Anxiety and immobility must be uncoupled, methods to come out of freezing and dissociation must be learned
- Dream analysis without interpretation from the therapist's side. The client will and can find his own answers.

Re-Experience/Trauma-Reconstruction

"Un-discharged toxic energy does not go away. It persists in the body and often forces the formation of a wide variety of symptoms such as anxiety, depression, unexplained anger and physical symptoms from heart trouble to asthma" (Levine 1997, p. 20).

Since the prenatal and early child does not have a developed prefrontal cortex and hippocampus, which is only fully mature at the age of three years, these early events and injuries can not be understood by cognition, but they will be stored in the amygdala as wearing emotions and symptoms (Herman 2010, p. 60).

To communicate with the early traumatized prenatal or perinatal child one has to speak the language of the brain stem, the limbic system and the body-memory. A right hemisphere to right hemisphere dialogue between the therapist and the client should be established (Shore, 1994).

When dreams, physical postures or memories show up that indicate pre-or perinatal trauma (sometimes they are there from the very beginning) the process step by step goes back to the womb-time and the birth experience with the help of:

- Working with dreams
- Learning to differentiate between the adult and the child, the therapist and the original caretakers
- Understanding the symptoms as the language of the wounded child
- Carefully developing analytical understanding and the discovery of the why and when and what happened
- Fingerprint diagnosis (Dowling, Nathanielsz)
- Diving deeper into one's sub-consciousness and one's inner world by bringing the client into an alpha-state (Place of super-learning, Lipton, 2007)
- Technique of guided imagery in an alpha-state. Without any information about the time in utero or about the birth one can precisely perceive and feel what happened
- Re-living and re-experiencing the time in utero and/or the birth in a healing new way
- Sometimes literally going back into a symbolized womb, covered underneath a darker sheet, and with the legs grounded in the therapist's belly. In a dialogue with the unborn we can find out how it really felt, why it may-be did not want to be born or in some cases why it had a reluctance to settle down in the womb of this specific mother at all. The client must deeply understand and learn to believe, that the danger is over, that if he now moved and lived fully in the womb and in his life and if he decided to be finally born there is no cold or disinterested or disturbed mother anymore, but that he will now be received and accompanied by a warm, welcoming therapist and the grown-up part of the client himself.
- Prenatal breathing
- Specific rhythmic breathing exercises
- Specific prenatal rhythmic physical exercises for the integration of the not integrated primitive reflexes. These rhythmic exercises also dampen the sympathetic tone, promote activation of the emotive, social vagus (Porges, 2011) and a stimulation of the brainstem. They are done while the client is lying down and the therapist moves the client rhythmically and softly, beginning with the feet, then the knees, hips, chest and head.

  This specific passive rocking simulates the mother's movements, heartbeat and breathing. By activating the brainstem, higher parts of the brain structures are also positively influenced and can maturate (Blomberg), 2011); the limbic

system can thus be soothed, that supported fight, flight or freezing behaviours (Porges, p. 190); and the HPA axis activity can also be inhibited.

- Establishment of the natural, involuntary birth-reflex that shakes the freezing loose and helps to prepare for the re-living of the delivery
- Finding out which primal instinctive reactions had not been carried out and have to be performed now
- Learning to express and integrate deeper feelings
- Understanding and integrating that one is no longer trapped inside a cold or rejecting or intoxicated home
- Several re-enactments of the birth process are usually needed until the clients really feel their own efficiency and potency and until they can realize that they are now able to manage to be born in a normal way with a now strong and grown up body
- Learning to find completely new solutions
- Understanding that the prenatal and just born baby had only very few possibilities to react, and could neither flee nor fight and that this is not the case anymore
- The therapist should go into resonance and feel what the baby felt without being overwhelmed and should encourage and comfort the inner child (Bauer 2011, Levine 2011, p. 65).
- The linking of the pre- and perinatal child's brain-stem and limbic system with the cortex and prefrontal cortex of the grown-up gradually has to be strengthened to help alter the strongest and earliest convictions and to better understand and finally accept the most deeply rooted experiences and perceptions of this period of life and to mentally and physically realize that it is all over.

6. Conclusion

Never again in our life will we be a part of someone else, will we be so deeply connected to someone else, so fundamentally influenced by someone else, never again will we be so vulnerable and dependent. Even before looking into the eyes of our mother we 'know' a lot about her personality, her strength, her health, her feelings, her sexuality, her attitude and especially about the quality of her bonding and loving feelings toward us. Our personal story starts long before we are born and if this first bonding was sufficiently optimal and positive, our birth-experience uncomplicated and our perinatal time with the mother was warm, loving and undisturbed, it provides us with a very important first secure base in this world. In cases where this did not happen it is inevitably necessary to go back to the very be-

ginning of our earliest and most forming injuries and imprintings, otherwise they will never be annihilated.

The prenatal and perinatal period creates the first important foundation and, of course, this period is just the beginning of a long story, but a beginning that can make a permanent impression on our entire later life. As Thomas Verny put it: *"Consideration of pre- or perinatal traumas without an exploration of subsequent traumas is as incomplete as psychotherapy that neglects the pre- and perinatal period"* (Verny 2013, p. 203).

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Feeling Ridiculous and the Emotion of Shame in Physical Experiences During Analysis

Giuseppe Carzedda

Abstracts

English

In this article, a clinical case is discussed according to Bioenergetic Analysis, focusing on the theme of shame and its presence in the patient's inner experience of feeling ridiculous when carrying out physical exercise proposed during psychotherapy.

Two aspects of the therapeutic process are highlighted: first, how the elaboration of this feeling can begin at the very early stages of therapy and second, how within dyadic analysis, the resulting complex and intense affective valences implied can render the approach to such a task quite problematic.

Such difficulties lead to the reconsideration of the role of the emotion of shame. Generally, it must be recognized as an integral part of the process of the individual's psychological development; the relevance of intersubjectivity within the analytic relationship is rendered even more evident. From this theoretical/clinical perspective, considerations derived from a phenomenological approach are recognized as having particular importance, as even imagined looks can assume a central relevance along the two-way relationship bridge that unites the therapist with the patient.

Key words: self defects, emotions of self-consciousness, shame, ridiculousness, narcissism, inter-subjectivity, grounding.

German

In diesem Artikel wird ein klinischer Fall aus der Bioenergetischen Analyse diskutiert. Er befasst sich mit der Scham, die ein Patient erlebt, der sich bei der Durchführung körperlicher Übungen während der Psychotherapie lächerlich vorkommt.

Zwei Aspekte des therapeutischen Prozesses werden hervorgehoben: Erstens stelle ich dar, wie dieses Gefühl schon in einem frühen Stadium der Therapie ausgearbeitet werden kann, und zweitens zeige ich auf, wie die sich daraus ergebenden komplexen und intensiven affektiven Wertigkeiten eine solche Aufgabe innerhalb der dyadischen Analyse recht problematisch machen.

Solche Schwierigkeiten führen zum Überdenken der Rolle der Scham. Scham muss allgemein als ein integraler Teil des Prozesses der individuellen psychologischen Entwicklung gesehen werden. Noch offensichtlicher ist die Bedeutung der Intersubjektivität in der analytischen Beziehung. Aus dieser theoretisch-klinischen Sicht haben Betrachtungen, die aus einem phänomenologischen Ansatz abgeleitet sind, besondere Relevanz. Selbst imaginäre Blicke können einen zentralen Stellenwert in der interdependenten Beziehung zwischen Therapeut und Patient erhalten.

French

Dans cet article, il sera question d'un cas clinique en analyse bioénergétique mettant en lumière le thème de la honte, de même que la présence de ce sentiment dans l'expérience subjective du patient qui se sent d'être ridicule au moment de faire les exercices physiques proposés dans le cadre de la psychothérapie.

On fera ici ressortir deux aspects du processus thérapeutique : premièrement, comment ce sentiment s'élabore dès les premières étapes de la thérapie, et deuxièmement, comment, dans le cadre d'une analyse prenant en compte les interactions dyadiques, les intenses charges affectives en jeu qui en résultent peuvent poser problème dans la manière d'aborder cette tâche.

De telles difficultés amènent à reconsidérer le rôle joué par le sentiment de honte. De manière générale, on doit reconnaître qu'en tant que partie intégrale du développement psychologique de l'individu, la pertinence du concept d'intersubjectivité à l'intérieur de la relation analytique devient encore plus évidente. À partir de cette perspective à la fois théorique et clinique, les considérations issues d'une approche phénoménologique sont vues comme ayant une importance particulière, alors que l'apparence physique telle qu'imaginée subjectivement peut revêtir une importance capitale dans cette relation à double sens qui unit le thérapeute et le patient.

Spanish

En este artículo se discute un caso según el Análisis Bioenergético, enfocando el tema de la vergüenza y su presencia en la experiencia interna del paciente de sentirse ridículo al realizar ejercicios físicos propuestos durante la terapia.

Se remarcan dos aspectos del proceso terapéutico: primero, cómo la elaboración de este sentimiento puede empezar en las fases iniciales de la terapia, segundo, cómo dentro de la díada analítica, las complejas e intensas valencias afectivas resultantes que están implicadas pueden hacer que la tarea sea bastante problemática.

Tales dificultades conducen a la reconsideración del rol de la emoción de vergüenza. Generalmente, debe reconocerse que una parte integral del proceso de desarrollo psicológico del individuo , la relevancia de la intersubjetividad en la relación analítica, se hace aún más evidente. Desde esta perspectiva teórico/clínica, se reconoce que las consideraciones que se derivan de un enfoque fenomenológico, tienen una importancia específica así como las miradas imaginadas pueden tener una importancia capital en la conexión bidireccional que une al terapeuta con el paciente.

Italian

Nell'articolo, attraverso la discussione di un caso clinico trattato con il metodo dell'Analisi Bioenergetica, viene affrontato il tema dell'emozione della vergogna e del suo possibile emergere nel vissuto soggettivo del paziente attraverso il sentimento del percepirsi ridicolo nelle esperienze corporee proposte in psicoterapia.

L'autore evidenzia come il processo terapeutico possa svilupparsi a partire dall'elaborazione di questo sentimento, ma anche come le complesse e intense valenze affettive che ne risultano implicate possano rendere difficoltosa la gestione di tale compito all'interno della diade analitica.

Tali difficoltà, che spingono anche a riconsiderare il ruolo che all'emozione della vergogna deve essere in generale riconosciuto all'interno del processo di sviluppo psicologico dell'individuo, rendono ancora più evidente la rilevanza assunta dal tema dell'intersoggettività all'interno della relazione analitica: in tale prospettiva di riflessione teorico-clinica viene anche riconosciuta una particolare importanza a considerazioni derivate dal pensiero fenomenologico e in base alle quali anche i soli sguardi pensati possono assumere una centrale rilevanza lungo il ponte della relazione che unisce bidirezionalmente il terapeuta con il paziente.

Introduction

Over the last *decades*, the renewed interest in psychological theories of consciousness has brought the ever-present theme of the relationship between mind-body back into focus, and inevitably with it, the need to overcome the Cartesian idea of separation between these two levels of functioning in an individual.

This revived attention is mainly the result of new discoveries and prospects. Studies have brought to light not only the adoption of relational and intersubjective models concerning psychological development and the dynamics that regulate the functioning of the mind, but also their no less important contribution in the field of neuroscience.

The influences on approaches leading to the field of body psychotherapy and, in particular, to Alexander Lowen's Bioenergetic Analysis, are numerous and profound, for example, the general process of revision and adaptation of the model such discoveries and prospects indicate. It must also be noted how numerous concepts originally formulated by W. Reich (Reich, 1973) and subsequently developed by A. Lowen (for example, cfr. Lowen, 1978, 1983) have taken on renewed importance and centrality.

Among these we can say it is precisely the concept of the functional identity of the *mind-body* that has once again found a particularly stimulating value from the point of view of both theoretical and clinical development. The merits of this concept, indeed still current today, must be recognized, not only for having opened up the way towards a holistic comprehension of the person in physical, behavioral and psychic terms, but also for having made it first conceivable, and then practicable that an analytic method, no longer based solely on the word, was possible and, finally that in a certain sense, analytic methodology had itself been dominated by verbal expression.

A particularly fertile concept which greatly stimulated this process of development and still today represents a fecund *humus*, is the concept of Self together with related emerging pathologies that we have to confront in our clinical work daily.

In this regard, we can consider that this experiential entity represents a privileged observatory for a psycho-physical matrix model such as Bioenergetics Analysis: in this sense even the subject discussed in this paper – the feeling of the *ridiculous* referring directly back to emotions of self-consciousness, in particular shame, triggered by a sense of exposure and nudity and the perception of the Self as being inadequate – can be seen as an example of this privilege, not only from a theoretical point of view in general, but also from a specifically clinical point of view.

The Case of M.

M. was an engineer of about 40 years of age, who had recently been promoted to a managerial position in an important firm where he had worked since graduating from university.

This new responsibility represented recognition on the part of the firm's management. They believed and invested in him, regarding him to be, not only the brilliant creator of new innovative practices, but also a gifted person with the right abilities and qualities for carrying out tasks of responsibility in the areas of sales and marketing.

This meant that after a very few months M.'s job underwent a radical transformation. In the beginning, his responsibilities were characterized above all by relations with colleagues, inside the business. Now his activities were suddenly projected outwards, requiring a completely new experience of self-exposure in terms of image.

M. felt very proud of himself for being recognized and, at first, was not intimidated at all by these new responsibilities. He considered them, after all, as part of the natural process in the ever-rising professional ladder, punctuated by a great deal of satisfaction and numerous successes.

In his account he underlined how, after an initial period of orientation regarding the new position, he had to stand in the so-called "frontline" before an audience of experts and several senior staff members invited for the occasion. The moment had arrived when he had to introduce not only the new services for which he was responsible, but also himself in this new role.

It was precisely on this occasion that something quite unexpected occurred, frightening him to the extent that he sought the help of a psychotherapist. Before the presentation, as the moment in which he was due to speak drew closer, he was suddenly overtaken by a fear caused by having to stand on the dais, a fear that turned into anxiety, increasing with each passing minute. The patient relates this episode as follows:

> "Suddenly I saw myself where my director had been speaking before me and I felt a sort of restriction in my stomach and chest; my heartbeat faster and I could feel the blood rushing to my face ... the prospect of having to stand before the gaze of everyone, exposing myself to their judgment, to their criticism, made me feel even less confident ... I tried to think of positive things to calm myself; to find my usual self-confidence, repeating to myself that what was happening to me was absurd, that everything was all right, that I was the only person in the hall with the expertise to speak about the subjects I was about to discuss ... but these thoughts did not help ... When I was called and had to stand up to go to the dais, I experienced something horrible ... I felt totally separate from my body ..., it was as if I were walking on a cushion of air and not on 'terra firma' ... at a certain point I was afraid that I might trip and fall ..."

Even the memory of the moment when he began to speak was still particularly painful and full of anxiety. The sensation of not being able to pronounce the words in a mental state characterized by a feeling of emptiness and disorientation made a specific impression on him.

Somehow he managed to begin his presentation and complete it, because, as he said, he was saved by a film he had prepared beforehand. The film helped him to keep to the topic of the discourse, but above all, to reduce the feeling of being the center of attraction and attention of those present. He defined this experience as the longest moment in his life, in which he also felt "undressed and with all eyes on me ... as if I were standing in a room whose walls were suddenly non-existent ..." With respect to what happened later that day, he remembered a strong feeling of anxiety characterized by both a need to find out what he looked like from the "outside" and the terror of having a more or less explicit external confirmation of what he had experienced internally.

In reality, some elements lead us to suppose that probably only a very small part of what he had experienced was visible externally, but this was obviously not the central point of the problem.

He was, therefore, very worried about what had happened and dreaded a similar recurrence in the future. The inner experience was also made worse by the fact that up until that moment he had not been able to find a plausible explanation for what had occurred.

The feeling that emerged from this first account was above all the fact that he no longer knew to what extent he could rely on himself. He felt "betrayed" by something unknown that had emerged in the form of an uncontrollable bodily experience of malaise, before which he felt, and still felt unprepared and impotent.

Regarding our meeting, he emphasized that it was the first time that he had ever turned to a psychotherapist; he had struggled against a part of himself that was tempted to let matters drop, putting it down to "a mere incident that can happen". However, he changed his mind once and for all, when he began to have dreams that re-connected him with what had happened. The common denominator in these dreams was the lack of control over his bodily responses in diverse contexts during oneiric activity – perspiring, increased palpitations, hot flushes and cold sweating.

M.'s account at our meeting, (the first of a collaboration which was to last approximately four years), enabled him to formulate several preliminary hypotheses which might in the context of this paper provide a starting point for further reflection.

An initial and simple observation concerns the grave narcissistic wound M. experienced. He had felt incapable of controlling himself and his reactions, above all, his bodily reactions – potentially visible especially before the eyes of his superiors and a packed hall.

For many reasons this was a traumatic episode. Regarding possible causes and failings at the basis of it, we can observe how the organization of the ego had maintained total cohesion and adaptability concerning its new tasks until the degree of self exposure before the outside world reached the threshold level – the conference, an important public event.

This situation had clearly revived feelings, which had previously been repressed. Their unexpected and uncontrolled emergence had caught his conscious functional system (on which rested his sense of equilibrium and self confidence), totally unprepared, causing the almost disastrous breakdown.

All this occurred because a series of concomitant circumstances, consciously desired and brought on by himself, had in a short time led him to realize that he needed to be able to organize himself and his emotions. He had unexpectedly discovered that he did not possess this ability, at least in certain contexts.

Reading the experience in structural narcissistic terms (Kohut, 1976, 1985; Kaiser, 1999) what stands out is the presence of an unrealistic and dysfunctional self-perception; several deficient but decisive parts of the Self had been hidden until the moment his unquestionable merits, abilities and resources were to find confirmation in a situation of exposure such as the one he had experienced.

Another aspect we can learn from M.'s account concerns the type of emotion he was overwhelmed by – its emergence following the unexpected self-perception of excessive visibility and exposure just prior to making a public presentation, and to a particular public at that. Both this and a series of precise elements which emerged during the course of the analysis, made it possible to identify the real emotion of shame, which had lain hidden behind those intense bursts of anxiety and general physical distress.

At this point, we can note that six months had passed before M. became aware of the fact that the episode in question was above all attributable to this emotion of shame; he had had to face it ever since he was a child, but had always tried to avoid it in every way possible.

The moment in which he could name it and the inexpressible could be put into words was a significant turning point in the analysis and the way he expressed himself confirms this:

"I realize that apart from the public image that I always put on for others and for myself above all, I was always deeply ashamed ...the fact is that I always felt worthless and unpresentable".

Even in the light of this awareness, this *insight,* we can say that he had had to cultivate a partially narcissistic image to compensate for this ever-present perception deficit, capable of deeply undermining his self-confidence and self-esteem.

His state as a whole, accompanied by this awareness is characterized by an intense emotive perception of the self. This was confirmed by the fact that when pronouncing these words, even his body assumed several cringing postures typical of this emotion – head stooping forward, sunken chest, hidden further by rounded shoulders, eyes focused on the ground – and he found it difficult to come out of this position.

As mentioned above, several months passed before reaching this significant turning point. There were many intermediate stages in our work, during which we concentrated on a series of emerging feelings; feelings which were already "speaking" of shame (regarding its origins, or even calling it by name), long before this emotion could exist, let alone discussing it on a conscious level.

Among these sentiments one in particular recurs. It is found in our patient, but it is observable in many cases – feeling and seeing oneself to be ridiculous while performing certain physical exercises.

After about two months from the beginning of the analysis, this became clearly apparent for the first time during the course of the following session.

I proposed a classical exercise in Bioenergetic Analysis to M. to help him know himself better, to feel *held up* and *supported* by the ground from under his feet. This experience is based on the concept of *grounding*, first developed by Alexander Lowen (Lowen, 1978, 1983, op.cit.) to theorize and describe the existing relationship between state and the relative perceptions of oneself, specifically accompanied by dimensions of a more closely psychological nature, noticeable in single individuals.

On the basis of this concept Alexander Lowen used for the first time in the history of analysis, the standing posture in the clinical workplace. This allowed for an alternative to the more regressive supine position, which until this time patients had always adopted. This made it possible for them to look at themselves and aspire to a more adult self, characterized, (in a strictly evolutionary sense so to speak), by "standing on your own two feet", feeling at the same time the connection and the support under their own feet with respect to the ground.

M. had already begun to familiarize himself with this type of work during previous sessions. I invited him to repeat it, reminding him of what it consisted of including all the simple steps that he would have to attempt. First, he had to stand, keeping his knees slightly bent so that he could perceive the sensations rising up through his legs from his feet positioned on the floor; he could also keep his eyes shut if he felt that this would help him concentrate on his perceptions and internal sensations. Once he felt more in touch with himself and his body, I then invited him to pronounce the word "I" concentrating, however, less on the explicit and obvious meaning of the term than on the internal resonance the word might produce in him. I invited him to remember every now and then to pay attention to two other things – his

breathing and the dual sensation *of holding himself up* and *being held up* by his own legs and by the ground under his feet. Finally, since we were at the beginning of the session, I emphasized that for this exercise he could take all the time necessary without hurrying. The exercise lasted about twenty minutes altogether without saying a word. Several very interesting things happened during this period from the point of view of implicit and observable non-verbal communication.

For specific reasons of interest, only what happened in the five minutes preceding the interruption of the exercise will be described here.

In this phase, at a certain point, M. entered into a mind-body state in which his whole being expressed a profound and intense participation. For example, the tone of voice became deeper while pronouncing the word "I", his posture was less prominent, his shoulders were slightly closed around his chest but not fallen, his facial expression over which there appeared a slight flushing was concentrated and the sound and the rhythm of his breathing became deeper and more synchronized. This state lasted no more than 30 seconds, after which at a certain point he lost it almost as if he had interrupted the exercise on purpose. Shortly after, however, he spontaneously tried to pick it up again without either of us saying anything in particular. After a while he managed to find the breathing rhythm again, showing at this point a renewed interest and curiosity in what he was unexpectedly experiencing.

Suddenly, signs of an increasing and unmistakable discomfort began to appear in his body. For the most part of the exercise his eyes had been closed, but now they opened, looking uncomfortable and evasive, as if trying to avoid being "seen" by himself (apart from the fact that I was sitting opposite, watching). Then he started to move his body rather nervously, signs of a growing rigidity and disjointedness increased, his breathing lost its fluidity and fullness and it was not long before his previous state had vanished, or disappeared.

When he sat down he was visibly shocked and confused, so much so that I suggested that he take his time before trying to tell me about how he had felt and what had happened to him. According to his account and from the reconstruction work carried out together, it emerged that at a certain point, just before the interruption, he had had a profound sensation of *"feeling whole"* from head to toe. Initially, this state was very pleasant; it was also accompanied by a pleasing, flowing sensation running throughout his body in various directions, creating an unexpected feeling of solidity and vitality. All this also reinforced both the perception of strength and the feeling of *selfsupport* in his legs, eventually becoming a pleasant and reassuring sensation of *heterosupport* received through the floor under his feet.

At this point, even though it was pleasant on the one hand, on the other, this per-

ception of himself began to make him feel progressively exposed and at the mercy of something; the more this sensation grew, the more he felt that he was losing control and getting closer to an unidentified danger. This state became unbearable when suddenly, in a flash, *seeing himself from outside* and *seen by me* as well, his self perception became that of an *"awkward and profoundly ridiculous person ... in that position and with knees bent! ..."* it was at this moment that he interrupted the exercise.

On analyzing similar sessions, above all, in sequence followed by diverse inner experiences and states, we observe how the first patients emerged, especially those who indicated decidedly positive signs – an opening up towards self-awareness, characterized by self-control, integration and vitality.

With the opening of this door and the process of expansion and amplification of the diverse sensations, M. began, however, to feel increasingly less able to contain and self-regulate what he was experiencing, so much so that he feared being overwhelmed. Shortly after these sensations emerged, quite contrary to the first signs, the door which had been opened, closed. This also confirmed the well-known phenomenon based on the process of "feeling oneself"- the passage which accesses the unconscious, making it possible for any content present to emerge, independent of its identity. In this case, what emerged unexpectedly at the end was precisely the unbearable feeling of "being an awkward and profoundly ridiculous person".

What happened in this session is a good example of how access can be obtained through Bioenergetic Analysis. Starting from somatic input and bodily sensations, a basis is subsequently created to connect and integrate with other levels of representation. Different codes (for example, linguistic), mediate to increase the capacity of containing and regulating diverse affective states through the development of a more integrated sense of self at different levels of consciousness.

We can note how another aspect of Bioenergetic Analysis seeks the same objective, but follows an opposite path, initiating for example, from codified verbal representations in an attempt to reach the experience of correlated and concomitant body states (Lowen,1983, op.cit.).

In this session, M. came into contact with the sentiment of feeling ridiculous, starting right from his body sensations and perceptions, through the senses of proprioception and enteroception. The latter, in particular, is at the forefront of studies being carried out in the field of neurobiology (Damasio, 2003, Siegel, 2009).

It was, therefore, through these senses and the focus on the feeling of the ridiculous that the work with M. proceeded until an awareness of the emotion subordinate to shame emerged. Parallel to this, he was able to access through memory several repressed episodes experienced with his parents during childhood from where not only this feeling but also this emotion might have originated.

Emotions and Feelings

An important question to raise at this point, is the definition of emotion and feeling, terms often used without distinction. On the contrary, it is felt in the clinical environment that the separation between the two concepts is useful; it can assist in observing the emerging phenomena in a clearer and more distinct manner.

It is understood that these two concepts both refer to the same cyclical process, originating with emotions and terminating with feelings (Damasio, 2003). The first represents the component visible to the outside world, constituted by "actions or movements to a large extent in public, or visible to others at the moment in which they take place – on the face, in the voice or in specific behavior" (Damasio, ibid., p. 40). Feelings, on the other hand, are always hidden, as are necessarily all mental images, invisible to everyone save their rightful owner" (Damasio, ibid.).

An important implication of this distinction regards the fact that the body is directly accountable for both phenomena, albeit from different perspectives. While emotions are, in fact, reactions that are expressed at a physical and somatic level, feelings "are like *thoughts* representing the body during its reactive involvement and in its particular being: "emotions perform on the stage of the body; feelings are in the mind" (Damasio, ibid.).

During the course of analysis, therefore, and the Bioenergetic Analysis exercises we propose, our patients are invited to pay particular attention to what they *feel in themselves* rather than what they *think of themselves;* we direct them towards a process that begins from internal experiences and aims at making contact with *their body's feelings*, in an attempt to connect with other levels of representation which might subsequently be integrated at a more general level, in the most coherent narrative possible of themselves and their own history.

It must be emphasized that "conscious feelings draw attention to the emotions which generated them and to the objects which in turn induced those emotions"(Damasio, ibid., p. 216). Besides, since they become contextualized with respect to the self's autobiography, becoming part of the memory system, their role is facilitated in evaluating situations and states that can evoke certain emotions. In some cases when the feeling is connected, for example, to a particularly painful emotion, the organism is alerted of an incumbent state of danger and led towards defensive mechanisms or driven away.

The Ridiculous and Shame

What we have said so far makes it easier to understand what happened to M. and why the feeling of the ridiculous appeared in analysis before the emotion of shame could re-emerge and once again become a part of his vocabulary.

Above all we can interpret what happened during that traumatic event; what brought him to analysis. It can be said his unconscious was the first to be caught by surprise. Being quite unaware that up until that moment he had had to cultivate an unrealistic narcissistic image of himself, M. could not have anticipated that a public context, like the one he had found himself in, could have evoked such a violent and uncontrollable emotion. It was obviously too late to do anything more than try to get to the end of the experience in the least damaging way possible.

Subsequently, during the course of the analysis, as has already been noted, before being able to face the subject of shame, he had to confront the feeling of the ridiculous which during a previous session and on other occasions had represented both a danger sign and a *stop* that forced him, in various ways, into interrupting whatever he was doing.

It can be said, therefore, that this feeling functioned as a warning depending on the situation; in spite of being in the safe context of analysis, it was something to be feared since it could evoke an indigestible emotion to the "ego". This warning-feeling revealed by his consciousness meant more or less the following: "Be careful, if you go ahead with this experience you might feel ashamed of yourself".

On the contrary, it must be noted that while in analysis, it was possible to consciously isolate this feeling, going back to its likely origins and several of its meanings. Previously, throughout his life, however, such feelings of shame, originating with the emotion and at the same time evoking it, had always been repressed. He was, therefore, never able to experience the emotion in its potential function at any level, neither with anticipation nor consciously, so deeply was the distress hidden inside him.

With respect to this general mechanism of becoming aware of feelings at certain moments, we must remember that it is the body which keeps us informed about what we are experiencing, through its physical reflex mechanism and the signals which reach the central level of control (Ruggieri, 2001; Siegel, 1999). It has been hypothesized that this mechanism functions due to "somatic markers", defined as preceptors and representations of the body's states and their relative changes at the level of the brain (Damasio, 1994). Damasio has also spoken about somatic markers, "as if" they were able to trigger off a sensorial response by simply referring to representations of answers from our body locked in the reality of the moment, or even activated on the basis of remembering states or only one emotional experience in some way associated with each other. Another aspect we need to emphasize regarding this mechanism is that the "changes ... seen in the muscles of the limbs and face" are particularly relevant in that they can be seen "as essential components of our emotional reactions ..." (Siegel, 1999, p. 142).

Support regarding physical retroactivity mechanisms advocated by Bioenergetic Analysis, makes it possible to describe an ulterior part of the process which after two

months led M. to perceive himself in analysis as being ridiculous. If indeed we take into consideration M.'s exact words when he said he felt "awkward and truly ridiculous ... in that position especially with bent knees! ...", it can be hypothesized that it was this position of the limbs experienced as unnatural and awkward which set off a visual representation of himself looking "ridiculous". Such a representation had in turn originated in past experiences that were completely repressed in his consciousness, as it clearly emerged later during analysis.

The Visible Body

In order to understand the reasons why the body occupies such a central position in the emotion of shame and in the correlated feeling of the ridiculous, however, the examination of several factors is unavoidable when considering the matrix to which our work must inevitably be related.

One of the first observations to be made regards the fact that the body theme tends to be self-stimulating. Besides a person's immanent desire for greater self-knowledge and self-control of this fundamental dimension, there is a further corresponding ambivalence which is expressed, for example, in the existing debate between the polarities of looking at and being looked at, of being seen and being able to see oneself. This is because it is precisely through our visible body that we exhibit ourselves or we withdraw, revealing ourselves or removing ourselves. At a literary level, this has been frequently expressed through the representation of external polarities of the person or the character, the face or the mask, in other words between being and appearing.

We note how these dimensions refer to a body, which is already relationally engaged. The single imagined act whether conscious or unconscious of looking at and being looked at, is a relational event collocated along a line separating the interpersonal from the intrapsychic, between the narcissistic sphere and the object sphere. The forms such acts assume are functions: the categories of being the subject and feeling the object of observation are brought together according to diverse symmetries. Therefore, it is our body that makes us visible, that removes us and reveals us to ourselves and to others. It can be or become the object of a particular look perceived from all possible angles, between the polarities of good and evil, from being accepted or rejected. It is from this very point of exposure in so far as the body represents our interface in respect to the external world that all possible feelings ranging from pleasure, suffering and pain can be triggered.

We can say that it is through our body that our intimacy and the image of ourselves

is at stake. There is the potential of being made public or being at the mercy of the other, through becoming visible to the other's eyes.

On the contrary, from the intrapsychic perspective, but never clearly separate from the inter-personal (it is always superimposed and interconnected to it in various ways), the exposure of the body to itself has above all to do with self-image and a whole series of evaluations and judgments on which our sense of identity rests.

With respect to the central position our body adopts when exposing its identity, perception is transformed into knowledge; what we feel we are is turned into sentiment. It represents the ridge where the intersection between the level of the interpersonal and the interphysical becomes evident, where their inextricability is felt and, therefore, can be seen in a particular way, since the object of a certain type of attention is perceived and vice versa. This inner experience in the present is also deeply rooted in past experience where the matrix of interpretation assumed consciously and unconsciously in the feelings of now, is very much a product of bringing attention up to date, of looks received and suffered during phases of one's existence even at an early age, going back to those figures who cared for us.

Specifically, there is a need to highlight the way in which the body theme evokes a series of personal inner experiences at all levels of consciousness. From the start there is a complex game of mirrors and reflections from where the Self and the Other to some extent (even though somewhat ill-defined) are already represented in many categories.

Already defined by W. James in 1890 (James, 1890) as perceptions of corporal states, the theme of the body and its close rapport with the emotions is not new in the field of psychology.

The emotional category which is specifically of interest here concerns the emotion in which a particular characteristic is activated in response to a judgment expressed in its regard. In turn it presupposes the existence of a judge represented internally, but which is not necessarily real and present in the here and now.

These are the emotions defined by self-consciousness or self-awareness (Lewis, 1992), or even the interpersonal (Battacchi, 2000) in which confrontation with the other is perceived as the present.

Emotions such as shame, embarrassment, pride and sense of guilt come into this category; they can be distinguished from other basic emotions such as anger, sadness, surprise and joy. However, the other does not necessarily require their presence in order to be set in motion as defined above.

In the case of shame, in particular, it is the feeling of being seen and discovered before oneself or others (M. Lewis, op.cit.) which triggers the emotion. It is as if one were experiencing oneself according to those characteristics which are regarded as being unbecoming or ridiculous. This experience is pervaded by a perceptive type

of sensation whose access into the conscious can be very rapid, to the degree that it can provoke a sudden, violent and often disabling sense of nakedness and paralysis. It is often accompanied by a strong impulse to disappear, defined by Charles Darwin (Darwin, 1890) as central to this phenomenology.

Shame is categorized among those emotions which are defined as complex although this perceptive phenomenon is more or less immediate, often accompanied by manifestations attributed to the autonomous nervous system such as facial blushing, loss of strength, perspiration, accelerated heart beat etcetera. Compared to other emotions, it appears late during the course of development, requiring in terms of consciousness and self reflectivity the presence of a sufficiently developed Self.

In the case of emotional self-awareness, we ourselves are the objects of observation in the presence of conscious states: the attention is focused on the object Self and, therefore, inwards and towards states and stimuli that originate within (Lewis, op.cit.).

Analyzing the emotion of shame structurally, the bipolar level is clearly evident: the subject pole that leads to the Ego's Ideal and deals with the exposure of a defective part of the Self putting the ideal image of the subject at risk (Kohut,1986); the objective pole represented by the eye of the observer, the other who passes judgment. In that case, the knowledge or even just the thought of being the object of a particular type of look can trigger off this emotion.

Moreover, the intensity of the social impression of being involved counts insofar as shame can be seen as a signal of a possible, or even an already established compromise between the *good impression* and the subject's own self-esteem (Castelfranchi, 1998; Matarazzo, 1999).

What is more important to emphasize here, is the powerful somatic characterization of this emotion. It can instantly involve the body in numerous subject/object dimensions (cfr. in Lowen, 1985) to the point of putting the complex sense of the Self at risk in serious cases in which the whole person is invaded by a sort of overwhelming sensation. This is demonstrated in the case of M. who felt visible, found out, "naked" before the eyes of the external world, accompanied by the often unsightly and uncontrollable somatic manifestations of the neurovegetative origin mentioned above.

We can consider this emotion extremely important in the development of the therapeutic process (Lowen, 1984), not only for the whole series of representations which originate from it and in turn evoke it, but also for the diverse physical manifestations that precede and accompany its emergence within the psychotherapeutic experience, above all, if it is the corporal analytic type.

On the other hand, it can be observed how its centrality tends to be easily lost with the introduction of defensive mechanisms into the analysis by both the patient and the therapist. There is a tendency to deviate the focus of their attention on to

other emotive registers, for example, anger or the sense of guilt – emotions perceived as being more manageable both to access and to treat.

The reasons for this can be traced back to several specific and intrinsic characteristics of this emotion, which even taken individually, can partially explain this tendency.

It has already been said how this emotion appears with such unexpected and overwhelming attacks that the sense of self can be annihilated (Schore, 2008). Similarly, however, these attacks can disappear just as suddenly as they came, making way for other emotions, particularly, anger, but also sadness, envy and jealousy. So distressful and unbearable is the experience that its disappearance from the foreground of consciousness is strongly reinforced by the desire that it will never emerge again. This is certainly one of the reasons why it is so difficult to bring the emotion to the forefront for analysis.

Conversely, it can be considered a basically intersubjective emotion, and a noticeable characteristic in its phenomenal structure is that the self is divided and located simultaneously both as subject and other. For this reason it is also characterized by strongly contaminated valences which move along the relational bridge between patient and therapist – in both directions in a manner that is difficult to contain and is almost instantaneous. Feeling ashamed even through the simple observation of the other can put the therapists into direct, unexpected and very close personal contact with the patient. In such cases, the latter can be distanced through different types of defensive mechanisms, for example, by changing the analytical register.

Finally, we must remember a particular characteristic of the emotion that significantly contributes to rendering contact with it difficult. Different from guilt, in that one does not feel guilty for feeling guilty, it tends to strengthen itself in a circular manner: one feels ashamed for feeling ashamed. This is a greatly feared circuit for its uncontrolled self-perpetuating potential.

Shame in the Analytic Body Relationship

On the basis of what has been discussed above, it can be said that M. had unexpectedly and painfully discovered that he was not a good speaker. His professional history demonstrated that he had many other attributes but public speaking was not one of them, at least not at that moment.

With the emergence, in fact, of the state of uncontainable anxiety and distress, which consequently revealed a deep-seated and long repressed shame even at a personal lexical level, M. had experienced the possibility of freeing himself of the illusionary part of his own image. This was destroyed in an instant in that hall where he had been exposed

to potentially judgmental looks and the disdain of observers and in particular his superiors. At the moment in which his vulnerability became an unavoidable conscious and physical perception, only a few minutes before taking the floor, he unexpectedly wanted to hide and return to that reassuring state of anonymity. However, as usually happens with this emotion and all its related physical manifestations, it was precisely at the moment of maximum recognition and visibility of himself and of others that he felt completely stripped naked -"when the walls suddenly became non-existent". This sense of being totally unmasked (apart from what really transpired vis-à-vis the outside world) was so violent and all encompassing because the judgmental eyes his ego had to face were, above all, those of his consciousness, of his true self in front of whom it was neither possible to hide nor flee.

In this sense it was, however, both a moment of defeat, and at the same time an important moment of truth. M. could begin to detach himself from an illusory idea which up until then he had doggedly pursued. Not only had it threatened him insofar as he had been unknowingly engaged in challenges he was neither ready for nor even interested in, but it distanced him from a real awareness of himself and from the opportunity of being able to cultivate his more genuine resources and personal attributes with greater pleasure and not simply as a narcissistic derivation.

Obviously it is a most complex and difficult task to follow these objectives, as was the case of M. for all the above-mentioned reasons. The mere thought of experiencing shame brought back a particularly unpleasant inner experience in which he perceived himself as weak, inadequate and seriously deficient despite the fact that he had the desired final outcome to look forward to in the future, but it was not enough.

The transformation of this difficult inner experience into an opportunity for personal growth requires crossing a very complex terrain, not only for the patient but also for those of the analytic dyad including the involvement of the above-cited powerful intersubjective component – if in fact, we mean by the latter "this shared experience with another human being" (Trevarthen, 1998, cit. in Lavelli, 2007, p. XIX). The outcome of such a task might be evident, particularly in the presence of this emotion, and from the point of view of the therapist, even arduous.

From another perspective, these irrefutable difficulties can be considered in terms of parallel opportunities offered by our Bioenergetic Analysis model. The importance of the role that intersubjectivity (Orange et al., 1999) holds within the entire analytic body experience (up until now in the background) is pertinent to the theme of the body and all its implications with respect to the emotion of shame.

In this regard, let us consider the work on *grounding* again by observing this type of experience, within the original monopersonal matrix of the model, based on a psychological theory centered on intrapsychic functioning. For a long time, factors

contextualized in terms of psycho-body "blocks" were a principal focus. In this way the patient was limited or prevented from fulfilling his adult-self in a complete and profound manner, both in analysis and in life.

The types of interventions generally followed were mainly "patient-focused" aimed at eliminating those causes revealed at a strictly bodily level (tensions, stiffening, anaesthesia, etc.) considered decisive both because of their origin and their preservation of the here and now in the "block" itself.

Similarly, it is necessary to point out how this type of focus and approach contributed to hiding another important aspect of a specifically rational nature implicit in the use of vertical posture in analysis. The patient, in standing on his own two feet before the on-looking therapist, became a "visible" and observed body; he thus became not only a more adult *subject* capable of actively sustaining himself, but also, at the same time, an *observed body,* a state and position capable of strongly evoking all previously mentioned themes related to shame. In fact, the scenario can be considered relational, induced potentially by this type of exposure where one is standing before the Therapist-Other-Observer. It is, in a certain sense, archetypical in what this emotion can (even in relation to the numerous representations), consciously and, above all, unconsciously evoke.

Furthermore, it must be pointed out how Lowen did not fail to see the existing connection between exposure, particularly of the face (meaning the *face* in the accepted sense), regarding the expression of this emotion, even though he does not pursue a more in-depth study of the many related themes. "The word *face*," he said, " is used to refer to the image of a person, connecting the concept of the face to the ego ... *Lose face* means that the ego has undergone a humiliation ... *Hide your face* implies a sense of shame, a humiliation of the ego" (Lowen, 1983, p. 76; cfr. also Anolfi, 2000).

Moreover, it is generally true that whatever type of psychotherapy the patient chooses, this presupposes a visibility of intimate and fragile parts of the self. In other words, the patient *sticks his neck out*, insofar as it is his body that becomes visible and exposed, especially in this classic experience, as well as in all other bodily experiences offered to the patient present before us.

In this sense we must keep in mind that this path leading the patient towards being an active subject, able to increasingly protect himself, inevitably anticipates a territorial crossing dominated by shame, while being uncomfortable and at the same time delicate for the therapist and the relationship as a whole.

There are consequently numerous reasons for bringing this emotion to the forefront: most likely "... it is responsible for the path our psychic life follows ... more than sex and aggression ..." (Lewis, op.cit. p. 6).

Among these reasons in an evolutionary vision of the model and technique of Bioenergetic Analysis, there is definitely one in particular which forces a more open

confrontation with the relational dimension of analysis: the observation of what happens on that ideal bridge which bi-directionally unites the therapist to the patient even if it is only through imagined eye-contact.

We can to this effect confirm, as we have previously stressed, that the renewal of the psychological theory of awareness accompanied by the adoption of this theoretical-practical model is very significant: the focus of observation is no longer the patient-object, but rather it is the relationship itself that becomes the center of observation. The patient is given back his personal dignity, and at the same time, the therapist becomes "more of a person".

In this bi-personal logic, what happens in therapy, therefore, is not only "in him" but also "in me", between us"; it is above all, unconsciously shared and interactive in the depths of our relationship and our conscious mind-body state.

Let us return to the case of M. at this point and, in particular, to the session in which he interrupted the *grounding* experience when he felt awkward and ridiculous. This self-image also emerged as a result of the relational inner experience in analysis, especially at the moment when *he saw himself from the outside, seen by me* in the play of mirrors and reflections where my image became the eye of his judging consciousness.

During the following sessions, it was not easy to explore this area together with M. When, for example, after several meetings I suggested repeating the same *grounding* experience, he felt a deep antagonism towards me, saying that I wanted "to make him go through that unbearable sensation". While he was saying this to me, I deeply felt his distress and anger and inevitably had to face up to the sensations which were being activated in me – feeling myself an object of those powerful emotions and remembering well how, many years earlier during my training and also my personal analysis, I had sometimes experienced analogous sensations in a similarly painful way.

With this awareness I decided to continue cautiously without forcing the issue, giving myself time to take in the sensations that his intense inner experience had evoked in me, and integrate them more fully.

Together we took into consideration the fact that what M. was experiencing was not so distant and disconnected from what he had gone through at the conference. I think that this choice gave us the strength in the following sessions to find a reason and sufficient courage to try another experience of this type of exposure.

Moreover, I also think that this was why he was able consequently to start a process through which he began to gradually realize that the judge identified in me was in fact his own inner judge, and this allowed him progressively to take his attention off me and concentrate on the inner object within himself.

It was precisely during this process that at a certain point he was able to name the shame recalling how he "had always felt unworthy and unpresentable".

Slowly the doors opened to other memories, and in particular, those regarding his father. During several sessions, two years after the therapy had started, he came out with the following reminiscences:

> "I'm sure my father always loved me very much and I loved him too ... Several images remain impressed on my mind ... I was quite small, I'd say about three or four ... I especially remember his bright eyes, looking at me full of affection when he came home from work ... His eyes were always very important for me ... I always looked at them whenever I could because they told me that I was doing all right ..."

During the context of these sessions when the theme of looks (even in general), was a recurring topic, he brought this episode:

> "Last Sunday I went to my cousin's. After dinner we watched a few home-movies my aunt had made. One of these ... it was Christmas dinner ... I was about five. In our family on such occasions after eating and before opening the presents, my three younger cousins and I used to recite typical Christmas rhymes. In the movie when it comes to my turn, you can see my father pick me up and stand me on the chest where we used to recite. I began my poem with a show of confidence, but at a certain point I made a mistake and felt confused ... I tried to go on but I made another mistake. You can see within a few seconds how I changed expression and then began to cry desperately and before the scene changes you see my father's arms picking me up from the chest."

About that specific episode M. said that he had not remembered anything from that incident at all, not even after having seen the movie.

Seeing himself in those old movies progressively brought back other memories to do with his life with his parents. In particular, his father and the sequence in which his confidence abandoned him, turning into desperate tears after making a mistake, which lead him to presume that what had happened that Christmas might have happened on other occasions.

He began to remember how his father was visibly proud every time he had a success, for example, at school with his marks; how he could read this sentiment in his father's eyes which sometimes would glisten to the point of being overcome with emotion. But sometimes things didn't go well "and this easily happened ..." M. admitted. His father would suddenly become stiff and those eyes would change "into sort of sharp blades", far more effective than any verbal criticism. M. was forced to lower his eyes and enter into a state of implosion where at a certain point he could recognize that there was an intense feeling of shame.

In this phase of the analysis, his interest and growing curiosity for this emotion,

buried for so many years far from consciousness and now so much a recognized part of him, urged him to fill those empty spaces of his memory by visiting his parents to look at some of the old photo albums they kept.

One morning M. arrived for the session saying that after looking at these albums he had discovered something important. In one of them there was a series of photos taken by his father on the occasion of a school recital organized every year at the end of term before the summer holidays.

The sequence of these photos abruptly ended on the occasion of a play in which M. had participated when he was in the third grade. On asking his parents as to the reason for the interruption in the photo sequence, he was told that "the third grade recital had not gone well". Apparently at a certain point M. had been so nervous that he could not recite his part and from then on he had categorically refused to participate in any event of that type in spite of the insistence of his parents and various teachers.

Even after this clear and unequivocal account, M. only managed to find a vague memory of that particular experience and it was he himself who put down this mental void to the fact that it must have been "too horrible ... and I can just imagine how my father must have taken it ... I could only eliminate the memory of it".

This persistent void in his memory did not, however, interfere with the development of the process of an overall awareness of himself. Diverse experiences which had remained on the periphery or even totally excluded from his consciousness progressively joined together into a meaningful emotional coherence.

In his relationship with his father, mainly through eye-contact expressing affection or, on the contrary, unexpected rejection, he had come to the realization that he had experienced a condition "... of often feeling in heaven or feeling totally annihilated". In the presence of accepting looks like the ones exchanged during analysis or those in which he held a high degree of expectation as in the case of his commercial manager, he was aware that a feeling of deep distress could unexpectedly be triggered. The association with the original experience was unconsciously activated where the process of his opening up induced by a person could be a prelude to a great sense of humiliation and profound shame.

However, this and further knowledge integrated at a conscious level were of no use, until we had a session aimed at making M. a brilliant orator, a personal characteristic he had ideally believed to possess. This new knowledge served, for example, to make him aware of his limits and to be more cautious in his public encounters. He learned to read from notes rather than trust his memory and his ability to improvise. He began to accept his public image without feeling defeated and humiliated.

Above all, however, more generally speaking, this awareness enabled him to better manage and regulate his own states of shame in a process he himself had once defined with great satisfaction, "the capacity to unmask my own shame".

Conclusion

When shame is spoken of generically, in reality it is the family of emotions that is referenced (Nathanson, 1987). They can assume so many different forms, just like the numerous feelings that turn up at the door of consciousness such as the feeling of the ridiculous in particular. The latter is a dimension that is never easy to treat in analysis, and perhaps it is for this reason that there is a tendency to prefer other interpretive registers.

Apart from what has already been said, it is important to restore it to its central role of a constructed function (on this we fully agree), on the basis of which "it is shame that leads us to depression or antisocial behavior. Our interior struggles are not conflicts between our instincts and reality, but rather conflicts that typically see us struggling against the elements shame releases, and with damaging frequency" (Lewis, op.cit., p. 6).

The implications of this assumption are many for a model with a psychocorporeal matrix such as Bioenergetic Analysis, especially since the close relationship binds the theme of shame to that of the body. Given the privileged position of observer this method has always offered us, it is opportune to ask in spite of this, why the emotion of shame has received up until now such little attention both in terms of theoretical reflection and clinical practice. It would seem, in fact, that in adhering to its characteristics it has hidden itself, remaining, in these circumstances, distant from consciousness. However, it is evident that in so doing it has without a doubt continued to operate in an even more trenchant manner after a process of partial or total repression.

This observation obviously poses many important questions that can serve above all to stimulate a fruitful debate on the theme, not only of a general character, but also specifically within the Bioenergetic Analysis model and method.

In this context for the present, it must be emphasized that in the case of M. it was possible to obtain the result reached – that the patient felt he was an active subject, able to unmask his own shame – because the feeling of the ridiculous was kept in the foreground in the analyst/patient relationship – an arduous journey, and at times, fraught with difficulties.

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Bioenergetic Analysis, the Clinical journal of the IIBA is published annually and is distributed to all members of the international organization. Its purpose is to further elaborate theoretical and scientific concepts and to make links to enhance communication and broaden our connection with other schools of therapy, as well as with academic psychology, medicine, and other psychosomatic schools of thought. This journal has been published in English since 1985, making it the oldest journal for the IIBA.

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