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Maria Rosaria Filoni (Ed.)
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With contributions by Len Carlino, Thomas Fellmann, Louise Fréchette, Arild Hafstad, Yael Harel, Sara Invitto, Patrizia Moselli, Homayoun Shahri and Laurie Ure

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Content

Letter to the Journal

Honoring a generosity

Léia Cardenuto

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Dear readers of this Journal.

Some of our members that were born in the last century, like me, might have memories of the beginning of Bioenergetics, in America, as a great school of psychotherapy. At that time, when Lowen started to teach he gathered a few brave men and women psychotherapists to form a team of pioneers on body therapy, a technique that was as revolutionary as it was bold.

To be part of that team required a lot of passion. One of the most passionate was Ed Svasta, who had lefts us last year. I would say that passion is a word that could not define him properly, but because I didn't know him closely, I just stay of some of his acts that I could view.

I will tell you an anecdote, that happened when I was going to do a PDW (Professional Development Workshop) in Colorado. I am a Brazilian psychologist and had just received my CBT in São Paulo.

I went there by plane, with Liane Zink and Odila Weigand, my teachers, and we had a stop in New York that made us arrive a bit later to the place where the workshop was located. We missed the first meeting and Ed received us and gave us a lecture on how we couldn't have missed it! I was ashamed and at that moment felt him as a very strict teacher. And I also hoped I will not be assigned to his group. I wasn't assigned, but I was wrong!

I was with Virginia Hilton as my trainer there for those days, and I was enchanted with her way of teaching. But I, at the same time, I got to know Ed Svasta more. He was sweet, always caring of the students and schedules, and when the workshop ended, all groups and their trainers went to a place to dine. After dinner we stayed for a while, and each one sang songs of everyone's countries. I don't remember the music I sang at that time, but Ed, who was a very attuned singer, sang "Don't fence me in", an American popular song from "good old times". My English was not that good, but I understood that the theme of the song, (fences

as armors) fitted with Bioenergetics perfectly. This night we all sang and laugh, and this was a very good memory I have of him.

I changed my idea of him being a strict trainer and started to view him as a generous man, very concerned with the Bioenergetic Analysis interests.

So, that is why I was pleased to know, and not so surprised when I heard about his legacy. Ed Svasta, who was so loyal and committed to the IIBA, left some money from his state to our institute.

Dear Ed, wherever you are, receive our gratitude.

You teach us with your loyalty and strength, and I hope you will always be remembered by that.

Celebration of Life

William Eugene White
September 7, 1939–March 9, 2024

Robert Hilton

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My Memories of Bill

I met Bill in 1967. At that time, he had recently graduated from Yale Divinity School and was an associate minister at the First Presbyterian church in Santa Ana. Bill joined a minister's group I was leading at the Institute for Therapeutic Psychology, which was also in Santa Ana. Shortly thereafter, in 1968 I was introduced to a new form of psychotherapy called Bioenergetic Analysis.

For the next four years, I continued my training in this new therapy while Bill eventually left the ministry and pursued his studies to receive his Ph.D. in psychology. In 1972 the Southern California Institute for Bioenergetic Analysis was formed in Newport Beach, California. This was a local branch of the main institute in New York where the founder and author of the books on Bioenergetics, Alexander Lowen, lived and practiced. Bill was the first student to enroll in this new Institute.

In the seventies and early eighties Bioenergetic Analysis became popular in Europe and South America. After 4 years of training, Bill quickly moved from being a student to being a local trainer to an International trainer teaching especially in Italy, Switzerland and locally in San Diego. Bill was gifted in languages.

He did the New York times Sunday crossword puzzle every week in ink. He studied Greek and German in college and taught himself Italian so he could better communicate with the students he was teaching. Bill was so popular as a teacher that graduates wanted him to continue with providing therapy and supervision for them and thus they organized Master Classes which Bill conducted until he moved to be with us here at Regents a little over 2 years ago. One of these

Master's classes met for 25 years. Eventually he was unanimously voted by his peers to be the Executive Director of the International Institute for Bioenergetic Analysis.

Bioenergetic Analysis was not just a theory Bill taught but it represented a community of dedicated therapists. He joined a group of Bioenergetic trainers in 1979 that have continued to meet regularly for the past 45 years. When Virginia moved out here from New York in1985 having received her bioenergetic training there, she and I and Bill and Karen became close friends. We had dinner together every Thursday night. He was my golfing buddy for many years and the only witness to my hole-in-one.

Bill was the least narcissistic person I ever met. He was always more interested in the other person than he was himself. He was also a true master of his craft. He was dedicated in mind and heart to his task as a therapist. His brilliant mind and his compassionate empathy created an exemplar for us all.

To quote Shakespeare: "His life was gentle; and the elements so mixed in him, that Nature might stand up and say to all the world, THIS WAS A MAN" He cannot be replaced only remembered and loved.

The night before he left us his family gathered around him in his hospital room and sang as he directed them in beautiful harmony. It was just the day before that Virginia and I visited Bill. He sat forward in bed and said, "I may not ever see you two again so I am going to be very demanding," which was not like Bill. "I want to leave this life with an open heart. So, come, sit beside me. I want to tell you what you mean to me."

The next day he left us. His family, sister, brother and close friends were all there. It was an experience Virginia and I shall never forget. Members of the family took turns holding Bill's hand while others played a guitar and sang. They reminisced about their life with this marvelous husband, brother, father, and grandfather. They recalled camping trips they took and humorous things that happened. They laughed, sang and cried. This expression of love did not happen by accident but was a spontaneous testimony to Bill and Karen's enduring love. I know that even though he could not respond, he heard and was pleased that his desire had come true, he was leaving this world and going home with an open heart.

In closing, I share this silent meditation using Bill's last words to me and Virginia.

Please take your time and in memory of Bill and the expression of your own heart, place your hand on your heart while you read his words. Let your heart be your guide as it explores the meaning of each line in *your* life.

I may never see you again
I want to leave this life with an open heart
Come, sit here beside me
I want to tell you what you mean to me.

Editorial Note

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Dear Colleagues of the IIBA Bioenergetic Community,

You may know that the issue of our Journal that you are about to read has been composed by a new Editorial Board: Thomas Fellmann, Yael Harel, Josette van Luytelaar, Homayoun Shahri and Rosaria Filoni. We are grateful to all the colleagues who preceded us with great passion and competence and we hope that we will also be able to do a good job. On the last page you can see our faces and read some information about who we are. For the last few months, we have been preparing this issue that we hope will meet your interest. I present it to you starting from the cover, whose image was donated to us by Vincentia Schroeter. Her works have long introduced us in a poetic way to the reading of Bioenergetic Analysis and I would also like to thank Vincentia for the help and advice that have generously comforted me in this adventure.

Thanks to the reviewers of the articles: Vita Heinrich Clauer, Odila Weigand, Laurie Ure, Peter Geisser, Susan Kanor, Margit Koemeda, Vincentia Schroeter, and Piero Rolando and to the colleagues who translated the abstracts: Angelina Sarmatova (Russian), Chiara Blasi (French), Christoph Helferich (German), Mae Nascimento (Portuguese), Rosaria Filoni (Italian), Rebecca Liu Gianpu (Chinese), IIBA Staff (Spanish).

We choose to open this issue by remembering some colleagues who have left us and who belonged to the first generation of Bioenergetic Analysts. With a letter to the IIBA members, Léia Cardenuto, President of the IIBA, remembers Ed Svasta and her meeting with him, Bob Hilton remembers Bill White with the words he pronounced in his funeral eulogy. We are also happy that, in another part of the Journal, Guy Tonella reviews the *Collected Essays of Robert A. Lewis*, edited by Gerald Perlman and tells us about Bob's life and work.

We continue with the publication of an article by Sara Invitto, IIBA colleague and member of the University of Salento and Patrizia Moselli, President of Siab

(Italy). Their article: *Exploring Embodied and Bioenergetic Approaches in Trauma Therapy: Observing Somatic Experience and Olfactory Memory*, was originally published in the prestigious Brain Science Journal, also thanks to the partial financial contribution of the IIBA Research Committee.

Here follows a series of articles that reflect on Bioenergetic Analysis and its updates. The first one you will encounter is the article by Len Carlino with Laurie Ure *A Reflection on the Exquisite Amalgam of Bioenergetic Analysis*. The authors state that "the uniqueness of bioenergetic analysis lies in the wide variety of facets that it incorporates. These include psychodynamic theory, character analysis, the physical dynamics of character structure, transference and countertransference, the therapist's use of self with an available heart, resonating with the patient, and the new concept of the pendulum illustrating both regression to progress and progression to regress" and with clinical vignettes they accompany us to understand the concepts they present to us.

Then we have the articles of two colleagues belonging to the Editorial Board: Thomas Fellmann and Homayoun Shahri, who reflect on Character and Object Relations.

Thomas Fellmann in his *The object relationship theory in bioenergetic analysis in the light of Kernberg's conception* offers us the possibility of reflecting on the thought of Otto Kernberg, substantially absent from the bioenergetic reflection and which instead offers significant possibilities for expanding our capacity for intervention with clients. "The grounding phenomenon known in bioenergetics is reinterpreted by means of Kernberg's psychodynamic understanding and the possibilities of the interventions derived from it are explained on the basis of a clinical example".

Homayoun Shari's article: *Character Structure – An Object Relations Perspective* "analyzes character structures based on Object Relations Theory and discusses four phases of object relating, 1) an undifferentiation phase, 2) an incorporating phase, 3) a pre-object relating phase, and finally, 4) a full object relating phase, resulting in internalization and introduces treatment approaches, notwithstanding somatic interventions, based on Object Relations Theory and the theory that he introduces in this paper".

Another theme, traditionally central in Bioenergetic Analysis is that of aggression and Louise Fréchette, in hers: *Aggression: destructive impulse or life force* "retraces the evolution of the concept of aggression from the Freudian understanding of that primary impulse to the contemporary analytical authors, as well as to the Reichian and the Lowenian view of it and in the second part presents how today's bioenergetic therapists conceptualize the aggressive impulse and how

they work with it in their clinical practice, so that they can help their patients transform what can be a destructive force into a life force sustaining self-expression and self-actualization".

In recent years, Polyvagal Theory has been at the center of interest of Bioenergetic Analysts and Arild Hafstad, in his: *Integrating Polyvagal Theory in Bioenergetic Therapy* brings his contribution to the reflection on its possible integration into bioenergetic clinical practice.

Yael Harel, in her article *Being discovered by the m/other* "delves into the intricate early stages of development through the unique perspective of experiences. It draws on a diverse range of disciplines, such as embryology, psychology, and philosophy, as well as the realms of imagination and metaphor, to seek a deeper understanding of this period".

And we come to the two book reviews that complete this issue of our Journal. We have already talked about Guy Tonella's touching review of the *Collected Essays of Robert A. Lewis*, edited by Gerald Perlman, and we conclude with Josette van Luytelaar and Homayoun Shahri who review of the book by Jens Tasche and Carsten Holle: *Psychodynamische Grundlagen der Bioenergetischen Analyse [Psychodynamic Foundations of Bioenergetic Analysis]*.

We wish you a good read.

Furthermore, as the Editorial Board, we are encouraging everyone to send us articles for the next issues.

We believe that the more colleagues write, the more our Journal can contribute to the dialogue between the IIBA and other psychotherapeutic modalities (and to the scientific growth of our organization). We eagerly look forward to reports on empirical research, case studies, theoretical elaborations, and conference materials that meet the IIBA editorial standards. Articles about Bioenergetic Analysis in different countries and socio-cultural realities or in specific fields are also of great interest. If you have an idea, we are here to work with you on how to formulate it up as a clinical article for our Bioenergetic Analysis journal.

We remind you that articles can be submitted from June 1st to September 1st of each year and that these articles will be read by two "double-blind" reviewers to ensure confidentiality and fairness.

Maria Rosaria Filoni

Exploring Embodied and Bioenergetic Approaches in Trauma Therapy[1]

Observing Somatic Experience and Olfactory Memory

Sara Invitto & Patrizia Moselli

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Abstracts

Recent studies highlight how body psychotherapy is becoming highly cited, especially in connection with studies on trauma-related disorders. This review highlights the theoretical assumptions and recent points in common with embodied simulation and new sensory theories by integrating bioenergetic analysis, embodiment, and olfactory memory in trauma and post-traumatic stress disorder (PTSD) therapy. Embodied memory, rooted in sensorimotor experiences, shapes cognitive functions and emotional responses. Trauma, embodied in somatic experiences, disrupts these processes, leading to symptoms such as chronic pain and dissociation. The literature discussed highlights the impact of burning odors on individuals with PTSD and those who have experienced childhood maltreatment. Burning odors can increase stress and heart rate in war veterans, with sensitivity to these odors intensifying over time since the trauma. Additionally, adults who experienced childhood maltreatment exhibit faster processing of unpleasant odors and increased symptom severity. Grounding techniques, such as adopting a balanced posture, enhance breathing and sensory capabilities, potentially aiding in managing symptoms associated with trauma-related disorders such as PTSD.

Keywords: olfactory memory, post-traumatic stress disorder, bioenergetic analysis, embodied cognition, embodied simulation

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1 This text is a reprint of: Invitto, S. & Moselli, P. (2024). Exploring Embodied and Bioenergetic Approaches in Trauma Therapy: Observing Somatic Experience and Olfactory Memory. *Brain Sciences, 14*(4), 385. https://doi.org/10.3390/brainsci14040385

Explorando Abordagens Incorporadas e Bioenergéticas na Terapia do Trauma
Observando a Experiência Somática e a Memória Olfativa (Portuguese)
Estudos recentes apontam como a psicoterapia corporal vem se tornando uma referência, bastante relatada – especialmente em estudos sobre desordens relacionadas ao trauma. Está resenha ressalta as afirmações teóricas e aspectos recentes em comum com a simulação corporificada e novas teorias sensoriais através da integração da análise bioenergética, da corporificação e da memória olfativa na terapia do trauma e da Desordem de Stress Pós Traumático (PTSD). A memória corporificada, enraizada em experiências sensório- motoras, formata funções cognitivas e respostas emocionais. O trauma, incorporado através de experiências somáticas, rompe esses processos, levando a sintomas como dores crônicas e dissociação. A literatura destaca o impacto de odores de queimação sobre indivíduos com PTSD, e sobre os que sofreram maus-tratos na infância. Cheiro de queimação aumentaram o stress e causaram aceleração cardíaca em veteranos de guerra, cuja sensibilidade a esses odores aumentaram ao longo do tempo, a partir do trauma. Somando-se a isso, adultos que experimentaram maus-tratos na infância, mostram processamento mais rápido desses odores desagradáveis e recrudescimento severo dos sintomas. Técnicas de *grounding*, assim como a adoção de posturas de equilíbrio intensificam a respiração e as habilidades sensoriais, auxiliando, potencialmente, no manejo de sintomas associados a desordens relacionados a traumas, como PTSD.

Exploration des approches corporelles et bioénergétiques dans la thérapie du traumatisme
Observation de l'expérience somatique et de la mémoire olfactive (French)
Des études récentes montrent que la psychothérapie corporelle est de plus en plus citée, en particulier en ce qui concerne les études sur les troubles liés aux traumatismes. Cette revue met en évidence des hypothèses théoriques et des points communs récents avec la simulation incarnée et les nouvelles théories sensorielles en intégrant l'analyse bioénergétique, l'embodiment et la mémoire olfactive dans le traitement des traumatismes et du trouble de stress post-traumatique (TSPT). La mémoire incarnée, ancrée dans les expériences sensorimotrices, façonne les fonctions cognitives et les réponses émotionnelles. Le traumatisme, incarné par des expériences somatiques, perturbe ces processus, entraînant des symptômes tels que la douleur chronique et la dissociation. La littérature discutée met en évidence l'impact des odeurs de brûlé sur les personnes atteintes de TSPT et celles qui ont été victimes de maltraitance pendant l'enfance. Les odeurs de brûlé peuvent augmenter le stress et le rythme cardiaque chez les anciens combattants, la sensibilité à ces odeurs s'intensifiant au fil du temps après un traumatisme. De plus, les adultes qui ont été maltraités pendant l'enfance présentent un traitement plus rapide des odeurs désagréables et une sévérité plus forte des symptômes. Les techniques d'ancrage, telles que l'adoption d'une posture équi-

librée, améliorent la respiration et les capacités sensorielles, ce qui peut aider à gérer les symptômes associés aux troubles liés aux traumatismes tels que le TSPT.

Esplorazione degli approcci corporei e bioenergetici nella terapia del trauma: Osservazione dell'esperienza somatica e della memoria olfattiva (Italian)

Recenti studi evidenziano come la psicoterapia corporea stia diventando fortemente citata, specialmente in connessione con gli studi sui disturbi correlati al trauma. Questa relazione evidenzia l'assunzione teorica e i recenti punti emergenti in comune con la simulazione incarnata e le nuove teorie sensoriali integrando ma l'analisi bioenergetica, l'embodiment e la memoria olfattiva nella terapia del trauma e del disturbo post traumatico da stress (PTSD). La memoria embodizzata, che affonda le sue radici nell'esperienza sensomotoria, plasma le funzioni cognitive e le risposte emotive. Il trauma, esperito nelle esperienze somatiche, interrompe questi processi, producendo sintomi come dolore cronico e dissociazione. La letteratura sottolinea l'impatto dell'odore di bruciato su individui con PTSD e coloro che hanno esperito maltrattamenti infantili. Adulti che hanno esperito maltrattamenti infantili manifestano maggiore velocità di elaborazione degli odori spiacevoli e aumento della gravità dei sintomi. Le tecniche di grounding, come l'adottare una postura equilibrata, enfatizzare la respirazione e le capacità sensoriali, sono potenzialmente d'aiuto nella gestione di disturbi correlati al trauma.

Körperorientierte und bioenergetische Ansätze in der Traumatherapie Die Rolle der somatischen Erfahrung und des Geruchsgedächtnisses (German)

Neuere Studien zeigen, dass die körperorientierte Psychotherapie mehr und mehr erwähnt wird, vor allem in Arbeiten über traumabezogenen Störungen. Unser Bericht unterstreicht die theoretischen Annahmen und Gemeinsamkeiten mit der verkörperten Simulation und den neuen somatischen Theorien, indem er die bioenergetische Analyse, die Verkörperung und das Geruchsgedächtnis in der Traumatherapie und der post-traumatischen Störung (PTSD) integriert. Das in sensomotorischen Erfahrungen verwurzelte verkörperte Gedächtnis formt die kognitiven Funktionen und die emotionalen Reaktionen. Das gleichermaßen in körperlichen Erfahrungen verwurzelte Trauma unterbricht diese Prozesse und führt zu Symptomen wie chronischem Schmerz und Dissoziationen. In der untersuchten Literatur wird der Einfluss von Brandgerüchen auf Personen mit posttraumatischen Störungen und auf Opfer von Kindheitsmisshandlungen hervorgehoben. Brandgerüche können den Stress und die Herzfrequenz bei Kriegsveteranen erhöhen, wobei die Empfindlichkeit gegenüber solchen Gerüchen in der Zeit nach dem Trauma zunimmt. Des Weiteren antworten Erwachsene, die in der Kindheit misshandelt wurden, mit einer schnelleren Reaktion auf schlechte Gerüche und mit einer erhöhten Heftigkeit der Symptome. Die Techniken des grounding, wie z. B. das Einnehmen einer ausgegliche-

nen Körperhaltung, verbessern die Atmung und die Fähigkeiten der Sinne und helfen potentiell bei der Bewältigung von Symptomen bei traumabezogenen Störungen wie dem PTSD.

Изучение телесного и биоэнергетического подходов в терапии травм
наблюдение за соматическим опытом и обонятельной памятью (Russian)
Недавние исследования показывают, что телесная психотерапия становится все более популярной, особенно в связи с исследованиями расстройств, связанных с травмами. В этом обзоре освещаются теоретические предпосылки и последние моменты, общие для телесного моделирования и новых сенсорных теорий, путем интеграции биоэнергетического анализа, эмбодимента и обонятельной памяти в терапию травм и посттравматических стрессовых расстройств (ПТСР). Телесная память, основанная на сенсомоторном опыте, формирует когнитивные функции и эмоциональные реакции. Травма, проявляющаяся в соматических переживаниях, нарушает эти процессы, что приводит к таким симптомам, как хроническая боль и диссоциация. В обсуждаемой литературе подчеркивается влияние запаха гари на людей с ПТСР и тех, кто в детстве подвергался жестокому обращению. Запах гари может повышать стресс и частоту сердечных сокращений у ветеранов войны, причем чувствительность к этим запахам усиливается с течением времени после травмы. Кроме того, взрослые, которые в детстве подвергались жестокому обращению, быстрее справляются с неприятными запахами и у них усиливается тяжесть симптомов. Техники заземления, такие как принятие сбалансированной позы, улучшают дыхание и сенсорные возможности, потенциально помогая справиться с симптомами, связанными с травмами, такими как ПТСР.

Enfoques corporales y bioenergéticos en la terapia del trauma:
Integración de la experiencia somática y la memoria olfativa (Spanish)
Unos estudios recientes hacen hincapié a que la psicoterapia corporal está siendo muy citada cada vez más, especialmente en relación con estudios sobre trastornos relacionados con el trauma. Este artículo destaca los supuestos teóricos y los puntos recientes en común con la simulación corporizada y las nuevas teorías sensoriales mediante la integración del análisis bioenergético, la corporización y la memoria olfativa en la terapia del trauma y trastorno de estrés postraumático (TEPT). La memoria encarnada, basada en experiencias sensoriomotoras, influye en las funciones cognitivas y las respuestas emocionales, mientras que el trauma, almacenado en el cuerpo, altera estos procesos, generando síntomas como dolor crónico y disociación. La literatura revisada pone de manifiesto el impacto de los olores a quemado en personas con TEPT y en aquellas que han sufrido abusos durante la

infancia. Estos olores pueden aumentar el estrés y la frecuencia cardíaca en los veteranos de guerra, y la sensibilidad a los mismos tiende a intensificarse con el paso del tiempo desde el trauma. Además, los adultos que vivieron malos tratos en su infancia procesan más rápidamente los olores desagradables y presentan una mayor severidad de los síntomas. Las técnicas de enraizamiento, como la adopción de una postura equilibrada, mejoran la respiración y las capacidades sensoriales, lo que puede ayudar a controlar los síntomas asociados a trastornos relacionados con el trauma, como el TEPT.

探索创伤治疗中的具身化和生物能量方法
观察躯体体验和嗅觉记忆 (Chinese)
最近的研究表明身心疗法如何变得备受推崇，尤其是与创伤相关疾病的研究。本文通过回顾在创伤和创伤后应激障碍（PTSD）治疗中整合躯体动力分析、具身化和嗅觉记忆，强调了具身化模拟和新感官理论的理论假设和最新共同点。具身记忆植根于感官运动体验，塑造认知功能和情绪反应。具身在躯体体验中的创伤会扰乱这些过程，导致慢性疼痛和解离等症状。讨论的文献强调了燃烧气味对创伤后应激障碍患者和童年遭受虐待者的影响。燃烧的气味会增加退伍军人的压力和心率，创伤后对这些气味的敏感性会随着时间的推移而增强。此外，经历过童年虐待的成年人对难闻气味的反应速度更快，症状的严重程度也会增加。扎根技术，例如采用平衡姿势等可增强呼吸和感知能力，从而可能有助于管理创伤后应激障碍等与创伤相关的症状。

Introduction

Recent studies highlight how body psychotherapy is becoming highly cited, especially in connection with studies on trauma-related disorders. Previously, the literature has not systematized theoretical assumptions and recent points in common with embodied simulation and new sensory theories by integrating bioenergetic analysis, embodied cognition, and olfactory memory in trauma and PTSD therapy. Trauma-related disorders (TRDs) and post-traumatic stress disorders (PTSDs) are expressions in which, by now, a somatic and psychophysiological component has clearly been highlighted. From a psychophysiological point of view, a recent meta-analysis highlighted that the anterior cingulate cortex and the bilateral amygdala are the areas most hyperactivated in PTSD [1]. In contrast, the ventromedial prefrontal cortex and the inferior frontal gyrus appear to be the most inhibited areas. The growth of PTSD involves, as a rule, the shift of the brain state from the high-level processing of multimodal contextual and mnemonic stimuli to primitive formation mediated by the amygdala, of timed sensory associations [2]. The personality differences of each individual (e. g., intelligence, neuroticism, and attention) will influence the stimulus threshold where

this change occurs, and consequently affect the subject's vulnerability [1]. These aspects, connected to an alert system, also profoundly involve the olfactory system, which shares common substrates with emotion, especially fear [3,4]. The theoretical assumptions and recent points are shared with embodied cognition and new sensory theories by integrating bioenergetic analysis, embodied simulation, and olfactory memory in PTSD therapy. Embodied memory, rooted in sensorimotor experiences, shapes cognitive functions and emotional responses. Trauma, embodied in somatic experiences, disrupts these processes, leading to symptoms such as chronic pain and dissociation. Bioenergetic analysis is body psychotherapy developed in the 1950s by Alexander Lowen [5,6] from Reichian assumptions [7]. This analysis focuses on the body's sensory, perceptual, and cognitive expression, starting from the idea that the unconscious is not a symbolic cerebral representation, even though the unconscious is expressed through the body as a whole. The terms in bioenergetic analysis are linked to "grounding" (i.e., experience) and are strongly connected to the most recent cognitive neuroscience theories on embodied simulation and grounded cognition [8–11]. In addition, the aspects of the grounded experience link it in a very specific way to the theory of integrated information, which sees consciousness as part of a sensory process linked to causality [12–14].

Embodied cognition is an approach that states that mind and body are not distinct, but concur in determining mental and cognitive processes [15]. Gallagher wrote a specific cognitive contribution entitled "How the body shapes the mind", speaking of "embodied cognition". In bioenergetic terms, the body shapes the mind, meaning that bodily action in an ecological environment changes our cognition, emotions, and actions. Furthermore, this aspect could be taken to the extreme if we also talk about aspects of epigenetics.

Bodily action can even modify the expression of our phenotypic aspects if we compare these aspects to comparative evolutionary elements. For example, recent studies on environmental (social) handling/enrichment and on neurodegenerative processes in animal models demonstrate how genotypic aspects may not manifest themselves in purely clinical phenotypic aspects [16,17]. This aspect of direct action on the body and with the body seems critical to how body therapy can be read according to different psychophysiological interpretative levels.

The concept of "embodied" begins with W. Reich and A. Lowen, and later in other somatic therapies [18–20]. However, simultaneously, psychophysiology and cognitive neuroscience demonstrated precisely how the body and bodily experience are essential for the development of homeostatic physiological processes and of processes connected to thought and consciousness, as are, in part, the

processes described in bioenergetic terms by the bodywork [21,22]. The main concepts of bioenergetics have borrowed the main concepts of embodied theories, albeit in different ways. Grounded cognition and simulation involve the reactivation of perceptual, motor, and introspective states acquired during experience with the world, body, and mind, and offers a unifying vision of cognition [23], emphasizing dynamic brain–body–environment interactions and perception–action links as standard foundations of simple behaviors, as well as of complex cognitive and social skills. Situated cognition is based on the hypothesis that the ecological human–environment interaction can influence individual human development [24,25].

Being "grounded" is also a central aspect of bioenergetic analysis and requires a sense of rootedness that starts from motor/bodily aspects to arrive at emotional and cognitive factors [26]. The meaning of embodied memory arises from a paradigm change that has developed over time, namely the idea that the meaning of symbols is obtained through the sensorimotor experience located in an environmental context. On these premises, many theoretical studies converge on the idea that the body represents how to model higher-level executive functions such as memory.

Starting from these models, the aim of this review would provide a focus on the intersection of bioenergetic analysis, TRD, and PTSD, particularly emphasizing the somatic and psychophysiological components involved. The content explores how trauma affects both the mind and body, leading to symptoms such as chronic pain, dissociation, and altered sensory processing, according to the theoretical underpinnings of embodied simulation and bioenergetic analysis, the first school of thought in body-focused psychotherapy.

Furthermore, the paper delves into the role of embodied memory, highlighting how sensorimotor experiences shape cognitive functions and emotional responses, and how trauma disrupts these processes. It explores the concept of "body muscle memory" and how trauma can lead to muscle tension and various somatic symptoms. The paper also discusses the importance of reconnecting with the body in trauma therapy, emphasizing the role of body psychotherapy in addressing trauma symptoms. Additionally, the paper examines the role of olfactory memory in trauma, emphasizing how smells can trigger traumatic memories and how olfactory stimuli are closely linked to emotional processing. It explores the potential therapeutic implications of incorporating olfactory stimuli into trauma therapy sessions. Overall, the paper aims to provide a comprehensive understanding of how trauma could affect mind–body unity and explore embodied therapeutic approaches in addressing trauma-related disorders (see Figure 1).

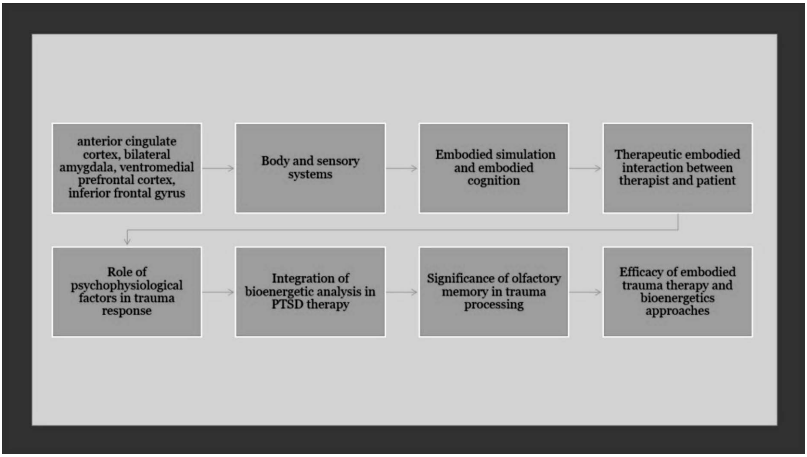

Figure 1. TRS and PTSD in an embodied therapeutic approach through somatic experience and olfactory memory.

Embodied Memory

Common knowledge of embodied memory constitutes those memories thanks to which, for example, action of sitting down or that allow us to orient ourselves easily in spaces of customary use [27–29]. Furthermore, listening to music can viscerally evoke a conversation in the past, and hearing a particular smell can bring to mind an emotional experience [30]. Therefore, sensorimotor reactivation is configured as a constituent of the mnemonic traces through which our cognitive system can retrieve information.

Fuchs stressed that this memory is implicit, that repeated bodily experience is the basis of the process that connects the body to its intention to operate in the environment [31]. In favor of this, Merleau-Ponty expresses the idea of a sensorimotor vision of body memory, capable of providing itself with know-how or the knowledge of how to act with or towards a part of one's body [15]. Finally, Gallese and Sinigaglia elaborate on a conception of body memory as "a multiplicity of possibilities of action that allows the practical tuning of the body with its environment" [32,33]. Through knowledge of the conceptions that have gradually been endorsed, our experience of the body is not direct, but mediated by perceptual information, influenced by internal information and recalibrat-

ed through the implicit and explicit body representation stored, which is body memory. Therefore, it is possible to idealize that memory and, in general, cognitive functions have evolved to serve human action and facilitate interactions between humans and their environment. Thus, cognitive and memory processes are grounded in human experience and intervene in a real-world environment that interferes with perception and involves action. Individual personality is another factor that interferes with our interaction with the environment; according to modern theories, the latter develops through environmental and hereditary factors. Specific to the bodily psychotherapeutic concepts of personality, namely, the bioenergetic model, is the basic idea that life experiences and emotionally significant attitudes manifest physically. Conversely, habitual use of the body affects mental attitudes and basic moods [6]. Consequently, the body should provide relevant information about a person, not only indicating their current emotional state and/or immediate willingness to act, but also about the stable dispositions of thinking, feeling, and behaving. Therefore, according to this perspective, the body is an indispensable component of human existence, and from this point of view, the cognitive and somatic processes evolve in parallel. Another relevant concept is that memories can, to a certain extent, be triggered and brought to consciousness by affective, motor, or sensory stimuli. The experiences of interaction with the environment evoke cognitive and psychosomatic coping strategies or defense [34]. Connection with one's body has, therefore, played a central role in psychotherapy since its inception: the founders of psychoanalytic therapy considered somatic tensions as an expression of mental conflicts. On the one hand, the body is the stage on which mental disorders develop: in primary care, most patients with psychiatric disorders have somatic symptoms. On the other hand, it is the prerequisite of the psychotherapeutic process in which the patient and therapist communicate verbally and in a bodily dialogue [35,36].

In the case of pathology, Weizsacker's model of the "Gestaltkreis" explains the invisibility of an individual's psychological conflict when somatic symptoms replace it [37]. In this sense, psychotherapy strives to find an explanation and a functional solution in which thought, feeling, bodily experience, and expression can be intertwined. For example, "functional relaxation" understands breathing exercises as a semiotic process in which the therapist takes in a client's bodily signals, interprets them as their own, and verbalizes the result. For this reason, the bioenergetic perspective fits well into the embodied mind paradigm that prevails today in the cognitive sciences. According to this position, human cognition cannot be explained only as a function of the brain, but as an interaction of the entire body and its environment. Shapiro points out that information processing begins

in the sensorimotor periphery [38]. From this inevitable evolutionary perspective, human experience and behavior should be understood by their genesis and grounding. Similarly, Petzold and Sieper propose a hermeneutical point of view in which the informed body contains a person's mental history and state [39].

Recent evidence presents the efficacy of bioenergetic psychotherapeutic treatment in an outpatient setting in Germany and Switzerland, highlighting how, after six months of therapy, the patients showed a significant improvement that tended to be maximized after two years of treatment and was confirmed in follow-up [40]. A systematic review of randomized studies using body psychotherapy in a clinical setting revealed a moderate effect in terms of efficacy on psychopathology and psychological distress [39].

Embodied Trauma and Bioenergetic Therapy

Embodied trauma is represented very well in the conditions of violence suffered. The verbal aspect loses value within a homeostatic process, which instead flows into the somatic system [26,41,42]. This can happen in terms of both awareness and habituation, in posttraumatic stress disorder (PTSD) and also in situations of chronic violence (e. g., domestic violence) [43]. To give meaning to one's existence, the individual designs, produces, and creates satisfying relationships. Trauma interrupts this process by preventing the individual from staying in the present, so the outside world appears distant, inaccessible, or intrusive. Traumatic experiences, therefore, leave traces in the mind and emotions as well as in the biology and immune system.

The autonomic nervous system, strongly involved in endogenous responses to stress and trauma, is regulated by integrated brainstem reflexes and cranial nerves. It activates the facial, ear, and throat muscles, allowing us to scream, grimace in fear, and listen to incoming help responses [44–46]. If no one responds to the request or the individual does not have the necessary time to ask because the danger is imminent, the body returns to a less relational but more primitive mode of survival, which constitutes the second level: the fight or flight responses (i. e., sympathetic nervous system) [47]. In this, the limbic system comes into play, which activates the sympathetic nervous system by mobilizing the muscles, heart, and lungs to allow for a quick release. If there is no escape, the third level comes into play: freezing or collapsing.

When a person suffers a trauma, they develop somatic symptoms that are a bodily expression of psychological problems; consequently, the body also suffers. This

trauma, according to Caizzi, is embodied in the subsymbolic modality that involves the affective, somatic, sensory and motor modalities of mental processing [48]. It is important to note that for many trauma survivors, the body can become a source of pain, intrusion, and shame. Therefore, survivors can often feel disconnected from their bodies. It has been established that exposure to the threat of trauma stimulates the autonomic nervous system, with consequent sympathetic hyper-excitation and parasympathetic hypo-excitation states that accompany survival responses (fight, flight, submission, and freezing). The relevant literature highlights how trauma produces a recalibration of the brain's alarm system, an increase in stress hormones, and alterations in the system responsible for discriminating irrelevant information. Trauma compromises the area of the brain that transmits the physical, corporeal perception of being alive. These changes account for why traumatized individuals are hypervigilating the threat at the expense of being spontaneously involved in their lives. The human body acts as a "warehouse" for everything an individual experiences during life; this leads to repressed and trapped emotions within multiple parts of the body that cause muscle tension. One of the causes of muscle tension can be precisely trauma: when an individual lives a traumatic experience and does not face it consciously, they are afflicted with fear, a stress that, if chronic, can define the structure of PTSD. All this accumulates within the body, resulting in muscle tension, which contributes to numerous other diseases, such as chronic pain, fibromyalgia, gastrointestinal disorders, and hypertension [49–51]. In this case, we speak of "body muscle memory", which refers to the traces that the past has imprinted on an individual's body. There are different types of body memory: memory constituted by the baseline tone of the muscles, which can be altered due to traumatic experiences; memory constituted by habitual postures that represent a limitation in the flexibility of relationships and an unconscious source of malaise and discomfort; memory of movements that, if repeated several times in the same circumstances, become characteristic of a person; and finally, memory of the breath, which, if altered, weighs on the well-being of the subject [52–54]. Therefore, trauma results in a fundamental transformation of how the mind and brain organize perceptions, changing the way we think, our actual ability to think, and our physical and hormonal responses. At the same time, the mind needs to be supported in restructuring the meaning processes associated with trauma; the body needs to learn that the danger has passed and can return to live in the present reality. Therefore, since trauma affects the mind and body, one of the many treatment approaches used is sensorimotor psychotherapy; those who have suffered a trauma lose the "somatic connection" with the present reality: at the body level, the responses are experienced as past events that occur "again and again"; therefore, sensorimotor therapy

allows evaluation of and intervention with the trauma symptoms, dealing directly with the body and then accessing the most primitive, automatic, and involuntary brain functions that underlie traumatic and post-traumatic responses [55]. The individual learns to regulate the hyperactivation and physical insensitivity (bodily, cognitive, and emotional experiences) associated with the trauma in a conscious way, being encouraged to observe and carefully describe the interaction between thoughts, emotions, physical sensations, and bodily movements that occur in the here and now. The person can thus discover that the reactions elicited in everyday life are fed by the cognitive patterns linked to the trauma, which activate the defensive responses aimed at survival. It should be noted that memories of trauma are prone to distortion; in fact, most people remember more trauma than they actually experienced. This distortion is due to a failure to monitor their sources: following an experience, intentional and involuntary memories can introduce new details that are assimilated into the person's memory of the event. To heal from trauma, it would be advisable to start by improving the survivor's awareness and knowledge of the body's responses to trauma, with the ultimate goal of localizing a sense of security within the body. This allows the survivor to operate with a deep self-awareness rather than classic conditioning [56].

Trauma victims cannot heal until they become familiar with their bodily sensations. Being scared means having the body always on alert. To change, people need to become aware of their feelings and how the body interacts with the world around it. Body selfawareness is the first step to getting rid of the past. The therapeutic process, therefore, starts primarily from the physical sensations underlying the emotions, such as pressure, heat, muscle tension, tingling, and a sense of emptiness. Observation of bodily changes, such as chest tightness or stomach cramps, when verbalizing negative events from which the person declares not to be disturbed can give space to what is defined as somatic re-enactment or somatic responses to flashbacks related to the unprocessed event. The mind therefore needs to be re-educated to feel physical sensations, and the body needs to be helped to tolerate and enjoy contact well-being. Psychotherapy can therefore act as an intermediary to guide the individual towards a better perception of themself (bodily, emotional, and cognitive) and of the context in which they live. In doing so, psychotherapy will contribute to the psychophysical health of the individual.

Furthermore, healing can be favored by the mirror neuron system, which, due to its plasticity and immediacy, can contribute to new positive experiences that promote the formation of new adaptive, implicit procedural models. This activation can also reside in the prefrontal cortex and is part of a complex neural network that includes afferent and efferent connections to the limbic system, par-

ticularly the amygdala and the premotor and motor cortex [57,58]. Recent studies have suggested that MNS-based therapies provide a non-invasive approach to treating emotional disorders because they can modulate them through the mechanism of empathy [58–61].

Olfactory Memory and Bioenergetics: A Model of the Embodied Response Connected to Trauma

Studying the mechanisms of olfactory memory can provide information on the mechanisms of human emotions that can also be applied to the mechanisms of mental disorders involving pathological emotional processing. PTSD is of particular interest because one of its psychobiological mechanisms consists of the failure of the extinction of emotional or traumatic reminders conditioned by fear [45,62].

Olfactory memory is particularly relevant because it is closely linked to intense emotions and is distinguished from other types of memories, such as auditory and visual memory, in that it does not automatically generate verbal and/or visual representations but is, by choice, the most embodied one and evokes affective states and significant episodes. In contrast to the extensive empirical literature on the cognitive processing of verbal and visual memory, few studies have examined the role of smell in emotional or traumatic memories and in trauma-related disorders. The proximal space that the bioenergetic therapist establishes in the session and the use of the body allow, in this case, wider variation and modulation of the olfactory aspect, and also in connection with the gut-brain axis. Within this digression, Gerda Boyesen was one of the first bioenergetic psychoanalysts focused on the interoceptive system and able to use gut–brain feedback [63,64]. An information processing approach commonly includes auditory and visual stimuli to assess perception. Although these involve processes similar to those seen in olfactory memory (processing, encoding, consolidation, and retrieval), olfaction is rarely used to investigate them [65]. This is interesting because it has long been known that adding a salient olfactory cue during learning and retrieval facilitates memory recall [66].

Olfactory Stimuli, Body, and Memory in Trauma

Intrusive re-experiencing, a core symptom of PTSD, has traditionally been described through the mechanism of classical fear conditioning [45,67]. In a study of 100 refugees attending a psychiatric clinic, 45% reported having panic attacks

triggered by olfactory stimuli; among these, 58% experienced at least one intrusive memory due to the smell [68]. Patients with PTSD respond intensely to trauma-related danger signals, even in objectively safe environments, and are apparently incapable of adapting their responses based on the contextual signals present. A Vietnam veteran said he was fine until, many years after the war, a Vietnamese restaurant opened near his home: he could not stand the aroma of a typical sauce used to season fish, which he had smelled several times in Vietnam. The former soldier stated that the smell brought back memories of his war experiences, making him feel discomfort and the strange sensation of being torn and covered in blood [69]. Some studies have also demonstrated increased odor detection and sympathetic arousal, including skin conductance and heart rate, in correspondence with odors related to fear, trait anxiety, or mood disorder anxiety [70]. Smells can trigger ancient and emotional memories, including memories of traumatic experiences, because the anatomy of the olfactory system involves activation of the same brain structures that support emotion processing (limbic system and medial temporal lobe circuits) and declarative memory [71].

To understand the cerebral processes involved in PTSD, it is also important to study the functioning of the breath and the olfactory system. Some studies in the literature have examined the effect of burning odors on war veterans, and it has been demonstrated that heart rate increases as a function of the negative valence (i. e., the unpleasantness), causing an increase in the stress and anguish suffered by soldiers with PTSD [72]. Sensitivity to burning odors is also correlated with the time that has passed since the trauma: in contrast to the general symptoms of PTSD, which tend to become less severe as time passes, the symptoms triggered by these types of odors can intensify [73]. Additionally, a study conducted by Croy and colleagues measured odor-related chemosensory potentials in adults who had experienced childhood maltreatment, reporting a faster processing of unpleasant odors and the increased severity of symptoms of the disorder. Grounding – positioning the subject in a posture in which they should be balanced – allows and amplifies the possibility of breathing [74]. In turn, breathing enables an increase in attentional and sensory capabilities, both physical and chemoreceptive, and also enhances aspects connected to interoception and memory retrieval [71,75].

Conclusions

This review explores the intersection of TRD, PTSD, and body psychotherapy, mainly focusing on the concept of embodied simulation and its implications

for therapeutic intervention in bioenergetic psychotherapy. It emphasizes that trauma affects both the mind and body, necessitating integrated and embodied therapeutic interventions. The concept of embodied memory, rooted in sensorimotor experiences, is highlighted as a critical aspect of understanding how trauma affects cognitive functions and emotional responses. Recognizing the role of bodily sensations and reactions is crucial in addressing trauma-related symptoms. The efficacy of bioenergetic psychotherapeutic treatment in addressing TRS suggests significant improvements in psychopathology and psychological distress over time. Moreover, the paper discusses the significance of olfactory memory in trauma processing and symptomatology. It suggests that olfactory stimuli can trigger emotional memories, emphasizing the need to incorporate olfactory experiences into therapeutic interventions. These aspects have practical implications for clinical practice, including incorporating somatic interventions, breathwork, and sensory experiences into trauma therapy sessions.

We also emphasize the need for therapists to be attuned to clients' verbal and nonverbal cues, including bodily sensations and emotional responses.

Future research could focus on exploring the neural mechanisms underlying embodied memory, investigating the specific effects of olfactory stimuli on trauma processing, and further evaluating the long-term effectiveness of bioenergetic therapy for trauma-related disorders.

Furthermore, this review highlights the importance of adopting an integrated, embodied approach to trauma therapy, incorporating insights from clinical psychology, cognitive neuroscience, psychophysiology, and bioenergetic practice.

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A Reflection on the Exquisite Amalgam of Bioenergetic Analysis

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Abstracts

The uniqueness of bioenergetic analysis lies in the wide variety of facets that it incorporates. While advanced bioenergetic therapists and trainers may have a clear understanding of the many aspects of bioenergetic analysis, this article introduces several new concepts and outlines seven distinct facets that together make up the exquisite amalgam of the bioenergetic approach to psychotherapy. These include psychodynamic theory, character analysis, the physical dynamics of character structure, transference and countertransference, the therapist's use of self with an available heart, resonating with the patient, and the new concept of the pendulum illustrating both regression to progress and progression to regress. Throughout the article, we explain these areas and offer references for further understanding. We include case examples to illuminate some of these principles, such as regression to progress and progression to regress.

Keywords: character structure, regression, relational trauma, therapist-patient resonance, therapist's use of self

Uma Reflexão sobre a Extraordinária Amálgama da Análise Bioenergética (Portuguese)
A singularidade da Análise Bioenergética está na enorme variedade de facetas que ela incorpora., embora terapeutas bioenergéticos experientes e *trainers* possam ter uma compreensão clara dos seus muitos aspectos, estre artigo apresenta vários conceitos novos e salienta sete facetas distintas que, juntas, configuram a extraordinária amálgama da abordagem bioenergética na psicoterapia. Elas incluem: teoria psicodinâmica, análise do caráter, a dinâmica física da estrutura de caráter, transferência e contra-transferência, o uso, pelo terapeuta, de si mesmo, mas com o coração aberto, ressoando com o paciente, e o novo conceito do pêndulo – ilustrando tanto a regressão para o progresso como o progresso para

a regressão. Ester artigo explica aquelas áreas e oferece referências para uma melhor compreensão do assunto. Incluímos exemplos de casos, para ilustrar alguns desses princípios, tais como regressão para o progresso e progresso para a regressão.

Une réflexion sur l'amalgame exquis de l'analyse bioénergétique (French)
La particularité de l'analyse bioénergétique réside dans la grande variété de facettes qu'elle intègre. Bien que les thérapeutes et les formateurs bioénergétiques avancés puissent avoir une compréhension claire des nombreux aspects de l'analyse bioénergétique, cet article introduit plusieurs nouveaux concepts et décrit sept facettes distinctes qui, ensemble, constituent l'amalgame exquis de l'approche bioénergétique à la psychothérapie. Il s'agit notamment de la théorie psychodynamique, de l'analyse du caractère, de la dynamique physique de la structure du caractère, du transfert et du contre-transfert, de l'utilisation du soi par le thérapeute avec un cœur volontaire, de la résonance avec le patient et du nouveau concept de pendule qui illustre à la fois la régression vers le progrès et la progression vers la régression. Tout au long de l'article, nous expliquons ces domaines et proposons des références pour une meilleure compréhension. Nous incluons des exemples de cas pour clarifier certains de ces principes, tels que la régression vers le progrès et la progression vers la régression.

Una riflessione sullo squisito amalgama dell'analisi bioenergetica (Italian)
L'unicità dell'Analisi Bioenergetica risiede nell'ampia varietà di sfaccettature che incorpora. Mentre i terapeuti e i formatori bioenergetici avanzati possono avere una chiara comprensione dei numerosi aspetti dell'Analisi Bioenergetica, questo articolo introduce diversi nuovi concetti e delinea sette sfaccettature distinte che insieme costituiscono lo squisito amalgama dell'approccio bioenergetico alla psicoterapia. Questi includono la teoria psicodinamica, l'analisi del carattere, le dinamiche fisiche della struttura del carattere, il transfert e il controtransfert, l'uso del sé da parte del terapeuta con un cuore disponibile, la risonanza con il paziente e il nuovo concetto del pendolo che illustra sia la regressione al progresso che la progressione alla regressione. In tutto l'articolo spieghiamo queste aree e offriamo riferimenti per una maggiore comprensione. Includiamo esempi di casi per chiarire alcuni di questi principi, come la regressione al progresso e la progressione alla regressione.

Eine Reflexion auf das exqusite Amalgam der bioenergetischen Analyse (German)
Das Einzigartige der bioenergetischen Analyse liegt in der Vielfalt ihrer Facetten. Während erfahrene bioenergetische Therapeuten und Trainer sicher ein klares Bewusstsein dieser mannigfachen Aspekte der bioenergetischen Analyse haben, führt dieser Beitrag verschiedene neue Konzepte ein und beschreibt sieben unterschiedliche Aspekte, welche zusammengenommen das exquisite Amalgam des bioenergetischen Ansatzes in der Psychotherapie ausmachen. Dieses Amalgam beinhaltet psychodynamische Theorie, Cha-

rakteranalyse, die körperliche Dynamik der Charakterstrukturen, Übertragung und Gegenübertragung, Gebrauch des Selbst seitens des Therapeuten mit einem offenen Herzen, die Resonanz mit dem Patienten sowie ein neues Pendelkonzept, welches sowohl die Regression zum Fortschritt als auch die Progression zum Rückschritt erläutert. Im Laufe des Beitrags erklären wir diese Bereiche und bieten Hinweise für ein vertieftes Verständnis. Wir führen auch klinische Beispiele an, um einige dieser Begriffe wie z. B. die Regression zum Fortschritt und die Progression zum Rückschritt zu erklären.

Размышление об изысканном сочетании биоэнергетического анализа (Russian)

Уникальность биоэнергетического анализа заключается в широком разнообразии аспектов, которые он включает в себя. В то время как продвинутые биоэнергетические терапевты и тренеры могут иметь четкое представление о многих аспектах биоэнергетического анализа, эта статья вводит несколько новых концепций и очерчивает семь различных аспектов, которые вместе составляют изысканную смесь биоэнергетического подхода к психотерапии. К ним относятся психодинамическая теория, анализ характера, физическая динамика структуры характера, перенос и контрперенос, открытость сердца терапевта как инструмент, резонанс с пациентом, и новая концепция маятника, иллюстрирующая как регресс к прогрессу, так и прогресс к регрессу. На протяжении всей статьи мы объясняем эти вещи и предлагаем ссылки для дальнейшего понимания. Мы приводим конкретные примеры, чтобы проиллюстрировать некоторые из этих принципов, такие как регресс к прогрессу и прогрессирование к регрессу.

Reflexión sobre la exquisita amalgama del análisis bioenergético (Spanish)

La singularidad del análisis bioenergético radica en la diversidad de facetas que integra. Aunque los terapeutas y formadores bioenergéticos con más experiencia suelen tener una comprensión clara de los diversos aspectos del enfoque, este artículo introduce varios conceptos nuevos y describe siete facetas distintas que, en conjunto, conforman la exquisita amalgama del análisis bioenergético en psicoterapia. Estas facetas incluyen la teoría psicodinámica, el análisis del carácter, las dinámicas físicas de la estructura del carácter, la transferencia y contratransferencia, el uso del terapeuta de sí mismo con un corazón abierto, la resonancia con el paciente y el nuevo concepto del péndulo, que ilustra tanto la regresión hacia el progreso como la progresión hacia la regresión. A lo largo del artículo, se explican estos aspectos y se ofrecen referencias para profundizar en su comprensión. Además, se incluyen ejemplos clínicos que ilustran algunos de estos principios, como la regresión hacia el progreso y la progresión hacia la regresión.

对躯体动力分析精巧组合的反思 (Chinese)
摘要：躯体动力分析的独特之处在于它所包含的方方面面。虽然高级躯体动力分析治疗师和培训师可能对躯体动力分析的许多方面都有清晰的了解，但本文介绍了几个新概念，并概述了躯体动力分析心理治疗方法的七个不同方面，这些方面共同构成了躯体动力分析心理治疗方法的精巧组合。其中包括心理动力学理论、人格分析、人格结构的物理动力、移情和反移情、治疗师带着一颗心的使用自我、与患者共鸣，以及说明从退行到进步和从进步到退行的钟摆新概念。在整篇文章中，我们对这些领域进行了解释，并提供了进一步理解的参考资料。我们还列举了一些案例来说明其中的一些原则，如从退行到进步和从进步到退行。

Introduction and Personal Note

In this article, I'd like to share how I came to understand Bioenergetic Analysis and how to present/teach bioenergetics to students who are in the process of becoming bioenergetic therapists. I believe I have a unique perspective, having been a student of bioenergetics for over 50 years, an IIBA trainer for over 40 years, and a patient, student, and colleague of Dr. Alexander Lowen for 25 years. I encourage others with similar rich experiences to contribute their unique perspectives.

As the title of this article states, bioenergetics is exquisite in how it integrates many theoretical psychotherapeutic approaches. The most profound is the integration of the body with the psyche. Further, bioenergetic therapy offers more than a specific technique or even a series of techniques. The bioenergetics approach incorporates a complex combination of factors to address the full range of issues clients present effectively.

While staying true to the IIBA curriculum, I found that using the framework presented in this article gives a rich, comprehensive, and simplistic way of understanding and teaching the exquisite amalgam that is bioenergetics. I have crystallized the ways I work as a bioenergetic therapist into seven distinct categories, which I will describe in this article.

Finally, Laurie Ure has enriched this article with her writing and editorial skills. She has added useful therapeutic examples and has brought my ideas alive and more relatable. I hope you enjoy reading our joint effort.

Psychodynamic theory

The foundation of our understanding of our clients, as bioenergetic therapists, rests in psychodynamic theory – that is, the understanding that early childhood

experience profoundly impacts a person, including both who they are and the problems they bring to the therapy. In bioenergetic therapy, we integrate basic Freudian theory and other psychodynamic theories, including Self-Psychology, Object Relations Theory, Attachment Theory, etc.

Psychodynamic theories further influence our understanding that childhood experiences impact a person's development and current perceptions of the world. Bioenergetic theory expands psychodynamic/developmental theory with the belief that early childhood experiences impact the form of a person's body as well as their current life functioning.

While we perceive that early childhood experiences form the root of a person's struggles, our clients are often unaware of the significance of their childhood. The past lives in their unconscious, and it becomes our job as therapists to help them link their past to their present realities. We do this through verbal exploration of their memories, our understanding of what we see in the shape of their body, and making connections between the past and their current challenges. In bioenergetic analysis, we also understand that developmental experiences contribute to how a person functions, what they feel, and their expectations in present relationships.

By being aware of the significance of psychodynamic understanding, we can, when appropriate, specifically point out the link between a person's present situation and their early experience. This enables us to increase our understanding of the roots of the client's presenting problems and offer psychoeducation as a therapeutic intervention.

In the article "Analysis of Developmental Trauma," Shahri (2014) excellently describes the intersection of psychodynamic theories with bioenergetic analysis. He comprehensively explains theories of child development and their impact on the formation of the individual. Shahri also covers findings of neuroscience, including Polyvagal Theory, and discusses how these theories contribute to the bioenergetic concept of character structure as rooted in developmental trauma.

Character Analysis

A thorough understanding of character analysis forms the basis of Wilhelm Reich's contribution to bioenergetic analysis and the field of psychotherapy. Reich introduced affect into analysis. In Reichian work, the therapist confronted the patient's character, which often elicited an emotional response from the patient. Reich emphasized how something was said and not just what the patient

said. Character analysis aims to make the patient identify their character as a neurotic formation that limits and interferes with vital ego functions.

Character is the basic defensive attitude with which a person confronts life – e.g., proud, ashamed, sarcastic, seductive, overly friendly, seeking to please others.

Additional examples of expressions of character that need to be observed and analyzed by the therapist include:

- haughtiness
- sarcasm
- whining
- hostility
- nastiness
- passivity
- envious
- spiteful
- bitter
- pushy
- shy/withdrawn
- boisterous
- overly polite
- overly accommodating
- overly happy
- smiling all the time
- cold

These qualities transcend character structures and become defensive styles to protect the person from further injury, similar to what they experienced as children. Therefore, they can be viewed as "defensive styles" of relating to people in their lives. For further explanation of the concept of defensive style, see the article "Defensive Style in Bioenergetic Therapy: What it Means and Why it Matters" (Ure, 2023).

Working with a patient's defensive style is related to more significant issues of character analysis. The topic of character analysis warrants additional ongoing and thorough exploration in the bioenergetic community. It is one of Reich's significant contributions to the field of psychotherapy and forms the basis for making accurate bioenergetic therapeutic interventions. The better the therapist's skill with character analysis, the better they will be at identifying a patient's defensive style and vice versa.

Dr. Lowen said that doing skilled character analysis (and, by extension, identifying a patient's defensive style) is the most difficult task for a therapist to master. It requires a lot of therapeutic experience as well as personal life experience.

Character analysis includes both a thorough understanding of the person's characterological defenses through reading the shape of their body and becoming familiar with their defensive style in relationships. When we have developed a solid relationship with the client, we can sometimes verbally confront their character. This analysis can be done through the therapist's direct statements highlighting the patient's harsh reality. Sometimes, interventions such as humor or gentle teasing work effectively to highlight the point.

Interventions to confront the client's characterological ways of being require that the therapist be mature and clear enough to know that they are not projecting their own feelings onto the client. Further, the therapist has to have an advanced understanding of the client, being certain that the client will be able to hear and accept the feedback without it causing them to become more defensive.

Two case examples from Laurie will illustrate this point. The first involves a client who has a history of being overly nice and fears he will lose the relationship if he expresses himself assertively. Occasionally, he asks to use the bathroom before a session by stating in a meek voice: "Would it be okay for me to use the bathroom before we begin?" I (Laurie) have worked with him for several years (I would not respond this way with a new client), so I feel comfortable confronting this defense with teasing by saying something like: "Oh boy, that's a lot to ask. I don't know if it's okay for you to use my bathroom, maybe you should just hold it until the end of the session." In response to this comment, we can laugh together.

Another client who had a history of severe self-deprivation, including barely eating enough calories, revealed to me that she sometimes does not eat before her mid-morning sessions with me. Again, we had worked together for several years at this time. On one occasion, I noticed that she spoke especially loudly, with pressured speech, and expressed anger about a situation out of her control. I asked if she had eaten anything before her session that day. When she said she hadn't and talked about not wanting to eat out of fear of gaining weight, I realized that her irritability was likely related to hunger. I stopped her irritable rant and told her that, going forward, she needed to eat before her sessions. I said I would not see her that day if she did not eat before she came. While this may sound harsh, I used this strong intervention to cut through her deeply rooted, characterological habit of self-deprivation and denial about the impact of poor self-care on her health.

Her eating habits and self-awareness shifted after this, and she said it helped her feel that I cared about her.

The Physical Dynamics of Character Structure

One of Dr. Alexander Lowen's most profound contributions involves correlating character structure with physical dynamics. He linked tensions he observed in a person's body to their childhood experiences that formed their body structure. He noticed that bodies develop patterns of tension to hold back expressions and feelings (including both sensations and emotions) that were not allowed or accepted in the childhood environment.

Dr. Lowen also developed active techniques to confront both the physical dynamics and the character structure. These techniques are designed to soften the physical tensions and, in some instances, strengthen flaccid and collapsed musculature. He designed all of the techniques to increase blocked energetic flow in patients.

Bioenergetic therapists develop knowledge and experience working with the body-based techniques of Dr. Lowen. A central aspect of practicing as a bioenergetic therapist includes understanding when and how to use body-based techniques that integrate movement, expression, breath, and emotion combined with understanding. These techniques include grounding, breathing backward over a stool, exercise ball, or roller, kicking, hitting, and asserting personal boundaries. Further, advanced bioenergetic therapists have the flexibility and creativity to design their own body-based techniques in the moment, to address needs presented by their clients.

For a thorough explanation of the bioenergetic concept of character structure, descriptions of each structure, and treatment approaches for addressing them, see the books *The Physical Dynamics of Character Structure* (Lowen, 1958) and *Bend Into Shape* (Schroeter & Thomson, 2016). Bend Into Shape offers a comprehensive reference guide to the bioenergetic character structures and treatment approaches for each type. It provides valuable information for both bioenergetic therapists and trainees.

Transference and Countertransference Phenomenon

Understanding the impact of transference and countertransference deepens our understanding of the relationships our patients experienced in their childhoods,

and how these influence their patterns and expectations in current relationships. Transference and countertransference involve recognizing and working with the unconscious projections of childhood experiences and attitudes of patients onto the therapist and of the therapist onto the patient.

As bioenergetic therapists, we have the added benefit of working with our own bodies to understand the patient's transference and when we are activated by countertransference. Bioenergetic therapists highly value ongoing in-depth self-exploration and development of our ability to sort out the impact of transference and countertransference within therapeutic relationships.

Further, bioenergetic therapists value the use of supervision to separate out the sometimes complex and intricate dynamics of transference and countertransference that can occur in long-term therapeutic relationships. The requirements for certification to become a bioenergetic therapist include extensive personal therapy and many hours of supervision, which reflect this value. Bioenergetic training programs also include training in in-depth processing to allow the working through of transference issues from one's own childhood.

Robert Hilton, PhD, CBT, discusses a bioenergetic viewpoint of countertransference in the article titled: "Countertransference: An Energetic and Characterological Perspective," which can be found in his book *Relational Somatic Psychotherapy: Collected Essays of Robert Hilton, PhD.* (Hilton, 2007, pp. 286–293). In addition, the 2009 clinical journal of the IIBA article contains an article about countertransference titled: "Personal Musings on Countertransference in the Context of Becoming a Bioenergetic Analyst" (Mills, 2009). In the article, Jacqueline Mills describes her experience with countertransferential challenges as a bioenergetic therapist.

The Therapist's Use of Self in Relationship with an Available Heart

The therapist's understanding and comfort in using his/her unique self to make therapeutic interventions in the context of an intimate therapeutic relationship becomes a valuable tool when the therapist feels comfortable using it. In addition, when the therapist can offer an available, open-hearted connection within the ethical boundaries of the therapy relationship, this can become an integral part of the healing dynamic.

In my article titled: "The Therapist's Use of Self" (Carlino, 1993), I explain what I mean by the therapist's use of self and how this differentiates from coun-

tertransference. I explain how I prefer the term the therapist's use of self rather than the psychoanalytic term of sharing the countertransference, stating: "This (term therapist's use of self), I believe, is more consistent with the bioenergetic tradition and the importance of self-expression for a healthy, functioning person." (Carlino, 1993, p. 91).

Further, I discuss how the use of self involves a keen awareness of my bodily sensations as I sit with the patient and the emotions the patient elicits in me, as well as an understanding of what the patient may need from me regarding relational repair from their childhood experience. It requires that I, as the therapist, maintain solid self-understanding to separate my unconscious countertransference from the patient's real needs in the relationship.

In my article, I outline guidelines and cautions for the therapist's use of self within the therapeutic relationship. I describe how honestly sharing my feelings with the patient requires that I do this solely for the patient's benefit and not my own, that I do it within the boundaries of the therapeutic relationship, and that I maintain awareness of the patient's ability to handle genuineness responses in their relationship with me. Finally, I state: "There is no single correct way to apply the use of self in therapy, but if the therapist is honest, direct, non-judgmental and comes from the heart, it will be the most effective" (Carlino, 1993, p. 92).

Most of our patients have experienced wounding within a significant relationship during their childhood. Healing these wounds requires that the person have a different relational experience. They learn to love themselves through our example of demonstrating love and care for them. By offering our heart – manifested in our care for them – we offer them an ability to relate differently to themselves – with love, respect, and kindness, rather than with contempt, hatred, neglect, seduction, or smothering.

Modeling a different relationship includes a thorough exploration of the client's childhood relational experiences to understand the expectations they bring into their present relationships. Exploring a person's relational patterns includes considering how they have learned to relate to themselves and others – often with contempt, hatred, criticism, or neglect. Understanding these patterns requires significant exploration because clients generally cannot tell us about their childhood relationships, as they are integrated into the person's beliefs about themselves and others and their behavior.

Further, relational patterns are generally deeply ingrained and often largely unconscious. In therapy, we learn about a person's relational patterns over time through how they relate to us, what they tell us about their relationships, and

through asking about their self-talk. Shifting relational patterns requires significant repetition and patience.

I (Laurie) described my work with a client on the journey from self-loathing and deprivation to self-love in an article titled: "The Enduring Power of Bioenergetic Therapy: From Trauma to Joy" (Ure, 2024). My genuine care for the client, which I communicated throughout our therapeutic relationship, enabled her to shift her deep depression into living a life focused on joy. In the article, I described interactions with my client in which I communicated my care for her. I discussed how she informed me that it was my care that made the difference, as she shifted from self-hate and self-deprivation that she learned from her relationship with her mother to self-love and self-care, which I modeled and expressed throughout her therapy.

Other articles in the bioenergetic literature elaborate on the theme of the significance of the therapist's relationship with the patient. Robert Hilton, for example, in his book *Relational Somatic Psychotherapy: Collected Essays of Robert Hilton*, offers essays about the significance of the therapeutic relationship. He includes an essay titled: "Relationships: Taking the Care" (Hilton, 2016, pp. 133–140) and another titled: "Ending With an Open Heart" (Hilton, 2016, pp. 199–214). Elaine Tuccillio offers a rich, in-depth discussion of unconscious relational dynamics in her article titled: "Somatopsychic Unconscious Processes and Their Involvement in Chronic Relational Trauma: Somatic Transference and its Manifestation in Relational, Family and Power Dynamics" (Tuccillo, 2013).

Resonating with the Patient

Increasing the therapist's energetic contact with the patient can facilitate understanding a patient's defensive style and character structure and make more accurate therapeutic interventions. The energetic contact happens when the therapist softens their character defenses and loosens their ego boundaries. This softening of personal boundaries enables the therapist to resonate with the patient's energetic self. The resonating contact can be compared to a tuning fork, where the patient represents one prong of the fork, and the therapist represents the other. The task of the therapist is to have the two prongs resonate together.

When the therapist is in resonance with the patient, contact becomes an energetic phenomenon, not merely mechanical or intellectual. The therapist can then use their theoretical and intellectual knowledge, integrated with their resonating body experience, to understand what the client experiences and may need

for growth. Using personal resonance facilitates the therapist's making profound, accurate, and grounded therapeutic interventions. While the evolving scientific research on mirror neurons is inconclusive, it may one day find a neurological explanation for what makes bioenergetic resonance in therapy a reality.

In his book *Character Analysis*, Wilhelm Reich (1949) focuses on the importance of flowing freely in the work rather than clinging to intellectual knowledge. He states:

> "Treatment rests largely on intuitive comprehension and action. Once one has overcome the typical tendency of the beginner immediately to 'sell' his knowledge of the case if one lets oneself flow freely, then the essential basis for analytic work is established. This ability of the analyst to let himself flow freely in the work, instead of clinging to his intellectual knowledge, depends, of course, on certain conditions of a characterological nature ..." (Reich, 1949, p. 137).

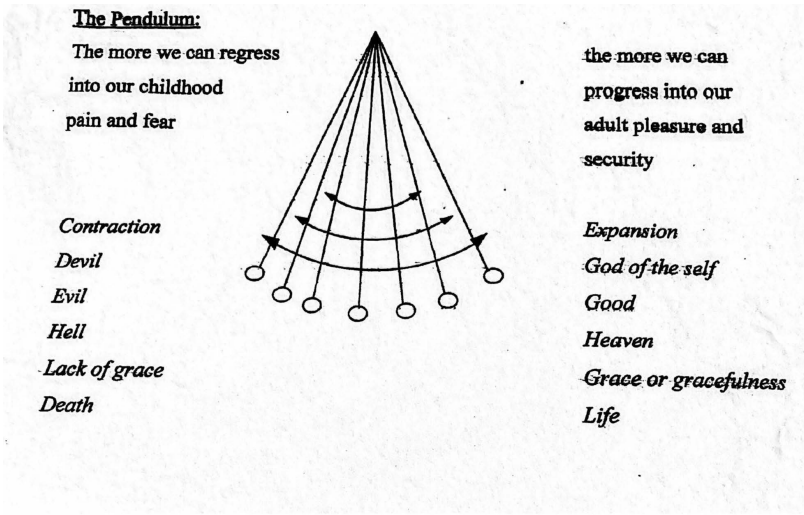
As a therapist, I attempt to resonate with what the patient experienced as a child even before they have expressed it in words or even are conscious of it. This resonance gives me an energetic insight into what they experienced or didn't experience as a child and guides my interventions with the client. Because of the subtlety in this way of working, learning to resonate with a patient energetically is the most challenging skill for a bioenergetic trainee to develop.

"The Pendulum:" Regress to Progress and Progress to Regress

Bioenergetic therapy values the use of regression via catharsis. However, regression is only productive to the extent that the uncovered feelings can be grounded and integrated. Similarly, growth via insight alone is not productive unless the insights are grounded in past pain and trauma. Productive analytic body therapy, thus, involves the ability to increase feelings via both regressive and progressive work.

I believe that the further we can regress in a grounded way, the more we can progress. Similarly, the more we can progress by strengthening the ego, the more the ego is capable of regressing. To represent the process of regression and progression I use the analogy of the pendulum. The swing to the left represents regression, and the swing to the right represents progression. The further we can regress, the further we can progress, and vice versa. The left side or regressive feelings represent pain, fear, contraction, the devil, evil, hell, lack of grace, and death.

The right side, or progressive feelings, represents pleasure, security, expansion, the God of the self, good, heaven, grace, gracefulness, and life. The following diagram further illustrates this:



We can also correlate character structure as viewed via the pendulum swings as follows:

Character Type	Regressive	Progressive
Schizoid	Fear of annihilation	Self-Integrity
Oral	Longing and insecurity	Connected and safe
Narcissistic continuum	Denial of the true self	Self-possession
Masochistic	Feeling constricted and controlled	Free and independent
Rigid	Inability to open heart and connect with sexuality	Open heart connected to sexuality

To give an example of how this pendulum swing works with a patient – I invited a client to go backward over the stool. In a regressive, cathartic movement, she cried

strongly to express how frightened and abandoned she felt as a child. After several minutes of crying, she seemed stuck in the crying, and I believed it had ceased to be productive. She had lost contact with her adult sense of self, and to stay there would have affirmed her childhood experience of feeling sad and being alone.

I wanted to help her build tolerance for the pain from her past, which she could not feel as a child, but also not stay in this overwhelmed state. I wanted her to separate the past, when she was helpless as a child, from the present, where, as an adult, she can reach out for what she needs and wants.

Gently, I encouraged her to stop crying and focus on breathing deeply to feel her body, especially her legs and feet. I then suggested that she lower her pelvis so it would start vibrating. In this, she can feel herself as an adult woman, with the capacity to feel and enjoy pleasure in her body, especially in her pelvis. Expanding this feeling of pleasure disrupts the despondency and despair from her childhood experience.

The progression includes moving towards a greater sense of self. It involves deepening the awareness and feeling of what our patients experienced as children while differentiating that as adults, they have a different reality, with more capacity to build strength and make choices.

Important points regarding the concept of the pendulum:

- The pendulum swing is a natural phenomenon. Grounded regression often brings forth growth on its own. Patients frequently report that when we identify their childhood reality and invite them to feel the feelings they could not feel as children, growth "progression" happens spontaneously in their lives.
- Likewise, the more we invite progression, by way of strengthening the ego, through grounding exercises, asserting boundaries, and expressing strong feelings, the more the patient can tolerate deeper regression.
- As the patient builds tolerance for their painful, regressive feelings, they can become grounded and embodied in their painful past. This increased tolerance makes the movement towards progression to an adult state possible. By regressing repeatedly, we aim to build tolerance for painful feelings rather than simply focusing on catharsis. Repeated regression is in the service of building tolerance for the childhood pain and trauma.
- Every psychotherapy session can have this dynamic of both regression and progression present. The pendulum swing from regression to progression can happen either slowly or rapidly.
- Basic bioenergetic exercises can be used both progressively and regressively. Kicking, for example, can be used to expand and express childhood impotence (regression) and with the expression "I didn't feel seen." It can be progressive

when instructing the client to kick with straight legs and strongly express: "See me!"

➢ A word of caution: the therapist must be careful only to regress the patient to the extent that they can integrate and ground the regressive feelings. Regressing the patient with integration and grounding allows growth and vitality, not flooding, overwhelming, or retraumatizing them with the experience. When and how to focus on regression vs. progression is a clinical decision that the therapist makes with caution and expertise.

Conclusion

I use this framework of the seven aspects of bioenergetic analysis when I do therapy. I keep all seven parts of the amalgam in the background of my consciousness while focusing on one or more of these aspects at any given moment. Based on my intuitive understanding and observations of what the client presents and how they respond, I then intuitively rotate the focus from one part of the amalgam to another. Doing profound bioenergetic analysis requires utilizing and integrating all seven aspects presented in this article. As therapists, we need to incorporate all seven aspects without eliminating or leaving any of them out. Our ability to weave these aspects into the therapy correlates to our effectiveness as therapists. Integrating these varied and rich facets makes Bioenergetic Analysis an exquisite amalgam, unique and different from any other form of therapy.

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The object relationship theory in bioenergetic analysis in the light of Kernberg's conception

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Abstracts

It is shown how the students further developed Lowen's bioenergetic concepts, which, in the light of object relations theories, can be traced back to Winnicott in particular. However, to date, Kernberg's ideas are largely absent from the bioenergetic literature. Lowen's model of pathogenesis, with the idea of pleasure orientation as the main motivation for human action and physical defense as a means of repressing anxiety in connection with suppressed impulses, is contrasted with Kernberg's idea of the dynamic unconscious. Based on a modified drive model, he understands affects as the basic motivation for human action. These organize themselves according to their valence into antagonistic poles of aggression and libido. He understands the defense function as a means of splitting painful relationship dyads from conscious self-experience. The three-elements of the object relations are also understood in their physically tangible dimensions, with a focus on the energetic aspect. Daniel Stern's concept of RIGS supports this connection, which Kernberg does not conceptualize in this way. Krause's modular affect theory provides guidance for working with the element of affect. The grounding phenomenon known in bioenergetics is reinterpreted by means of Kernberg's psychodynamic understanding and the possibilities of the interventions derived from it are explained on the basis of a clinical example.

Keywords: object relations theory, psychopathogenesis model, affect theory, enactment, grounding, RIGs, dynamic unconscious

A teoria da relação de objeto na Análise Bioenergética à luz da concepção de Kernberg (Portuguese)

O artigo mostra como os estudantes foram desenvolvendo conceitos bioenergéticos de Lowen, os quais, à luz de teorias de relação de objeto, podem ser associadas particularmente a Winnicott. Entretanto, até o momento, as ideias de Kernberg estão praticamente ausentes na literatura bioenergética. O modelo de patogênese de Lowen, cuja ideia central se baseias na orientação para o prazer como a principal motivação para a ação humana e na defesa física como meio de reprimir a ansiedade em conexão com impulsos suprimidos, contrasta com a ideia de inconsciente dinâmico de Kernberg. Baseado num modelo modificado de drive, ele entende serem os afetos a motivação básica da ação humana. Estes se organizam, de acordo com sua valência, em polos antagônicos de agressão e libido. Ele entende a função de defesa como um meio de separar as relações diádicas dolorosas da autoexperiência consciente. Os três elementos das relações de objeto são também compreendidos em sua dimensão fisicamente tangíveis, com foco no aspecto energético. O conceito de RIGS Daniel Stern apoia essa conexão, a qual Kernberg não conceitualiza dessa maneira. A teoria de afeto modular de Krause oferece uma direção para trabalhar com o elemento do afeto. O fenômeno do *grounding*, conhecido na Bionergética, é reinterpretado através do entendimento psicodinâmico de Kernberg e as possibilidades de intervenção daí derivadas são explicadas através de um exemplo clínico.

La théorie des relations d'objet dans l'analyse bioénergétique à la lumière de la conception de Kernberg (French)

Il est montré comment les chercheurs ont développé les concepts bioénergétiques de Lowen, qui, à la lumière des théories des relations d'objet, peuvent être attribués en particulier à Winnicott. Cependant, à ce jour, les idées de Kernberg sont largement absentes de la littérature bioénergétique. Le modèle de pathogenèse de Lowen, avec l'idée de l'orientation au plaisir comme motivation principale de l'action humaine et de la défense corporelle comme moyen de refouler l'anxiété en relation avec les impulsions refoulées, est en contradiction avec l'idée de Kernberg de l'inconscient dynamique. Sur la base d'un modèle modifié de pulsion, il comprend les affects comme la motivation fondamentale de l'action humaine qui s'organisent en fonction de leur valence en pôles antagonistes d'agression et de libido. Il comprend la fonction de la défense comme moyen de séparer les dyades relationnelles douloureuses de l'expérience du soi conscient. Les trois éléments des relations d'objet sont également compris dans leurs dimensions physiquement tangibles, en mettant l'accent sur l'aspect énergétique. Le concept de RIGs de Daniel Stern soutient ce lien, que Kernberg ne conceptualise pas de cette manière. La théorie modulaire de l'affect de Krause fournit des conseils pour travailler avec l'élément de l'affect. Le phénomène d'ancrage connu en bioénergétique est réinterprété au moyen de la compréhension psychodynamique de

Kernberg et les possibilités des interventions qui en résultent sont expliquées sur la base d'un exemple clinique.

La teoria delle relazioni oggettuali nell'analisi bioenergetica alla luce della concezione di Kernberg (Italian)

Viene mostrato come i suoi allievi abbiano sviluppato i concetti bioenergetici di Lowen, che, alla luce delle teorie delle relazioni oggettuali, possono essere ricondotti in particolare a Winnicott. Tuttavia, fino ad oggi, le idee di Kernberg sono in gran parte assenti dalla letteratura bioenergetica. Il modello di patogenesi di Lowen, con l'idea dell'orientamento al piacere come motivazione principale per l'azione umana e la difesa corporea come mezzo per reprimere l'ansia in relazione agli impulsi repressi, è messo in relazione con l'idea di Kernberg dell'inconscio dinamico. Sulla base di un modello di pulsione modificato, egli comprende gli affetti come motivazione di base per l'azione umana che si organizzano in base alla loro valenza in poli antagonisti di aggressività e libido. Egli comprende la funzione di difesa come mezzo per separare le diadi relazionali dolorose dall'esperienza di sé cosciente. I tre elementi delle relazioni oggettuali sono anche compresi nelle loro dimensioni fisicamente tangibili, con un focus sull'aspetto energetico. Il concetto di RIGs di Daniel Stern supporta questa connessione, che Kernberg non concettualizza in questo modo. La teoria modulare dell'affetto di Krause fornisce una guida per lavorare con l'elemento dell'affetto. Il fenomeno del grounding noto in bioenergetica viene reinterpretato per mezzo della comprensione psicodinamica di Kernberg e le possibilità degli interventi che ne derivano vengono spiegate sulla base di un esempio clinico.

Die Objektbeziehungstheorie in der bioenergetischen Analyse im Licht von Kernbergs Konzeption (German)

Lowens Schüler haben seine bioenergetischen Konzepte weiterentwickelt, die von der Objektbeziehungstheorie her besonders auf Winnicott zurückgehen. Allerdings blieben in der bioenergetischen Literatur Kernbergs Theorien bis heute großenteils unberücksichtigt. Lowens Modell der Pathogenese, das auf der Idee der Lustorientierung als Haupttriebkraft des menschlichen Handelns basiert, sowie der Abwehr zur Bewältigung unterdrückter Regungen, wird Kernbergs Idee des dynamischen Unbewussten gegenübergestellt. Von einem modifizierten Triebmodell ausgehend, versteht dieser die Affekte als Grundmotivation des menschlichen Handelns, welche sich je nach Valenz in die antagonistischen Pole von Aggression und Libido unterteilen. Die Abwehrfunktion wird als ein Mittel aufgefasst, durch Abspaltung schmerzliche dyadische Beziehungen von der bewussten Selbsterfahrung auszugrenzen. Weiterhin werden die drei Elemente der Objektbeziehungen in ihren körperlich erfahrbaren Dimensionen verstanden, wobei der energetische Aspekt im Mittelpunkt steht, Daniel Sterns Konzept der RIGs unterstützt

diese Verbindung, die Kernberg allerdings nicht in dieser Weise auffasst. Krauses modulare Affekttheorie zeigt die Richtung für die Arbeit mit den Affekten. Das bioenergetische Konzept des grounding wird von Kernbergs psychodynamischem Verständnis her neu interpretiert; anhand eines Fallbeispiels werden die davon ausgehenden Interventionsmöglichkeiten veranschaulicht.

Теория объектных отношений в биоэнергетическом анализе в свете концепции Кернберга (Russian)
Показывается, как студенты развивали биоэнергетические концепции Лоуэна, которые, в свете теорий объектных отношений, восходят, в частности, к Винникотту. Однако, до сих пор идеи Кернберга в значительной степени отсутствуют в биоэнергетической литературе. Модель патогенеза Лоуэна, с идеей ориентации на удовольствие как основной мотивации человеческих действий и физической защиты как средства подавления тревоги в связи с подавленными импульсами, противопоставляется идее динамического бессознательного Кернберга. Основываясь на модифицированной модели влечений, он понимает аффекты как основную мотивацию человеческих действий. Они организовываются в соответствии со своей валентностью в антагонистические полюса агрессии и либидо. Он понимает защитную функцию как средство отделения болезненных взаимоотношений от осознанного переживания себя. Три элемента объектных отношений также понимаются в их физически осязаемых измерениях, с акцентом на энергетический аспект. Концепция RIGS Дэниела Стерна поддерживает эту связь, которую Кернберг не концептуализирует таким образом. Модульная теория аффекта Краузе дает рекомендации по работе с элементом аффекта. Феномен заземления, известный в биоэнергетике, переосмыслен с помощью психодинамического подхода Кернберга, а возможности вмешательства, вытекающие из него, объясняются на основе клинического примера.

La teoría de las relaciones objetales en el análisis bioenergético desde la perspectiva de la concepción de Kernberg (Spanish)
Se examina cómo los alumnos han ampliado y desarrollado los conceptos bioenergéticos de Lowen. Estos conceptos, desde el punto de vista de las teorías de las relaciones objetales, pueden vincularse especialmente con las ideas de Winnicott. Sin embargo, las ideas de Kernberg continúan estando en gran medida ausentes en la literatura bioenergética. El modelo de patogénesis de Lowen, con la idea de la orientación hacia el placer como la principal motivación de la acción humana y la defensa física como un medio para reprimir la ansiedad en relación con los impulsos reprimidos, se contrasta con la

idea de Kernberg del inconsciente dinámico. Basado en un modelo pulsional modificado, Kernberg entiende los afectos como la motivación básica para la acción humana. Estos se organizan según su valencia en polos antagónicos de agresión y libido. Kernberg concibe la función defensiva como un medio para escindir las díadas relacionales dolorosas de la experiencia consciente del yo. Los tres elementos de las relaciones objetales también se comprenden en sus dimensiones físicamente tangibles, con un enfoque en el aspecto energético. El concepto de RIG (Representaciones de Interacciones Generalizadas) de Daniel Stern apoya esta conexión, que Kernberg no conceptualiza de esta manera. La teoría modular de los afectos de Krause proporciona orientación para trabajar con el elemento afectivo. El fenómeno de "grounding", fundamental en la bioenergética, se reinterpreta a la luz de la comprensión psicodinámica propuesta por Kernberg. Las posibilidades de intervención que surgen de esta nueva perspectiva se ilustran con un ejemplo clínico.

从科恩伯格的概念看躯体动力分析中的客体关系理论 (Chinese)

研究表明，学生们是如何进一步发展勒温的生物能概念的，根据客体关系理论，这些概念尤其 可以追溯到温尼科特，然而，迄今为止，科恩伯格的观点在躯体动力分析文献中基本没有出 现。勒温的病理学模型认为，愉悦取向是人类行动的主要动机，而身体防御则是与被压抑的冲 动相关的抑制焦虑的一种方式，这与科恩伯格的动力无意识概念形成了对比。基于修正后的驱 力模型，科恩伯格将情感理解为人类行动的基本动机。这些情感根据其价值将自己组织成攻击 性和性欲的对立两极。他将防御功能理解为将痛苦的二元关系从有意识的自我体验中分裂出来 的一种方式。客体关系的三个要素也被理解为有形的物理层面，重点是能量方面。丹尼尔-斯 特恩（Daniel Stern）的 "RIGS"概念支持这种联系，而科恩伯格并没有将其加以概念化，克劳 斯的模块化情感理论为情感元素的工作提供了指导。本文通过科恩伯格的心理动力学的理解方 式，重新诠释躯体动力学中的扎根现象，并以临床实例为基础，解释了由此衍生的干预的可能性。

Introduction

Lowen's character structures represent an evolution of the character typology conceived by Reich in his book *Character Analysis* (Reich, 1933). Lowen's thinking is guided by ego psychology. His writings lack references to object relations theorists such as Melanie Klein, Winnicott, Fairbairn, Guntrip, Bion, Balint, and Margaret Mahler, or to Heinz Kohut's self-psychology. It was left to his students, including Bob Lewis, Bob Hilton, Stephen Johnson, Scott Baum, Vincentia Schroeter, Guy Tonella, Jörg Clauer, and others, to integrate more recent psychoanalytically-oriented theoretical models into the understanding of bioenergetics and to derive practical clinical conclusions from them. All these later authors base

their work on the so-called "soft" or "maternal" object relations theories (Fonagy et al., 2003). These theories tend to take a supportive, structure-building, and nurturing approach, aligning with the so-called relational turn in psychoanalysis, which emphasizes a two-person psychology. In contrast, the contributions of Otto F. Kernberg, a contemporary theorist whose work remains influential in the treatment of personality disorders, particularly borderline personality disorder and narcissistic personality disorder, have received little attention within the bioenergetic community. Kernberg belongs to the "hard" object relations theory school, which aligns with a "paternal" conceptual framework characterized by uncovering, interpreting, and confronting dynamics (Fonagy, 2003). This paper aims to make an initial attempt to bridge this gap. The focus is less on Kernberg's specific conceptualization of borderline personality disorder and the overarching borderline personality organization (Kernberg, 1980) with its emphasis on identity diffusion, and more on his fundamental model of the psyche, which integrates the diverse and multifaceted aspects of object relations theory. The goal is to demonstrate how this fundamental model of the psyche can explain clinical situations within the framework of bioenergetic analysis and serve as a guide for therapeutic action.

Object Relations Theory: A Definition and Framework

To begin, it is important to clarify what is meant by object relations theory. In broad terms, this encompasses all theories that address both real, external persons and the internal experiences associated with them, as well as the impact of these experiences on psychological functioning (Fonagy & Target, 2020 [2003], p. 153).

Kernberg offers three definitions of object relations theory:

1. The first, very general and non-specific, originates from Freud's drive concept, which posits that a drive is directed toward a goal and an object, where it finds satisfaction (Freud, 1915c, p. 215).
2. The second, the narrowest definition, confines object relations theory to the characteristic approaches of the so-called British school, including Melanie Klein (1997 [1948]), Fairbairn (1954), Winnicott (1976 [1958a]), and Bowlby (1975 [1969]).
3. The third and most relevant definition for Kernberg, which he relies on for his understanding, integrates concepts from ego psychology, particularly the works of Erikson (Erikson, 1973 [1959]) and Jacobson (Jacobson, 1973

[1964]), alongside the British school. Kernberg identifies himself as an ego-psychological object relations theorist.

This third definition serves as the foundation for the discussion that follows.

Kernberg's Conceptualization of Object Relations

At the core of Kernberg's model is the formation of dyadic intrapsychic representations of self and object images, each of which possesses a bipolar intrapsychic quality. These representations originate in the early mother-child relationship and influence the later development of dyadic, triadic, and multiple internal and external interpersonal relationships. Interpersonal relationships are thus understood as reenactments of earlier ones.

According to Kernberg, all experiences occur as simultaneous formations of self and object. The self is understood as a composite structure resulting from the integration of multiple self-images. The object refers to internal objects or object representations, derived from the integration of multiple object images into broader representations of others. A key aspect of Kernberg's theory is that internalization always involves a dyadic, bipolar characteristic, where each unit of self- and object-image is embedded in a distinct affective context. These self-object-affect units constitute the primary determinants of the totality of the psychic structures (id, ego, and superego) (Kernberg, 1997, p. 55).

Object relations theory thus concerns itself with the causes and psychological development leading to a more or less integrated ego, superego, and id. It is a theory of early development but also provides a framework for therapeutic techniques addressing a wide range of pathologies, including psychosis, borderline personality disorder, pathological narcissism, and neuroses (Kernberg, 1995).

Limitations of Kernberg's Approach

An essential point to highlight is that Kernberg's object relations theory is rooted in representations that he conceptualizes as cognitive constructs, though he does not elaborate on their nature. It can be assumed that he refers to cognitive and imaginative properties or processes. However, he does not extend his conceptualization to include the physical domain, such as processes involving bodily sensations, posture, or movement. In his writings, Kernberg only hints at the im-

portance of observing patients and attending to their communication channels to guide the choice of focal topics during therapy sessions. He references nonverbal cues such as tone, voice modulation, posture, gestures, and facial expressions but does not integrate these into his theoretical framework for object relations (Clarkin et al., 2006 [2008], p. 97).

A Proposed Expansion

In the following discussion, an attempt will be made to address this gap by integrating the physical and nonverbal dimensions into the object relations framework. This expansion aims to provide a more comprehensive understanding of therapeutic interactions and their underlying processes.

Fundamental Differences Between Object Relations Theories

First, however, I will provide some introductory and further remarks on the various object relations theories. They diverge on several key points, including:

1. *The Role of Freudian Drive Theory:* The extent to which Freud's concept of drives (libido and aggression) is retained or rejected.
2. *The Nature of Aggression:* Whether aggression is considered an innate component of human nature or a secondary phenomenon resulting from the frustration of libidinal needs.
3. *Unconscious, Innate Fantasies:* The existence and role of unconscious fantasies, as well as their interaction with the infant's real-life experiences with significant others.
4. *Therapeutic Technique:* The degree of emphasis placed on transference and the significance of the reality aspects of the therapeutic relationship.

Variations in Perspective

Fairbairn's Theory:
Fairbairn rejects libido and aggression as primary motivational systems. He proposes that object relations themselves serve as the central motivational force, equating libido with the drive for relational connection. He dismisses the no-

tion that libido's primary function is pleasure-seeking (Fairbairn, 2000 [1946], p. 171). Fairbairn emphasizes the critical role of a nurturing early environment in fostering healthy psychological development (Bacal, 1990).

Sullivan and Interpersonal Psychoanalysis:
Sullivan (Newman, 1990), like Fairbairn, disputes the existence of innate drives. Both theorists consider aggression secondary, arising from frustrated libidinal needs, particularly in the context of traumatic experiences in the early mother-child relationship.

In contrast, theorists aligned with Freud's dual-drive theory, such as Melanie Klein, argue that aggression is innate and pivotal in shaping early interpersonal dynamics. To some extent, Winnicott and certain ego psychologists in the object relations tradition share this perspective (Kernberg, 2002, p. 15).

Kleinian Approach:
Kleinian theorists posit that unconscious fantasies exist from birth as expressions of libido or destructive impulses, including the death drive. These fantasies profoundly influence how infants perceive their real relational experiences, which are shaped by, but not determined by, external environmental factors.

The perspective of interpersonal psychoanalysis, on the other hand, as represented by Sullivan or Guntrip, regarding the significance of unconscious fantasies, posits that early internalized object relations are maintained with minimal structural modifications and deny the existence of unconscious fantasies from birth. Consequently, transference developments reflect quite accurately the actual traumatically internalized object relations of the past (Kernberg, 2002, pp. 15–16).

Divergences in Therapeutic Technique

Kernberg's Approach:
Kernberg, in the tradition of Klein and Jacobson, interprets transference relationships as manifestations of reactivated intrapsychic conflicts. His approach heavily emphasizes countertransference, particularly when addressing severe personality disorders.

Interpersonal Psychoanalysis:
In contrast, theorists such as Guntrip and Greenberg & Mitchell prioritize the reality of the therapeutic interaction in the present moment, focusing on the

therapist's personality rather than on the patient's innate unconscious fantasies (Greenberg & Mitchell, 1983).

Underlying Philosophies of Human Nature

Romantic View:
The romantic paradigm, endorsed by Balint, Winnicott, and Guntrip, portrays humans as inherently good and capable, shaped largely by external influences. It attributes psychopathology to developmental deficits stemming from unfavorable conditions and assumes a significant, optimistic potential for growth and healing. This perspective also underpins humanistic psychology.

Classical Psychoanalytic View:
The classical paradigm, rooted in the work of Anna Freud, Melanie Klein, Kernberg, and certain British object relations theorists, views humans as naturally flawed but capable of addressing some shortcomings. It interprets psychopathology as the result of unresolved conflicts and emphasizes the inescapable nature of aggression and destructiveness. Life, according to this view, is a constant struggle against the resurgence of infantile conflicts (Fonagy & Target, 2020 [2003], pp. 156–157).

These fundamental differences in theory and technique highlight the diverse approaches within the field of object relations, each shaped by distinct philosophical assumptions and clinical priorities.

Commonalities Among Different Object Relations Theories

Despite their differences, object relations theories share several fundamental similarities:

1. Origins of Severe Pathologies: Severe psychological pathologies are believed to originate in the pre-oedipal phase, specifically during the first three years of life.
2. Developmental Complexity of Object Relations: Object relation patterns become increasingly complex as development progresses. This maturation follows a sequence but can be disrupted by adverse individual experiences.
3. Fixation and Repetition of Early Patterns: Early patterns of object relations tend to repeat and, to some extent, become fixed over the course of a person's life.

4. Emergence of Characteristic Pathologies: Disruptions in early object relations leads to the development of characteristic pathologies during psychological development.
5. Therapeutic Exploration of Early Relationship Patterns: The patient's responses to the therapist provide an opportunity to explore both healthy and pathological aspects of early relational patterns (Fonagy & Target, 2020 [2003], p. 155).

These shared elements underscore the central importance of early relational experiences in shaping psychological development and their lasting impact on personality and pathology. They also highlight the therapeutic value of examining these early patterns in the context of the therapeutic relationship.

Lowen's Original Pathogenesis Model of Mental Disorders

Alexander Lowen's conceptualization of mental disorders stems from the mid-20th century, shaped by Wilhelm Reich's psychoanalytic framework, with whom he underwent analysis between 1942 and 1945 (Lowen, 1975), and Freud's drive theory. Thus, he is located with his views in classical psychoanalysis. His approach integrates ego psychology and focuses primarily on the biological and energetic dimensions of psychological functioning diverging from developments in relational and object relations theories.

Key Elements of Lowen's Pathogenesis Model

1. Pleasure Principle as a Primary Motivational System: The pleasure principle, biological in nature, governs infantile experience from birth. Limitations, punishments, or frustrations imposed by external factors on the pursuit of pleasure result in the rise of the reality principle, which introduces pain or neurotic anxiety.
2. Development of Neurotic Anxiety: Neurotic anxiety arises from internal conflicts originating in early life, what we call infantile conflict. This anxiety contrasts with real fear, which serves as a necessary survival mechanism against external threats.
3. Defense Mechanisms and Physical Manifestations: Psychological defenses like repression, denial, rationalization and their physical correlates like mus-

cular tensions emerge to manage neurotic anxiety. However, the complete repression into the unconscious fails. Such defenses diminish vitality, disrupt the flow of energy, and contribute to symptoms. A compromise is formed and symptoms arise, such as restricted breathing. In a broader understanding, the defense keeps away all affects that are unpleasant for the ego, such as sadness, depression, shame and insult, in addition to anxiety. These bodily conformations are reflected in Lowen's original concept of character structures. They are formed in order to avoid the neurotic fear.

4. Role of Regression: Understanding a patient's problems begins with a stressful situation that triggers them. However, this objective conflict situation cannot explain the emotional relevance as experienced by the patient concerned. Rather, it points to an actual conflict. This is characterized by the disproportion between the triggering event and the inadequate subsequent reaction. This is associated with a feeling of anxiety or other negative affects. As an adult, the patient attempts to resolve the actual conflict by means of physical tension and psychological defense mechanisms or childish means. In doing so, he falls back on an infantile form of experience, which we call regression and understand as a reactualization of the infantile conflict. The relief unconsciously hoped for by the patient fails, the conflict intensifies, tension and anxiety increase. The conflict becomes unsolvable and causes suffering or symptoms. (extended from: Hoffmann & Hochapfel, 2009, pp. 61–62).

   In short: Stressful situations in adulthood trigger reactualization of infantile conflicts through regression. Attempts to resolve these conflicts using defensive strategies fail, leading to intensified symptoms and emotional distress.

5. The Bioenergetic Therapy: Therapy aims to restore energy flow by deepening breathing, reducing muscular tension, and increasing motility. These physical changes foster emotional release, induce associations and insights, and culminate in a sense of liberation (Lowen, 1984, p. 2).

Limitations of Lowen's Model of the One-Person Psychology

Lowen's model centers on the inner psychodynamics of the individual, with limited consideration for relational dynamics or external interpersonal influences. He makes no reference to a counterpart who reacts sensitively in contact and thus makes safety possible. For Lowen, the conscious feeling of safety is limited exclusively to one's own experience, especially that of grounding, i. e. to the way

in which contact with the ground is established and felt. In the article (Lowen, 1995), he refers to failed therapies by Wilhelm Reich. His patients did achieve the experience of the orgasm reflex and free movement in the pelvis during inhalation and exhalation through breathing work, accompanied by a feeling of pleasure. However, when they left the therapy room and lacked direct contact with Reich, this good feeling disappeared. For Lowen, this only meant that Reich neglected the work with and the strength in the legs. He disregarded the importance of the therapeutic relationship, the support it provides and the experience of support it creates. Lowen remained theoretically in the 50s of the last century. He did not participate in the further development and theoretical debates of psychoanalysis. There are no references to the object relationship in his writings.

From Lowen's One-Person Psychology to Bioenergetically Inspired Object Relations Theory

Several of Lowen's students have further developed his approach to one-person psychology, incorporating concepts from object relations theory. This evolution marks a departure from Lowen's paradigm, which posited that all character structures involve an energy deficit caused by suppressive defense mechanisms. In cases of severe psychopathology, such as borderline personality disorder or borderline character structures, there is instead an excess of energy.

This section highlights key students of Lowen and their contributions to object-relations-oriented approaches.

Bob Hilton developed a method of relational somatic psychotherapy, inspired by Winnicott and Guntrip (Sieck, 2007; Hilton, 2012) and shaped by his personal experiences as a patient of Lowen. Hilton emphasizes the therapeutic relationship as the central element for fostering change. He attributes psychological problems to a dual source of trauma:

1. The infant's lack of adequate contact with the mother, which stunts the child's life impulses, and
2. Developmental trauma caused by neglect and abuse during childhood, influenced by Peter Levine's concept of somatic experiencing.

Hilton identifies the disturbed mother-child relationship as a core issue, suggesting that the development of blocks and withdrawal into the self can be traced back to this early relational dynamic. This manifests on two levels: Physically, in the form of numbness, immobility, and apathy (a "broken heart"), and relationally

through superficial attachments, over-adaptation, and substitute gratifications – what Winnicott (1958b) termed the "false self".

Hilton rejects the classical psychoanalytic interpretation of resistance as mere stubbornness. Instead, he views resistance as a self-protective function that must be respected to avoid retraumatization. His therapeutic stance is guided by three principles:

1. Creating a sense of being understood,
2. Viewing chronic muscular tension as inhibited impulses, and
3. Fostering relationships that are "good enough" to support the discovery of the "true self."

This approach enables patients to relinquish resistance as a protective mechanism, paving the way for deeper self-exploration and healing.

Johnson (1985) situates Lowen's five character structures within a developmental framework, referencing the work of Margaret Mahler. He attributes the schizoid character to developmental disruptions in the autistic phase (up to the 8th week of life) and the oral character to impairments during the symbiotic phase (up to 6 months). Johnson incorporates Winnicott's concept of the "false self", which arises as a response to the frustration of the "true self" and appears across various character structures.

In his work "The Narcissistic Personality Style" – which Lowen refers to as the psychopathic character – Johnson explores developmental issues within the rapprochement phase (15–24 months) and classifies object relations according to Kohut into three levels of severity:

1. Fusion: The patient experiences a psychic merger with caregivers, expanding the inflated self and perceiving a sense of entitlement to use others.
2. Twinship transference: The patient accepts separation but attributes largely identical psychology – similar preferences and aversions – to the other person.
3. Mirror transference: The other person is used to validate and inflate the false self.

In his book Body and Word in Psychotherapy (1996), *Downing* integrates object relations theory with body-oriented psychotherapeutic approaches, drawing partly on Kernberg's concepts. Downing views internal representations not merely as images of people but as motor-encoded beliefs about others. He discusses object relations units in the sense of Kernberg, which revive the patient's past relational experiences – such as those with the mother – within the therapeutic

process. Downing connects these units with affective-motor schemas, composed of three elements:

1. Motor behavioral components,
2. Affective coloring, and
3. Cognitive evaluations.

Through this approach, Downing provides a body-psychotherapeutic perspective that proves particularly useful in clinical practice, especially through his detailed focus on working with affects during therapy.

Baum explores object relations theory extensively in two works, connecting it with body-oriented psychotherapeutic approaches. In his first work (Baum, 1997), he examines borderline personality disorder in the context of Lowen's grounding concept, incorporating elements of Kernberg's theory, albeit without explicitly naming him. Baum expands the grounding concept to include not only the physical perception of contact with the ground but also the energetic and psychological perception of reality. He describes the identity disturbance in borderline patients as a lack of self-coherence and an inability to perceive others in a differentiated way, which he links to a deficiency in grounding. This is associated with somatic issues, such as insufficient contact with the ground and limited proprioception in the legs, resulting in an inner withdrawal from reality.

Baum broadens the concept of reality testing, incorporating the ability for internal anchoring and the retrieval of comforting memories. Therapeutically, he emphasizes the importance of the therapeutic relationship, which he describes as being based on a so-called therapeutic matrix, characterized by equality and mutual sensitivity to perceptions – though he does not clearly define the concept of equality. Classical bioenergetic techniques, such as kicking and deep breathing, also play a role in his approach.

In his later article (2017), Baum develops the concept of the therapeutic matrix further, grounding it in Winnicott's concept of the "holding environment". He highlights the central role of the therapeutic relationship as a key factor in psychotherapy. However, unlike his earlier work, Baum now qualifies the principle of equality, describing the relationship as inherently asymmetrical: the patient is at the center, and the dynamic is not about mutual exchange. Baum defines the therapeutic matrix through three categories:

1. Containment – the holding of emotional content,
2. Holding – the emotional and physical "holding" of the patient, enhanced by body-oriented therapeutic elements, and
3. Receptivity – the therapist's openness to the patient's needs.

Baum rejects a purely relational therapy, instead integrating the principles of abstinence and neutrality on the part of the therapist, drawing on the principles of object relations theory and inspired by Bion.

Klopstech describes the therapeutic approach as contingent upon the clinical situation, framing it either as a one-person therapy or as therapy in the context of object relations theory (Klopstech, 2002). She differentiates between the one-and-a-half-person psychology and the two-person psychology, a concept introduced by psychoanalyst Martha Stark (Stark, 2000).

The one-and-a-half-person psychology model assumes a structural deficit in the patient and is based on two theoretical frameworks:

1. Self-psychology (as developed by Kohut), where the therapist acts as an empathetic self-object, offering the patient affirmation and validation of their experiences.
2. Object relations theory, where the therapist is seen as a kind of good mother figure, providing a corrective emotional experience.

This model highlights the "price" (a deficit) the child pays for parental inadequacies. Key proponents of this perspective include Balint and Winnicott.

In contrast, the two-person psychology is grounded in a relational understanding of the therapeutic relationship. Here, the patient and therapist form a dynamic relationship based on mutuality and reciprocity. The therapist assumes the role of a subject and an active participant in the relationship.

Klopstech's approach thus enables a flexible therapeutic framework that focuses either on the patient's structural deficits or on the relational dynamics between the patient and therapist, depending on the needs of the clinical situation.

Heinrich (Heinrich-Clauer, 2008) utilizes her own bodily sensations, internal images, and emotions, interpreting them as resonance phenomena in the sense of somatic countertransference and using them as a starting point for therapeutic interventions.

Lewis (Lewis, 2008) explains the development of the "false self" (as described by Winnicott) through the premature development of the head-neck-shoulder musculature. When a mother – potentially exhibiting traits of borderline personality disorder – lacks sensitivity, the infant is forced to prematurely support themselves against gravity in an attempt to self-regulate and withdraw from the mother. This results in chronically tense neck muscles and a mask-like facial expression, indicating a split between body and mind. The patient "lives in their head" with limited access to bodily sensations. Lewis refers to this condition as cephalic shock.

Tonella demonstrates that the "self" is a complex functional unit comprising "representation, emotion, motor activity, sensory function, and energy". He argues that the self develops against the backdrop of two motivational systems: sexuality and attachment. His work refers to Bowlby's attachment theory (Tonella, 2008).

Cockburn (Cockburn, 2012) develops an understanding of pre-oedipal transference from an object relations perspective, drawing on the work of Ogden and Bion. He explains the paranoid-schizoid position and the associated phenomena of splitting. Cockburn emphasizes the intensity of transference resonances and their energetic and somatic nature in severely disturbed patients, which can be physically experienced by the therapist as countertransference. He argues that Lowen's three bioenergetic principles are not limited to one-person psychology: psychological problems are integrated equally with physical expression in the therapeutic process; muscular tension is systematically addressed; and body-based interventions facilitate a more comprehensive understanding of transference and countertransference phenomena.

Koemeda (Koemeda-Lutz, 2006) highlights the importance of enactment in therapy, which can be understood both from an object relations and relational perspective. The term "enactment" refers to the spontaneous bodily movements of the patient and therapist, which initially appear as unconscious enactments. In this dynamic, in a first step the therapist becomes engaged in a non-verbal form of communication in the here and now. Through this scenically enacted process, past experiences are reorganized, and communication occurs through expressive actions and mutual handling (Heisterkamp, 2022). In the next phase, it is crucial for the therapist to consciously perceive their somatic countertransference and actively integrate it into the therapeutic process.

Resneck-Sannes (2012) emphasizes the importance of Bowlby's attachment theory, which she regards as part of object relations theory. This theory serves as her foundation and guide for understanding and contextualizing therapeutic processes. She critiques the fact that physical contact is often overlooked in scientific discussions. For her, this dimension, combined with relational orientation, is a central feature of bioenergetics and distinguishes it from other body-oriented psychotherapeutic approaches, such as Levine's Somatic Experiencing. In her view, physical contact in therapy must be precisely tailored to the individual needs of the patient. Variations in the intensity of touch, as well as the use of voice, including its volume and tone, aim to provide the patient with a comforting and healing experience.

Resneck-Sannes draws on infant researcher Ed Tronick (2007) and argues that therapeutic change arises only through resonance between patient and therapist. This resonance creates the space for a dyadic body-emotion awareness.

The effectiveness of therapy, according to her, lies less in interpretations and more in the therapist's genuine presence, characterized by spontaneity and affectivity. In her article on the borderline character structure, Vincentia Schroeter (2009) references Kernberg's description of psychopathological phenomenology, particularly primitive defense mechanisms such as splitting and projective identification. These mechanisms prevent borderline patients from developing an integrated and consistent sense of self and others. Patients with this character structure exhibit high energy levels, are explosive, and struggle to control their energy, leading to impulsive emotional outbursts. *Schroeter* views the therapeutic task as providing the patient with grounding and support, including on a physical level. The goal is to facilitate positive experiences through this support, which can then be internalized and experienced as an integrated part of the self.

Kernberg's Object Relations Theory

Kernberg's conceptualization of object relations theory has received little attention in bioenergetic literature to date. However, given its valuable contribution to understanding patient issues and guiding therapy, we will explore its fundamental concepts in detail in the following section. This provides the foundation for its meaningful therapeutic application.

Kernberg developed the most comprehensive and differentiated theoretical framework among the object relations theories proposed to date. On the one hand, he successfully reconceptualized psychoanalytic treatment and devised a manualized approach specific to severe personality disorders: Transference-Focused Psychotherapy (Clarkin et al., 2008). On the other hand, as a clinically oriented psychiatrist, his understanding of borderline pathology significantly influenced diagnostic criteria. This is evident in the description of borderline personality disorder in the DSM-III (Diagnostic and Statistical Manual of Mental Disorders) during the 1980s, as well as in the current DSM-5, particularly in the alternative model outlined in its appendix. The same influence is apparent in the upcoming ICD-11 framework.

Additionally, Kernberg designed a diagnostic classification system for clinically relevant personality disorders, integrating categorically defined disorders into dimensional domains that account for severity, introversion versus extraversion, and levels of identity development (Clarkin et al., 2006; 2008, pp. 10–11). This conceptualization was ahead of its time during the 1980s and 1990s, challenging the exclusively categorical thinking of psychiatry at that time. It holds

immense clinical significance and can also be highly beneficial for bioenergetic practitioners, enriching our body-psychotherapeutic thinking and interventions with invaluable insights.

1. Kernberg's Developmental Model

Kernberg's developmental model is partly based on findings from infant research, as described, for instance, by Stern (1992 [1985], p. 160). Starting from innate abilities, it outlines how a psychological structure emerges. Temperament, as a constitutional factor, fundamentally influences individual response patterns, such as intensity, rhythm, and thresholds for affective reactions to internal stimuli and environmental cues. "Constitutionally determined thresholds for activating positive, pleasurable, rewarding affects and negative, displeasurable affects form the primary link between the biological and psychological components of personality" (Yeomans, 2017 [2015], p. 4).

It is essential to note that the standard research paradigm in infant studies assumes results are derived from a specific infant state – namely, an awake and balanced infant (Dornes, 1993, p. 35). Under these conditions, innate abilities enable the differentiation between self and object.

> "An optimal interaction between the baby and the caregiver creates a warm, nurturing atmosphere for the infant, allowing them to sense that the caregiver loves them, understands their needs precisely, and satisfies them in a gratifying rhythmic exchange. In this context, the infant develops a secure attachment to the caregiver and begins constructing a coherent internal narrative about themselves and others, grounded in the confident and joyful expectation of being protected and cared for. This secure attachment helps the child manage negative experiences – moments of discomfort, displeasure, and pain – that are inevitable in any developmental process" (Yeomans, 2017 [2015], p. 7).

Through this process, from birth, a self-representation – or multiple self-representations – develops and gradually integrates. Additionally, secure attachment facilitates the development of realistic object representations, forming the structure of the "ego", which consists of an integrated self surrounded by integrated concepts of significant others or object representations. Stern refers to this process as the development of "Representations of Interactions that have been Generalized" (RIGs) (Stern, 1992 [1985], p. 160). Kernberg also incorporates Margaret

Mahler's phase model of psychological development. While Kernberg acknowledges the innate differentiation ability of infants, he rejects Mahler's concept of an initial autistic phase.[1]

Symbiotic Phase

The first developmental phase, the symbiotic phase, unfolds under conditions of peak affects during the first year of life and concludes in its second half. During this phase, structures develop in which an entirely good and entirely bad self-representation are related to an idealized entirely good and an entirely bad object representation. Intense experiences of hunger, pain, and isolation alternate with ecstatic satisfaction.

In these affect-intense moments, the infant's inner world merges self- and object-representations without boundaries. This dynamic form what Kernberg terms the "dynamic unconscious" or the "id". In contrast, low-intensity affect states allow the infant to perceive and relativize the external world, distinguishing it from their inner world. This merging of self and object representations in affect-intense moments characterizes the symbiotic phase, also observed in psychotic structures or dynamics between torturer and victim.

Separation and Individuation Phase

The second phase, separation and individuation, lasts until the end of the third year. In situations of intense affect, self-representations and object-representations remain separated. Splitting phenomena lead to oppositions between entirely good and entirely bad internalized relationships. While this phase is normal in young children, it characterizes pathological structures in borderline patients. These individuals struggle to integrate positive and negative aspects of themselves and others, leading to idealization or persecution of objects.

Object Constancy Phase

The third phase, object constancy, begins at the end of the third year and involves the gradual integration of polarized libidinal and aggressive representations into

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1 He originally adhered to Mahler's developmental model, beginning with the autistic phase, in which differentiation between self- and object representations is not possible (Kernberg, 1980, p. 120 [1988]). However, in his lecture on April 25, 1995, in Lindau, he moved away from this position, citing findings from infant research. This new stance is not addressed in Fonagy et al.'s seminal work on developmental psychology (Fonagy & Target, 2020 [2003]).

a "whole self" and "whole objects". The ego, superego, and id form as complete structures. The defense mechanism shifts from splitting to repression, allowing for the integration of self and object.

Final Phase

In later childhood, the final phase involves the integration of the ego and superego through abstraction, individuation, and depersonalization of the superego, strengthening ego identity. In Kernberg's view, the "id" is not a repository of chaotic drives but rather the primitive, split-off, persecutory, and idealized internalized object relations whose intensity – whether sexually or aggressively arousing – cannot be tolerated. These are completely separated from the ego through repression.

2. Motivational System

Kernberg posits that infants are born with a biological affect disposition, forming the primary motivations for human behavior. These motivations are categorized as positive (e. g., love, happiness, euphoria) or negative (e. g., fear, hate, anger). These affects integrate into two overarching constructs: libido and aggression. Affects thus serve as the building blocks of drives, which manifest clinically in the concrete affects of corresponding internalized object relations. By framing drives as affective integrations, Kernberg reverses the traditional psychoanalytic relationship between drive and affect.

3. Basic Elements of Psychic Structure

The drives – libido and aggression – refer to specific objects, always experienced in a relational context. Internalized object relations serve as building blocks of psychic structure, forming a triadic unit consisting of:

- A self-representation
- An object representation
- An associated affect linked to or representing a drive

These units, termed object-relation dyads, are not exact internal representations of past events but are shaped by internal processes influenced by primary affects and fantasies (Yeomans, 2017 [2015], p. 3).

4. Understanding Defense Mechanisms

Defense is no longer understood as an unconscious conflict between impulse and defense but as the repression of an internalized object relationship. A manifest dyad defends against another, repressed dyad. For example, a patient's overly friendly transference toward the therapist is not merely a reaction formation against aggression but reflects a submissive object relationship defending against an aggressive one.

5. Therapeutic Implications

Primitive, split-off object relations are activated not only in transference but also lead to role reversals. The patient projects their self onto the therapist, identifying themselves with the object representation in the relationship. Particularly with borderline patients, rapid shifts in role distribution may occur within a single session. These shifts demonstrate the activation and role reversal within the same object relationship.

6. Pathological States

Kernberg interprets pathological states in adult patients as failures to progress beyond normal developmental phases.

Body-Oriented Connection to Kernberg's Object Relations Theory

We understand subject representation, object representation, and their associated affect as the tripartite building blocks of psychic structure. These are formed in every relational episode (Luborsky, 1995). For us as bioenergetic therapists, the following questions arise: How can we understand this conception from a body psychotherapeutic perspective? What can we derive from it, and how can we utilize it therapeutically?

In psychoanalytic discourse, representation is often used synonymously with idea or image. However, an analysis of this term extends beyond a purely mental understanding or the notion of representations as photographs of ourselves and others that we carry within us. As described above, representations as elements of

psychic structure emerge through so-called RIGs (Representation of Interaction with Generalized Others), processes of introjection through which complete interactions or episodic representations of the environment are internalized. These processes involve factors such as gaze, gesture, facial expressions, voice, posture, the temporal structuring of movement, the experience of force, and spatial orientation (Stern, 2011 [2010]).

These representations can have unconscious, preconscious, and conscious dimensions. Physical and psychological aspects play a decisive role and include, particularly in their unconscious dimensions, consistent relationships (Mertens, 1992). The processes involved lead to identificatory dynamics, in which the self seeks to emulate a model, initially often the mother. Beyond the dynamic unconscious as defined above, the unconscious also encompasses procedural knowledge or what is referred to as the procedural unconscious. This knowledge, inaccessible to conscious awareness, develops from birth. Being unsymbolizable, it is acted out and includes nonverbal signals such as posture, gestures, and affective motor patterns. This is evident, among other things, inaction dialogue.[2] Thus, the body significantly participates as an information medium in the formation of representations while simultaneously expressing them.

What do we understand by affect, the third component?

According to Krause, affect can be understood as a process or system comprising six subsystems or modules. Affect activates these subsystems but can also itself be influenced by them, demonstrating a reciprocal regulatory mechanism. Affect triggers an affective action and takes control over the internal world, the perception of others, intentional motor activity and signaling, as well as central and peripheral physiological processes (Krause, 2012).

For a body-psychotherapeutic approach, knowledge of these six modules is valuable, as each can be consciously attended to in the therapeutic process. Each module can take precedence depending on the specific clinical situation.

- The *motor-expressive module* controls facial expressions and vocalizations.
- The *motivational module* directs action readiness through the innervation of skeletal muscles and corresponding postures.
- The *physiological-humoral module* regulates the autonomically controlled internal milieu.

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2 In psychoanalytic understanding, the term action dialogue, also referred to as *enactment*, encompasses all forms of behavior beyond verbal exchanges during therapy. These actions reflect unconscious internal conflicts and manifest in non-verbal, physical-gestural expressions (Streeck, 2000, p. 12).

Although these three modules (referred to as "Occurring Emotion") can function without conscious cognition, they are externally observable.

➢ The fourth module involves the *cognition of these three bodily processes*, the fifth is responsible for their *labeling and explanation*, and the sixth encompasses *the social integration of affect* within the relational framework of self and object.

These last three modules are referred to as "Experienced Emotion." Based on specific motor-expressive facial expressions, discrete affects such as joy, sadness, anger, disgust, fear, surprise, and contempt are culturally invariant.

Grounding with Integration of Kernberg's Object Relations Theory

Body-oriented psychotherapeutic approaches based on object relations theory always initially focus on the currently present dyad. This dyad is either revealed in the transference dynamics between patient and therapist or becomes apparent from the patient's description of their experience in a relational episode outside the therapy room.

We understand this dyad as embodied manifestations of the three involved elements: self-representation, object representation, and the associated affect. Simultaneously, we view these three components as a constellation with a defensive function against an internalized conflict tied to a repressed dyad. From the perspective of its defensive function, the corresponding mode of experience is characterized by a specifically diminished sense of vitality. In the original bioenergetic framework, this diminished vitality typically aligns with one of Lowen's five character structures – or a blend of them – and is associated with a lack or withholding of energy. However, in the borderline character structure described above, we assume a high energy level. Reduced vitality, as observed in all character structures identified by Lowen, manifests in patients through shallow breathing, increased muscular tension in the thighs or calves, or an insecure sense of grounding.

First Phase: Identifying the Three Elements

In an initial therapeutic phase, the three elements – self-representation, object representation, and affect – are identified and elaborated on in as much detail as

possible, including their physical manifestations. These elements emerge through awareness of bodily posture, vocal expression, spontaneous gestures, facial expressions, eye contact, and muscle tension in different regions, which may point to suppressed impulses.

When these phenomena are physically explored with the therapist's support and described as precisely as possible, they typically trigger associations or set additional physical activities in motion. This process can lead to the emergence of relevant memories or the development of a narrative. The patient is encouraged to articulate, within the described relational episode or the current transference dynamic in the therapy room, the role they perceive for themselves and the role they attribute to the other. If this therapeutic approach reduces defensive mechanisms and muscular tension, an infantile relational constellation with the associated dyad may become visible.

Second Phase: Linking to Infantile Conflict

This means that the current transference constellation or described conflict can be traced back to an infantile conflict. The newly emergent object relational constellation is systematically explored again, physically and cognitively, using its three elements.

Third Phase: Revealing the Repressed Dyad

In the final step, the analysis of the infantile conflict uncovers the dyadic constellation that had been defended against. This conflict involves pain or disappointment, often accompanied by an overall sense of displeasure. It is managed through the development of an affect-motor schema, resulting in an embodied defensive mode. According to Kernberg's understanding of object relations, the defense is against a dyadic constellation, which must be identified in this third therapeutic phase.

A positive working alliance, characterized by a stable therapeutic relationship between patient and therapist, supports this process. The defensive mechanisms serve an essential function in protecting the patient from painful or threatening aspects of their internal world. Recognizing and respecting this function is crucial in therapy, as undermining or breaking the defense should never be the goal of an intervention.

Grounding and Object Relations Theory

Examining the phenomena that arise during grounding through the lens of object relations theory allows for a nuanced recognition of self- and object-representations along with their associated affects. To apply object relations theory to the central grounding paradigm in bioenergetic analysis, conceptual clarification is necessary.

Grounding is a cornerstone of bioenergetics. Lowen associated it with the idea that a core aspect of psychic functioning involves the movement of energy from the center to the periphery, accompanied by a reduction in tension (Lowen, 1981 [1958], p. 77). The focus is on standing, walking, and breathing, which reveal where energy and vitality are being withheld in the body. "All energy eventually finds its way into the earth; this is the principle we call 'grounding'" (Lowen, 1981 [1958], p. 103). Lowen viewed grounding work as a means to strengthen self-expression, enhance body awareness, and increase joy in life.

Expanded Perspectives on Grounding

Lowen's students expanded the concept of grounding beyond mere physical contact with the ground. Notable contributions include works by Conger (1994), Clauer (2011), Baum (1997), and Heinrich (2001). Their broader understanding of grounding finds expression in various domains:

1. *Self-Perception:* The degree and nature of self-awareness manifest in the entire phenomenal experience of the self – eyes, arms, hands, voice, abdomen, breath, gaze – and connect with Lowen's notion of grounding.
2. *Emotion Perception:* Grounding involves awareness of emotional states and their bodily connections, encompassing the ability to feel, localize, and express emotional energies.
3. *Relational Grounding:* This relates to how relationships are initiated and maintained, including how a person communicates through breathing, voice, gaze, gestures, facial expressions, touch, and spontaneous body movements.
4. *Containment*[3] *and Discharge:* Grounding is seen as a prerequisite for containing emotions and discharging bodily excitation into the ground.

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3 Containment is a key concept developed by Wilfred Bion, referring to a psychodynamic process in which an individual – often a mother or a therapist – takes in the unprocessed, chaotic, or overwhelming emotional states of another person, processes them, and returns them in a transformed, more tolerable form.

5. *Reality Testing:* The ability to ground oneself supports the psychological processes necessary for reality testing.

This expanded understanding of grounding goes far beyond Lowen's original concept and can be integrated into Kernberg's model of the three components of psychic structure.

Bridging Bioenergetics and Object Relations

In grounding, the self-pole, or self-representation, is physically expressed in upright posture, breathing patterns, subjective body awareness, and embodied self-feeling. Simultaneously, there is an intentionality – a directedness toward another in a relationship, representing the object-pole or object representation. Additionally, grounding involves a subjectively experienced contact with the ground.

For example, object representation may symbolically point to a specific form of relational experience, such as how the patient perceives the floor as hard and cold, reflecting an unconscious dyadic object relational constellation. In this case, the self-representation may describe a rejected and unaccepted self encountering an unattainable and distant object.

The third element, the associated affect, is revealed through bodily self-awareness and might manifest as sadness. Initially, this constellation is preconscious and may point to a manifest current conflict or the ongoing transference relationship. In later therapy stages, it could be traced back to an infantile conflict, for instance, memories of early childhood rejection.

In the final phase, the repressed dyadic constellation may emerge, revealing a self-representation where the patient feels warm, soft, and desired, in relation to an object representation perceived as benevolent, attentive, and supportive, fostering a sense of love and security.

Clinical Implications

In clinical practice, grounding phenomena – particularly the transition from standing with locked knees to a posture with slightly bent knees while focusing on the feet and their contact with the floor – can reveal significant changes in bodily awareness. These changes may represent different, even opposing, dyadic

object relational constellations, which must be explored in detail. Patients often report sensations of flow and permeability in their legs, deepened breathing, relaxed shoulders, or spontaneous vibrations in their legs. From an object relations perspective, such changes reflect a transformation in the dyadic object relational constellation. Therapy should then investigate how the patient perceives themselves and the floor as a symbolic object representation, along with the accompanying affect.

Conclusion

Kernberg's concept of psychic structure enriches and deepens the understanding of grounding, distinguishing bioenergetics from other psychotherapy approaches. By integrating object relations theory, Lowen's original one-person psychology expands into a two-person psychology, offering new therapeutic strategies and perspectives. Each of the three elements can be given a physical expression. Focusing on the object representation allows the patient to consciously experience and embody this role, utilizing modalities such as voice, gaze, breath, movement, and posture.

Clinical Example of Grounding from an Object Relations Perspective

The following case study illustrates an approach that integrates a bioenergetically-oriented intervention with reflections guided by object relations theory.

The patient seeks therapy for daily anxiety accompanied by distressing sensations of pressure and tightness in the chest, alongside low self-confidence. His two-year romantic relationship with a woman has exacerbated these pre-existing symptoms. Structurally, he presents with a neurotic personality organization characterized by repression-based defenses. He exhibits an oral character structure with schizoid elements.

This therapy session begins with the patient recounting an incident from the previous evening. He felt criticized and belittled by his girlfriend after being too tired to interact following his physically demanding work as a carpenter. He had wanted to lie down for 30 minutes but did not dare voice this desire due to what he perceived as her critical look and tone. This scenario reflects a current relational conflict in his daily life.

The patient is instructed to mentally revisit this situation while standing barefoot. The therapist stands as well. The patient's posture becomes revealing: his knees are locked, his head tilts slightly forward, his forehead is tense and furrowed, his shoulders slump forward with a retracted chest, his breathing is shallow, engaging only the chest muscles. His arms hang limply, fingers pointing downward. His stance appears rigid, and his body stiff.

When asked about his subjective experience and bodily sensations, thus addressing his self-representation, he describes feeling insecure and lacking self-confidence. He reports feeling as though he never does anything right, perceiving himself as unable to meet others' expectations. He likens himself to a small child and notes sensations of chest pressure, shortness of breath, and an impulse to cross his arms protectively over his chest. He feels increasingly threatened, anxious, and torn between defending himself and retreating. In this posture, he envisions himself as a young boy being punished for doing everything wrong, experiencing guilt.

Here, we reference Heinrich, who emphasizes that grounding work requires a relational response from the therapist to facilitate the integration of a sense of self within the therapeutic setting. This relational engagement involves attentive observation, sensing, listening, and providing verbal affirmation while suggesting words to integrate the patient's experiences. To anchor the stabilizing and revitalizing sensation of energy flow in the legs and feet, and the enhanced awareness of physical posture, the therapist's relational presence is crucial (Heinrich, 2001, p. 68).

Through the bodily sensations described while standing, the patient identifies the dominant object relationship underpinning the conflict with his girlfriend. He articulates his embodied self-representation as a guilty, punishable boy in her presence. When directed to focus on his feet, he reports feeling "tied" at the ankles, with his feet cold, distant, and the ground beneath him hard, rejecting, and unreliable. He assesses his stance as shaky, his feet tense and cramped, providing little contact with the floor as he stands on their outer edges. For a moment, the sensation of the ground becomes a symbolic object representation – a stepping stone to approach his inner experience with his girlfriend.

In the next phase, he is asked to describe his imagined girlfriend, the object representation in this relationship. He portrays her gaze as stern, unjust, intimidating, and powerful. She seems distant, cold, and unreachable, constantly critical, issuing accusations and advice about how he should change. He feels perpetually unable to meet her expectations, seeing her as a strict, demanding, and just teacher. With this, the identification of the activated object relationship, including its three elements, is complete, allowing the grounding work to progress further in the session.

The patient is then instructed to slightly bend his knees while maintaining a shoulder-width stance and to notice the resulting changes in his bodily sensations. Gradually, he observes his feet warming, feeling larger, and perceives the carpet beneath him as softer. This induces a sense of heaviness and improved support. His stance feels steadier, and the fixation in his ankle joints diminishes, creating a sense of fluidity in his lower legs. The contact of his feet with the ground provides a sense of occupying his space and feeling entitled to it. He feels accepted, able to express himself authentically without restraint. The ground transforms into a symbolic object representation, offering security and stability – a kind of safe base that allows a curious, fearless engagement with the world.

Simultaneously, his breathing changes. He notices his abdomen expanding slightly during inhalation, the pressure under his sternum easing, and his spine straightening. His shoulders visibly relax, his chin lifts, and his gaze widens. He feels an impulse to raise his arms horizontally. This process unfolds over several minutes, supported by the therapist's encouragement to focus on bodily sensations and articulate them verbally. When asked about his self-representation, he reports feeling taller, older – more adult. He experiences a heightened awareness of his strength in his pelvis, recalling his identity as a man. Two sentences come to him: "I am someone too" and "I can stand up for myself." As he says this, he clenches his fists. After maintaining this posture, a feeling of pride emerges. He expresses surprise that the earlier fear has completely dissipated.

As the session progresses, he begins to move around the therapy room. His movements appear freer and more relaxed. Suddenly, he growls and roars, stomping his right heel forward while shouting, "Get away!" He starts recounting negative experiences with his father, such as nightmares about visiting him during summer vacations. His parents separated when he was six, and he only saw his father during the summers. Memories surface, and he shares stories of an unresolved childhood conflict.

This clinical example demonstrates the conscious self-experience of a painful aspect of the inner world, represented by the dyad: "As I am, I am wrong; my counterpart cannot bear me and punishes me for it, which frightens me". This dyad, reflected in the current relational conflict, points to early childhood experiences that shaped his expectations of relational dynamics (as per Stern's RIGs). These include an embodied strategy to cope with his unmet basic need for recognition and appreciation. At the same time, the dyad, marked by pain and fear, reveals a specific embodied defense mechanism. His life has been characterized by frustration, stemming from the desire and associated fundamental need to feel important and have a father who supports, believes in, and is proud of him.

The therapeutic task is to bring the fearful self-representation to consciousness and make it tangible, using the so-called work on the self-pole. By consciously perceiving facial expressions, shoulder and chest tension, avoiding gaze, and weakness in the legs – understood as an embodied defense – the initially vague affect of fear is amplified ("occurring emotion"). This "building block element" comes to the forefront. Through increased muscular innervation, related modules (4–6) are activated, initiating cortical associative connections. The self-representation of the rejected, frightened child becomes more explicit and vividly experienced ("experienced emotion"). The fear intensifies, unveiling the detailed internal image of a punitive object representation (work on the object-pole).

After intensifying the fear, the patient gradually experiences visible physical pride, directed toward a "good" father object (previously repressed dyad). This evokes a sense of being "seen". The emerging self-feeling – "I am someone too" – gradually finds its counterpart, not in the girlfriend but in the father. This temporary resolution of the infantile conflict becomes possible within the therapeutic framework. Here, the therapist assumes the role of the "good" father, enabling this resolution through a specific transference constellation.

Conclusions

Lowen's theoretical understanding remains rooted in ego psychology and thus within the framework of one-person psychology. However, his students have successfully adapted his concept of energy to the newer developments in psychoanalysis, thereby integrating and aligning it with contemporary psychoanalytic perspectives. This is particularly evident in the expanded conception of the grounding concept, a cornerstone of bioenergetics.

The theoretical advancements adopted by his students almost universally trace back to the psychoanalyst Winnicott, who laid the groundwork for the concept of the "False Self." Although Winnicott is not considered a direct pioneer of humanistic psychology – under which bioenergetics is categorized – his understanding of growth, authenticity, and creative expression can nonetheless be regarded as closely related to this school of thought.

While Kernberg, with his bipolar view of human motivations – aggression and libido – adheres to the classical psychoanalytic model of human nature and a distinct form of object relations theory, his concept of a psyche composed of three building blocks remains valuable. It can serve as a useful guide within a body-oriented therapeutic approach and inform intervention strategies.

In sum, the synthesis of Lowen's energy-centric ideas with newer psychoanalytic developments illustrates the dynamic evolution of bioenergetics, paving the way for innovative approaches in understanding and addressing human psychological and somatic experiences.

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Character Structure

An Object Relations Perspective

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Abstracts

In this paper, I analyze character structures based on Object Relations Theory. I discuss three phases of object relating, 1) an undifferentiation phase, 2) an incorporating phase, 3) pre-object relating phase, and 4) a full object relating phase, resulting in internalization. This approach naturally lends itself to identifying the schizophrenic character, and early and late borderline organizations. It is seen that the early and late borderline organizations are related to transitional periods between object relating stages. I also introduce treatment approaches, notwithstanding somatic interventions, based on Object Relations Theory and the theory that I present in this paper. I discuss a possible origin of certain types of auto-immune disorders which may be related to early trauma. I point out the difference between incorporation and internalization, as defenses related to early and late infancy. I present the implications of incorporation vs internalization in character formation as well as in auto-immune disorders vs psychological disorders manifested by attacks by the internalized bad objects. In this paper, I refer to the child as a boy, instead of a girl or they.

Keywords: antilibidinal ego, central ego, character structure, libidinal ego, object relations theory

Estrutura de Caráter
Uma Perspectiva das Relações de Objeto (Portuguese)
Neste artigo, vou analisar as estruturas de caráter com base na teoria das Relações de Objeto. Serão apresentadas as quatro fases descritas nessa teoria: 1 – Fase de indiferenciação, 2 – Fase de Incorporação, 3 – Fase de pré-relação de objeto, 4 – Fase de relação se objeto plena, que resulta na internalização. Esta abordagem conduzirá, naturalmente, à identificação do caráter esquizofrênico e organizações *borderline* – precoces ou tardias. Veremos

que essas organizações estão relacionadas com períodos transicionais entre estágios das relações objetais. Serão introduzidas abordagens de tratamento, que, apesar de intervenções somáticas, são baseadas na teoria das Relações de Objeto e na teoria que apresentarei neste artigo. Haverá a discussão sobre a possível origem de certos tipos de desordens auto-imunes – que podem estar relacionadas aos traumas precoces. Mostrarei, também, a diferença entre incorporação e internalização na formação do caráter, assim como nas desordens auto-imunes vs desordens psicológicas manifestadas em função de ataques de objetos maus internalizados.

Structure des caractères

Une perspective des relations d'objet (French)

Dans cet article, j'analyserai les structures du caractère basées sur la théorie des relations d'objet. Je discuterai de quatre phases de relation d'objet, 1) une phase d'indifférenciation, 2) une phase d'incorporation, 3) une phase de pré-relation d'objet, et enfin, 4) une phase de relation d'objet complète, qui aboutit à l'intériorisation. Cette approche se prêtera naturellement à l'identification du caractère schizophrénique et des organisations borderline précoces et tardives. On verra que les organisations borderline précoces et tardives sont liées à des périodes de transition entre les étapes de la relation objet. Je présenterai également des modalités de traitement, et des interventions somatiques, basées sur la théorie des relations d'objet et sur la théorie que je présenterai dans cet article. Je discuterai d'une origine possible de certains types de maladies auto-immunes qui peuvent être liées à un traumatisme précoce. Je mettrai l'accent sur la différence entre l'incorporation et l'intériorisation, en tant que défenses liées à l'enfance précoce et tardive. Je présenterai les implications de l'incorporation en ce qui concerne l'intériorisation dans la formation du caractère, ainsi que dans les troubles auto-immuns en ce qui concerne les troubles psychologiques manifestés par des attaques par de mauvais objets intériorisés. Dans cet article je vais parler de l'enfant en utilisant toujours le masculin singulier.

Struttura caratteriale

Una prospettiva delle relazioni oggettuali (Italian)

In questo articolo analizzerò le strutture del carattere basate sulla teoria delle relazioni oggettuali. Discuterò quattro fasi della relazione oggettuale, 1) una fase di indifferenziazione, 2) una fase di incorporazione, 3) una fase di pre-relazione oggettuale e, infine, 4) una fase di relazione oggettuale completa, che si traduce nell'interiorizzazione. Questo approccio si presterà naturalmente all'identificazione del carattere schizofrenico e delle organizzazioni borderline precoci e tardive. Si vedrà che le organizzazioni borderline precoci e tardive sono correlate a periodi di transizione tra le fasi di relazione oggettuale. Presenterò anche modalità di trattamento, che comprendono interventi somatici, basati sulla teoria delle

relazioni oggettuali e sulla teoria che presenterò in questo articolo. Discuterò una possibile origine di alcuni tipi di disturbi autoimmuni che possono essere correlati a traumi precoci. Sottolineerò la differenza tra incorporazione e interiorizzazione, come difese correlate all'infanzia precoce e tardiva. Presenterò le implicazioni dell'incorporazione rispetto all'interiorizzazione nella formazione del carattere, così come nei disturbi autoimmuni rispetto ai disturbi psicologici manifestati da attacchi da parte degli oggetti cattivi interiorizzati. In questo articolo, mi riferirò al bambino al maschile.

Die Charakterstruktur in der Perspektive der Objektbeziehungstheorie (German)
In diesem Aufsatz betrachte ich Charakterstrukturen von der Objektbeziehungstheorie her. Dabei werden vier Phasen der Objektbeziehung untersucht: 1) eine Phase der Undifferenziertheit; 2) eine Phase der Inkorporation; 3) eine Phase der Vor-Objektbeziehung und schließlich 4) die Phase der voll entwickelten Objektbeziehung, welche in der Internalisierung resultiert. Dieser Ansatz bietet sich natürlich zur Bestimmung des schizophrenischen Charaktertyps an sowie für frühe und entwickelte Borderline-Verfassungen. Es wird aufgezeigt, dass diese frühen und voll entwickelten Borderline-Verfassungen auf Übergangsperioden zwischen Phasen der Objektbeziehungen bezogen sind. Ich stelle auch Behandlungsformen dar, die trotz körperlicher Interventionen auf der Objektbeziehungstheorie beruhen sowie auf der Theorie, die ich im vorliegenden Aufsatz entwickle. Daraufhin behandle ich einen möglichen Ursprung bestimmter Formen von auto-immunen Störungen, die möglicherweise mit frühen Traumata zusammenhängen. Dann stelle ich den Unterschied zwischen Inkorporation und Internalisierung dar, und zwar als auf die frühe und spätere Kindheit bezogenen Verteidigungsmechanismen. Abschließend werden die Implikationen der Inkorporation gegenüber der Internalisierung in der Charakterformation untersucht, sowie bei auto-immunen Störungen im Vergleich zu psychischen Störungen, die durch den Angriff internalisierter böser Objekte auftreten. In diesem Aufsatz verwende ich das Wort "Kind" in seiner männlichen Form, statt in der weiblichen Form bzw. im Plural.

Структура характера с точки зрения объектных отношений (Russian)
В этой статье я проанализирую структуры характеров, основываясь на теории объектных отношений. Я расскажу о четырех фазах объектных отношений: 1) фаза недифференцированности, 2) фаза включения, 3) фаза предобъектного отношения и, наконец, 4) фаза полного объектного отношения, результатом которой является интернализация. Этот подход, естественно, пригодится для выявления шизоидного характера, а также ранних и поздних пограничных организаций. Будет видно, что ранние и поздние пограничные организации связаны с переходными периодами между стадиями установления объектных

отношений. Также расскажу о подходах к лечению, независимо от соматических вмешательств, основанных на теории объектных отношений и теории, которую я представлю в этой статье. И расскажу о возможном происхождении некоторых типов аутоиммунных расстройств, которые могут быть связаны с ранними травмами. Укажу на разницу между инкорпорацией и интернализацией как защитами, связанными с ранним и поздним младенчеством. Я расскажу о влиянии инкорпорации и интернализации на формирование характера, а также об аутоиммунных расстройствах и психологических расстройствах, проявляющихся в нападениях со стороны усвоенных плохих объектов. В этой статье я буду писать о ребенке в мужском поле, а не в женском (девочка) или множественном (они).

La estructura del carácter

Una perspectiva desde las relaciones objetales (Spanish)

En este artículo, analizaré las estructuras del carácter desde la perspectiva de la Teoría de las Relaciones Objetales. Examinaré cuatro fases fundamentales en la relación con los objetos: 1) la fase de indiferenciación, 2) la fase de incorporación, 3) la fase pre-relacional con el objeto, y 4) la fase de relación plena con el objeto, que da como resultado la internalización. Este enfoque resulta especialmente útil para identificar tanto el carácter esquizofrénico como las organizaciones borderline tempranas y tardías. Cabe destacar que estas últimas están vinculadas a períodos de transición entre las distintas fases de la relación con los objetos. Asimismo, propondré enfoques terapéuticos que integran intervenciones somáticas, desarrollados a partir de la Teoría de las Relaciones Objetales y los conceptos introducidos en este artículo. Analizaré un posible origen de ciertos tipos de trastornos autoinmunes que podrían estar vinculados a traumas en etapas tempranas de la vida. Haré énfasis en la distinción entre incorporación e internalización, entendidas como defensas características de la infancia temprana y tardía, respectivamente. Exploraré las implicaciones de estas dinámicas tanto en la formación del carácter como en la diferenciación entre trastornos autoinmunes y trastornos psicológicos asociados con ataques de objetos internos negativos. En este artículo, se utiliza el término masculino (“boy”) de manera genérica para referirse a jóvenes de cualquier género, reconociendo y respetando la diversidad de identidades.

人格结构--客体关系视角 (Chinese)

在本文中，我将根据客体关系理论分析人格结构。将讨论客体关系的四个阶段：1）未分化阶段；2）融入阶段；3）前客体关系阶段；最后，4）导向内化的完整客体关系阶段。这个方法自然地可以用来识别精神分裂症人格，以及早期和晚期的边缘组织。我们将看到，早期和晚期边缘组织与客体关联阶段之间的过渡阶段有关。我还将介绍基于客体关系理论和我将在本文中介绍的理论的一些治疗方法，

而不是常设的躯体干预。我将讨论某些类型的自身免疫性疾病的可能起源，这些疾病可能与早期创伤有关。我将指出与婴儿早期和晚期防御有关的融入和内化之间的区别，介绍融入与内化对人格形成的影响，以及对自身免疫性疾病与由内化的坏客体攻击所表现出的心理失调的影响。在本文中，我将把孩子称为男孩，而不是女孩或她们。

Introduction

It can be said that character structure forms because of a life preserving strategy to survive the developmental trauma. Since the development of the child occurs within a relationship, the character structure can be considered to form due to the relational misattunement between the infant and their primary caregivers. In an earlier paper (Shahri, 2022), I suggested that the unitary somatopsychic structure feeds on negative entropy. Entropy is a measure related to unpredictability and uncertainty within a system. I need to mention, for clarity, that entropy is a positive measure, and it can become negative, in an open system, at the expense of increasing it outside the system. Thus, the character structure can also be thought of as a life preserving strategy to reduce the entropy within the unitary somatopsychic structure inside the environment in which the child grows up. Therefore, the character structure will leave its mark not only on the soma but also on the psyche. Many authors, notably Lowen (1971, 1994), have discussed the physical dynamics of the character structure. I will, therefore, not discuss the physical aspects of the character structure but will focus on the aspects related to the psyche and relational failures that the infant/child experiences during various stages of development.

A brief historical perspective

Freud introduced his structural model in his book "Beyond the Pleasure Principle" (1922) and then completed it in his later work "The Ego and Id" (2023). Freud introduced a tripartite structure consisting of Id, Ego, and the Superego. Id, which is present at birth is the sum-total of the instincts, desires, and impulses which functions based on the pleasure principle, seeking gratification and release. Ego or the "I", functions are based on the reality principle and mediate the expression of the id impulses which may not be acceptable based on the reality principle. The superego forms as a result of internalization of the societal and cultural rules and prohibits the expression of the id impulses. It seeks to confine the

ego to socially and culturally acceptable behavior. The id is unconscious, while superego contains unconscious and conscious elements within the psyche, but the ego is mostly conscious. Freud believed that the patient transfers his forbidden id impulses to the therapist. He also believed that if a cure is to be achieved the present-day neurosis must be transformed to transference neurosis and analyzed. Freud implicitly realized the importance of the relationship between the patient and analyst within the therapeutic relationship but did not develop it further.

Klein (1975), while retaining Freud's tripartite model, introduced the world of internal objects. She believed that the infant splits the external objects into good and bad, internalizes both, and retains the good object internally and projects the bad object onto external objects. In contradistinction to Freud who emphasized the Oedipus complex as a cause of neurosis, Klein considered the failures in the mother-infant relationship during the first 4–6 months of life creating the "paranoid-schizoid" position. At 6+ months of life, Klein believes, the "depressive" position forms, which she considered to be the main cause of neurosis. She thus placed the emphasis on the interpersonal relationship of mother-infant dyad and the internal world of objects. Klein believed that splitting of the internal objects also results in splitting of the ego and believed that ego exists starting at birth.

Later, Fairbairn (1952) suggested that the infant internalizes his unsatisfying objects in an effort to control them internally because he cannot control them in the outside world. Let me further clarify this process. The infant's needs are partially met and partially frustrated. The frustration of the infant's needs results in higher tension and uncertainty within the infant. The infant, to gain some control over his environment and to be able to predict it (reduce unpredictability – entropy), must adapt to this situation and consequently form neural pathways that resemble those of his mother [the unsatisfying/frustrating object]. Thus, in effect he internalizes his 'bad' mother to reduce the uncertainty (anxiety) within his environment, and in doing so his immediate needs for his mother are reduced as well. The 'bad' internalized mother has two facets, on the one hand it allures but does not satisfy and on the other hand it frustrates and rejects! This is an intolerable situation and the infant, in an effort to control the situation, splits the internalized 'bad' mother into the needed or exciting object which allures but does not satisfy, and the frustrating or rejecting object. The infant will seek the exciting object (EO) throughout his life seeking a fuller human connection, in order to increase homeostasis within his unitary somatopsychic structure. The ego maintains a libidinal attachment to this internalized exciting object, result-

ing in a split within it. Fairbairn (1952) calls the endopsychic structure resulting from this split, the libidinal ego. Guntrip (1994) writes:

> "The libidinally exciting but unsatisfying object arouses and maintains in the infant a state of unrelieved need and craving. This intolerable aspect of experience is repressed in the form of an internal bad-object relationship between an intensely needy and never satisfied libidinal ego and an intensely stimulating but unsatisfying exciting object" (p. 110).

The infant chooses a similar strategy regarding the rejecting and frustrating aspects of his object (initially the mother in most situations). He forms neural pathways in his brain based on his experience with his mother and in effect will block and redirect his own drives to conform to his environment and the limitations imposed on him by his mother (bad object). That is to say that he internalizes and identifies (identification is a stronger form of internalization) with his mother in an effort to reduce the uncertainty of his environment and gain some level of control over it. This is, as I alluded to above, the rejecting and frustrating aspect of the 'bad' object (rejecting object – RO). Like the previous case, the ego maintains a libidinal attachment to the rejecting object which results in a further split within the ego. Fairbairn (1952) calls this endopsychic structure, the anti-libidinal ego, or the internal saboteur. Guntrip (1994) writes:

> "The libidinally rejecting object, whether passively rejective, indifferent, neglectful, or actively rejective, angry, aggressive, arouses fear and anger in the child. This intolerable aspect of experience is repressed in the form of an internal bad object relationship between a rejecting object which presents itself as a persecutor, and an ego that escapes persecution by abandoning the position of libidinal needs and demand and finding safety in identification with the rejecting object" (p. 110).

Fairbairn's theories are predicated on the existence of an ego which can split.

However, residuals of the original ego remain. This is the "I" that relates to the environment and to people in the outside world. Fairbairn (1952) called this endopsychic structure, the central ego (CE). Please note that the ego forms as a result of drives going through and being shaped by the reality principle within the mother-infant dyad. The ego is mostly conscious but may also contain unconscious elements. Guntrip (1994) writes: "The one thing that the child cannot do for himself is to give himself a basic sense of security since that is a function of object relationship. All that can be done is for the Central Ego to seek to become

independent of needs for other people" (p. 141). This is a very difficult situation as the central ego is weak and ungrounded as some of its energy has been consumed, limited, and shaped by the libidinal and antilibidinal egos. Its approach to the environment and objects may be tentative and cautious. The increased uncertainty and lack of groundedness of the central ego may be experienced as partial loss of the sense of self, due to its weakness and ungroundedness. The process of formation of endopsychic structure from the primal self is depicted in figure 1, below. Segment 1 is the primal self, segment 2 is the environmental negativity which causes the splitting of the primal self (pristine ego) of the child into the endopsychic structures discussed above, segment 3 is the redirection of the energy of the primal self which will result in the formation of the endopsychic structures, segment 4 is the antilibidinal ego, segment 5 is the libidinal ego, segment 6 is the central ego, and segment 7 is the muscular armor that reins in the primal self and impulses related to it. A simpler version of this diagram is discussed in Hilton (2008).

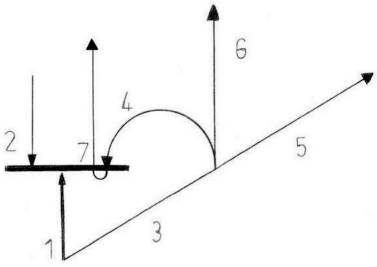

Figure 1. Relational Trauma

Fairbairn's theory of object relations and endogenous structures perfectly describes the inner life of the infant, but as I indicated, it is predicated on the existence of an ego which forms later in the life of the infant. This is the case as there cannot be any splitting of the ego unless there is an ego. Melanie Klein (1975) indicated that ego exists at birth. It is known that modern neuroscience entirely contradicts this assertion. The infant is born with basic instincts for survival but not an ego which requires an awareness of the self or "I". Winnicott's theories correctly describe the early life of the infant and the formation of his ego within his relationship with his caregiver, usually the mother.

> "Winnicott's work also goes beyond that of Fairbairn, in that Fairbairn's analysis had to take the existence of the ego for granted, in order to trace out the splits it

> suffers in its early experience of good and bad object-relations. But Winnicott takes us deeper than that to the most primitive experiences in which the first dim and uncertain beginnings of ego-growth occur as a result of the infant's existence in the peculiarly intimate primary mother-infant relationship." (Guntrip, 1968, p. 358)

Guntrip further indicates that the earlier the infant suffers trauma, the weaker his ego will be. Winnicott's works concentrate on the problem of how to initiate the growth of an ego which does not yet exist. Winnicott writes extensively on proper (good enough) mothering, healthy mother-infant relationship, and the facilitating environment as the necessary components for formation of a mature ego. A question that may be raised at this point is related to the infant's defenses against developmental traumas prior to the formation of an ego. Interestingly, Fairbairn partially answers this question. He suggested that the primary defense of the infant prior to the formation of an ego, is incorporation (1943, p. 39). Whereas the primary defense of an infant after the formation of a primitive ego is internalization (incorporation within his psyche). Thus, the infant incorporates his environment in order to control and master it. Furthermore, I must emphasize that the infant incorporates his unsatisfying objects in the parts of his body that are within his developing awareness (where else can he do it?). This process is not too dissimilar to immune cells incorporating threatening foreign objects. Thus, to summarize, the infant, not having an ego, incorporates the unsatisfactory world around himself in order to gain mastery over it and to control it.

The infant responds in multiple ways to the external unsatisfactory world. If he experiences trauma early in his life, he will incorporate his world in the areas of his body that he is aware of, as discussed above. If his environment remains unsatisfactory and impinging, he will rigidify in those areas of his body in order to contain and control it and gain mastery over the impinging environment. If this defense is not successful, he may go a step further and mount an autoimmune attack on the incorporated environment. In a recent study (Dube, Fairweather, Pearson, Felitti, Anda, & Croft, 2012), the authors write in the conclusion section of their work: "Childhood traumatic stress increased the likelihood of hospitalization with a diagnosed autoimmune disease decades into adulthood. These findings are consistent with recent biological studies on the impact of early life stress on subsequent inflammatory responses." It must be stressed that the autoimmune disorders generally appear later in life, perhaps late into adulthood, but frequently their origin goes back to early traumatic experiences. A more recent study (Boggs Bookwalter et al., 2020), the authors

> "examined the link between PTSD and autoimmune diseases in 120,572 active military personnel in the United States. The study looked at the following autoimmune diseases: rheumatoid arthritis, systemic lupus erythematosus, inflammatory bowel diseases, multiple sclerosis. The study found that in participants with a history of PTSD, there was a 58% increased risk of these autoimmune diseases compared with those with no PTSD history." (Sissons, 2023)

In his work (1998), Helfaer introduced the self-hate system. I would like to suggest that if the self-hate system was conscious then the person would hate himself, but if it was unconscious, the self-hate system would attack the body! If this defense is not sufficient to deal with the impinging environment, he will then resign at a cellular level and will give up. But the energy of the self-hate system is still in the body, and it is precisely this unreleased energy which makes it very dangerous. This is explained further below.

The central nervous system (CNS) which contains two branches, sympathetic nervous system (SNS), and parasympathetic nervous system (PNS) develop in-utero and can be activated early in the development of the fetus and the infant. Polyvagal theory, proposed by Porges (2011) has shown that mammals respond initially by activation of their sympathetic nervous system (SNS) when in distress. If the SNS response is not sufficient to restore homeostasis within the organism, then the dorsal vagal complex (DVC – a branch of the PNS) will be activated, and the organism will shift toward freeze – an organismic giving up and resignation. The ventral vagal complex (VVC – mediating social engagement) and the dorsal vagal complex (DVC) are known to be major constituents of the parasympathetic nervous system (PNS). This process is shown in figure 2.

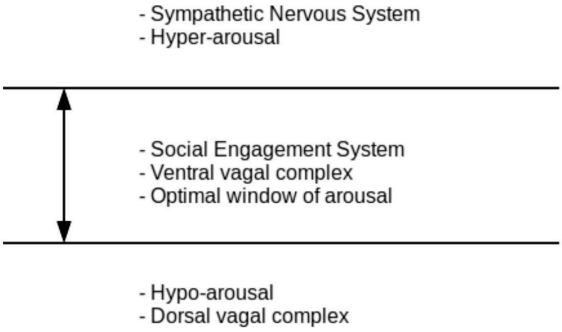

Figure 2. Social Engagement System

Once the infant begins to develop an ego his primary defense will be internalization of the unsatisfactory world around him. Internalization is akin to incorporation of the unsatisfactory world within the psychological apparatus. However, from the perspective of neuroscience, internalization is essentially the formation of neural pathways that are similar to that of the external object. But the process of mobilization of the defenses is nonetheless the same, that is if homeostasis is not restored then, the SNS is activated first in response to an impinging environment, and if that does not suffice in restoring homeostasis and the re-activation of the social engagement system (VVC), the human organism will activate the DVC branch of the parasympathetic nervous system (PNS). In this case the rigidity as well as the possible resignation can occur within the unitary somatopsychic structure. The defenses of rigidity and resignation are also known as the hyper and hypo responses to threats to the organism's integrity, respectively. The hyper and hypo responses may result in muscular contraction or flaccidity of muscles, described in Bodynamics created by Marcher (2010). At the end of this section, I must add the activation of the rigid and resignation responses may cause neurotic disturbances when an ego has developed but may result in organic diseases before the formation of the ego. I will elaborate on this very important point in the next section.

I need to make a few points clear. The infant in the womb is in an undifferentiated state. He is an undifferentiated part of the mother. Stern (1973) and his group have conducted studies and experiments on development of infants and their interpersonal world. He concludes that infants begin to experience an emerging sense of self right after birth. What I describe in my theory below does not contradict what Stern proposes (Stern, 1973, p. 101) and (Stern, 1973, p. 118–119). My use of undifferentiated state is related to the in-utero experience of the fetus/infant.

Thus, to summarize, I must mention that the infant is in an undifferentiated state in the womb and then once born defensively incorporates his world. The incorporated world eventually becomes the need satisfying part object (mother's breast), and eventually the mother which is seen as a symbiotic extension of the infant is separated from her. She (mother) slowly protrudes out and becomes a separate object. This represents the beginning of full object relationship which corresponds to the formation of a primitive ego which is very weak and unstable but gets stronger as the infant enters the practicing period of development (Mahler, 1975) when the infant crawls and walks. The undifferentiation changes to incorporation, which in turn changes slowly to internalization as the psyche develops further. Of significance are two transitional periods, namely the transi-

tion from undifferentiation to incorporation near birth and then the transition from incorporation (symbiosis) to internalization of the objects. These two transitional periods may result in the formation of early or late borderline personality organizations, respectively, if the infant is traumatized during these stages. I will describe the two transitional periods and stages in the next section.

Leading to the next section, I must reiterate that in terms of object relations, the first few months of life are objectless, after which the infant relates to part objects (mother's breast). This is followed slowly to the development of full object relations. I would also like to indicate the relationship between attachment and incorporation as well as internalization. We know from the rich literature on attachment system that it is psycho-biologically rooted in our evolution (Bowlby, 1950). The attachment system mediates the affective regulation and attunement between the infant and his primary caretakers. The incorporation and later internalization may occur if there is no repair and if there is a break in the attunement between the infant and his caretakers, and if it is not repaired. Based on the attachment theory, we can deduce that the infant cannot live without his attachment objects, and therefore he must compensate for their suboptimal attunement by first their incorporation early in his life, and then by their internalization later in his infancy.

Character structure and object relations theory: Pre-object character structures

Schizophrenic stage of development

The life of an infant starts in-utero as a fetus. This is a state in which the fetus does not differentiate between itself and its environment. The fetus continues its life in an undifferentiated state until birth but is still impacted by the mother in the womb. Many authors have related this state to schizophrenic period of development which may be related to development of schizophrenia (Fineberg, Ellman, Schaefer, et al., 2015). Schizophrenia is related to a sense of "vanishing me" and a nearly complete sense of loss of self, the "I" (de Vries, Heering, Postmes, 2013), if traumatized during this stage of development. "The individual feels that, like the vacuum, he is empty. But this emptiness is him" (Laing, 1960, p. 45). The individual lives under the threat of implosion. A strong connection to one's own independent sense of self and identity is required before one can relate to another human being, if this is not present, any relationship threatens the individual with

the loss of self and identity (Laing, 1960). In other words, the individual traumatized at this stage constantly fears that they will be engulfed by others. The main defense against the threat of engulfment and loss of identity is isolation (Laing, 1960).

> "... there is the antithesis between complete loss of the being by absorption into the other person (engulfment), and complete aloneness (isolation). There is no safe third possibility of a dialectical relationship between two persons, both sure of their own ground and, on this very basis, able to 'lose themselves' in each other" (Laing, 1960, p. 44).

Not having an identity and living a life in which the individual feels empty, creates a feeling that he has been turned into a "thing". This is petrifying as the person may feel that they may be turned into stone and defensively may feel that they can turn others into stone (Laing, 1960). The general complaint of such people is that they could not become a person. They have no 'Self', and they are only a response to other people, and have no identity of their own (Laing, 1960). Since the schizophrenic character lacks identity, in treating this character structure, the therapist must be aware of the client's attempts to engulf the therapist. The following quote from Laing (1960, p. 173) describes the process of treatment very clearly. The quote is about a patient who had recovered, and Laing quotes her words.

> "It was terribly hard for me to stop being a schizophrenic. I knew I didn't want to be a Smith (her family name), because then I was nothing but old Professor Smith's granddaughter. I could not be sure as though I was your child, and I wasn't sure of myself. The only thing I was sure of was being a 'catatonic, paranoid and schizophrenic'. I had seen that written on my chart. That at least has substance and gave me an identity and personality. [What led you to change?] When I was sure that you would let me feel like your child and that you would care for me lovingly. If you could like the real me, then I could too. I could allow myself to just be me and didn't need a title."

Robins (2010) also refers to the formation of the schizophrenic character as a result of in-utero trauma.

In figure 3, I depict the undifferentiated phase of in-utero development. Segment 1 represents the fetus, segment 2 is the mother, segment 3 represents the weak boundary between the fetus and the mother. Segment 4 is the representa-

tion of the undifferentiated state including both the mother and the fetus. The fetus energetically perceives that he and his mother are in an undifferentiated state. There is no distinct awareness of the self and not of the mother, but just an undifferentiated state.

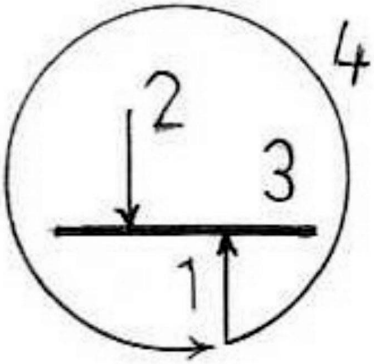

Figure 3. The undifferentiated phase

Case of Sean

Sean was a man in his forties who was gainfully employed. He lived alone and had never been married. Sean had not left his house during the last 3 years. His mother's life during her pregnancy and after was very chaotic. Sean's birth was not without complications either. He suffered birth trauma as well. He entered a world of violence around him. One could say that the only safe place for him was the undifferentiated stage of development in the womb. Sean did not have a strong sense of identity and was easily engulfed in others. In fact, he made his room dark with a light in a corner resembling the womb where he felt safe. Sean was a smart man who loved to study physics and contemplate the universe. He felt he was part of the universe but also had existential anxiety which he could not reconcile with his feeling of being part of the infinite universe. Sean's sense of time was not very clear. If he did not set an alarm clock, he would not wake up. He felt he was part of the unchanging universe of his earlier existence inside the womb. Over the course of a couple of years of work, Sean is slowly developing a sense of identity, but the work is painstakingly slow. Nonetheless, progress is being made.

Early borderline organization

With the birth of an infant his journey of life starts outside the womb. There is, however, a transitional time between the stage during which the fetus moves away from an undifferentiated phase to a phase where the infant incorporates his environment. This phase is marked by the perinatal experience of the infant and shortly after. In certain situations, if the infant is traumatized during this transitional stage, he may vacillate between undifferentiation and attempts to incorporate the world outside of himself. This is not totally unprecedented as one cannot expect that the undifferentiated phase can instantaneously change into incorporation. If traumatized during this transitional time, then the behavior that I will indicate may result. The adult patient will find safety in forming an undifferentiated union with others to feel the safety of the metaphoric womb. In that state he will try to incorporate his world as he attempted to do as a neonate but due to chaos surrounding him, could not. But this is impossible as he cannot be in an undifferentiated state and incorporate the world around him. Therefore, his attempts at incorporation are destined to fail. Thus, he will try to get out of the undifferentiated state in order to incorporate his world, but due to the perceived chaos that he experienced as a neonate, he cannot! Then he gets overwhelmed with fears and anxiety and tries to enter the undifferentiated phase, and the cycle repeats! The individual who was traumatized during this state lives his life in a very unstable way. The smallest perturbation may throw him into chaos from which there is little escape. He can attempt to incorporate or form an undifferentiated merger, but both will necessarily fail! This is the dilemma of the early borderline personality organization. Baum (1997, 2007) has written extensively about this personality organization. He writes that people with this personality organization want to go back to the womb, which was the only safe place they knew of, but then immediately attempt to get out. My findings agree with Baum's writings regarding this personality organization.

Case of Sara

Sara is a woman in her early thirties who came to see me due to anxiety and childhood trauma. Her relationship with her mother was tumultuous and at times violent. She would demand financial support from her mother and if she did not respond positively, Sara would get angry and verbally violent (financial support

could be interpreted as an attempt to incorporate her world). It was as if she were fighting the incorporated object with anger! If her mother submitted to her wishes, her anger would subside, and she would enter a blissful state, feeling in control of her world (successful incorporation), which of course could not last very long as inevitably her perceived world would betray her. She had to seek assurances that the incorporated world would remain that way, and so she asked for more, which inevitably led to resistance and that led to the end of her bliss. When this state ended, she said she would feel that an organ was taken away from her body. Now she was back to living in the chaotic stage of her immediate postnatal experience, from which she sought to enter the undifferentiated state of existence in the womb. Her comment was that "I don't want to accept that she (her mother) has a world outside of me." At times, she was successful in that her mother allowed her to enter the undifferentiated state which she experienced as heavenly! She felt safe in this undifferentiated state, which of course could not last as the slightest perturbation threw her in the chaos of separated objects with the hope of incorporating them to gain mastery and control over them. This cycle repeated endlessly. In our work, I had to become the object that she could merge with or incorporate. The work is challenging but we are making slow progress.

Schizoid stage of development

The first period in the life of the neonate, which is normal autism (Mahler, 1975), or the autoerotic phase (prior to primary narcissism) (Freud, 1963), or the Schizoid stage (Lowen, 1994) begins at birth. During this stage which in terms of object relations is objectless, the infant's drives are focused on himself (autoerotism). This period lasts about a month or two. The infant, having just been born, is faced with fears as the birth process which separated him from the undifferentiated world in which he lived for 9 months is very scary. The infant, in order to control his environment, responds to this fear by a process known as incorporation, having successfully passed through the transitional stage of early borderline. He simply incorporates his environment (his world). The infant defends against the unsatisfying environment by stiffening and contracting the parts of his body that he is aware of, that is the parts of his body that he has some control over. Similar to what I discussed above, if the stiffening and contraction is not successful, then he might mount an autoimmune attack on the parts of his body where his world is incorporated and if that is not successful, then he

goes into resignation and cancer may result. Let me justify my assertions. An important component of our immune system is the B-cells (the other components are T-cells and NK-cells or natural killer cells). B-cells are implicated in both autoimmune disorders as well as cancer and play a central role in both. Hampe (2012) discusses the role of B-cells in autoimmune disorders. A recent treatment for multiple-sclerosis (MS) is to deplete the body of B-cells which are hypothesized to attack the myelin sheath around axons. The role of B-cells is also well established in the autoimmune disorders of the skin, joints, and the gastrointestinal system. In a recent study Yuen, Demissie, & Pillai (2016) discuss the role of B-cells in fighting cancerous tumors as well as their growth in certain situations. In this study the authors examine the immunological mechanisms by which B-cells promote, as well as inhibit, anti-tumor immunity in a range of malignancies. It is my hypothesis that the attack on the immune system and the organismic resignation are potentially both carried out by the B-cells, as psychological defense mechanisms. Lowen in his monologue, "The Will to Live and the Wish to Die" makes this very clear (2012). We all, as adults, survived our traumatic childhood experiences. Our will to live was strong enough to counter the wish to die! Our wish to die stems from the heartbreak that we suffered in our infancy. But when the energy related to the will to live is exhausted, the wish to die dominates and activates the organismic resignation, and the person may end up with cancer. But before fully succumbing to full resignation, the organism, defensively may mount an autoimmune attack as a weapon of last resort, resulting in various autoimmune diseases!

At the beginning of this period the infant gradually develops his sensory and motor nervous system and via his central nervous system reacts to his environment. In response to impingements of his environment, he retreats to his central nervous system and retreats to his head. I described above that If this defense fails, he may wage an autoimmune attack on his central nervous system which may result in multiple sclerosis (MS). If this is not successful, then a total resignation within his organism may result in result in cancer (Reich, 1973).

If the infant does not successfully move through this developmental phase unscathed and is not severely traumatized, he may later, as an adult, continue to incorporate the world in his mind (early schizoid). He will face the external world primarily with his mental apparatus. Winnicott (1949) writes about the overactivity in mental functioning in response to certain failures by the primary caretaker(s), resulting in a conflict between the mind and the psyche-soma. In this situation, Winnicott (1949) writes that the thoughts of the individual begin to dominate and facilitate the caring for the psyche-soma. His psyche

may cathect his mind as an object of intense attachment. I must emphasize that retreating to the mind and cathecting it as an attachment object can happen later in the development of the infant/child as well, if the infant/child, due to the failure of his environment, must regress to an earlier stage for self-protection and self-preservation. The cathected mind as an object of attachment is called the mind-object (Corrigan & Gordon, 1995). The space between stimulus and response, in this situation, is mediated by the mental world. When this world is important, one creates a mind to protect and preserve the subject mind (Corrigan & Gordon, 1995). His intellect will become a psychological defense and he will hold on to it as if his life depended on it. The therapist working with such clients must appeal to the client's intellect as a conduit to slowly connect him to his body. That is the therapist must be able to provide a facilitating environment to hold the client's intellect (mind). He must connect with the client through his mind first, otherwise the client continues to use his intellect as a defense and will resist treatment. He will not trust that he is safe with the therapist and will not give up his defense (avoiding vulnerability). The good object for the client here is the therapist with a mind that the client can connect with. The bodywork initially should proceed slowly and appeal to the client's felt sense. If the client's intellect and mind is not honored as the only defense that the client could have mounted early in his life to survive, then the defense turns into resistance, and the work may be stalled if the resistance is not processed.

Near the end of this period the infant becomes aware of his joints and limbs (autoerotism) as well as his skin. This is the late schizoid character. He incorporates the external world in his joints and resists by stiffening his joints, making graceful movements difficult. If stiffening of his joint is not sufficient to fend off against the intrusive and unsatisfying environment, then an autoimmune attack may result in either rheumatoid arthritis or skin allergies, as well as fibromyalgia. At the end of this stage, the infant, if unscathed, has formed a relatively integrated image of his body, for example he knows that his limbs belong to him, even though his ego has not developed yet.

In figure 4, I depict the process of incorporation. Segment 1 is the presentation of the infant's primal self which meets the environmental negativity represented by segment 2. Defensively, the infant in order to feel in control, incorporates his environment and takes the struggle inside. This is represented by segment 4. The infant's demands, instincts, and needs for survival are represented by segment 3. Segment 5 represents the delineation between the infant and the outside environment.

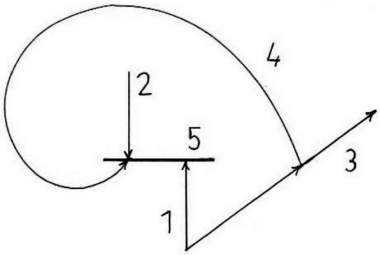

Figure 4. The incorporation phases – schizoid and oral

Case of Annie

Annie came to see me several years ago to seek consultation regarding her sons. But soon after that the focus of work became her. Annie disclosed that she had MS which was diagnosed about 10 years prior when she was in her 20s. She was a very educated and successful woman. Her eyes appeared dull and disconnected and her body seemed flaccid without a muscular tone. She was the second of 3 children. Annie had an older handicapped brother who needed much help and attention from her mother. In particular, her mother used to leave her alone in the house for hours to attend to the older brother and to seek medical treatment for him. Annie at this time was only several weeks old. This lack of contact was so severe that after a while when finally, she was picked up from her crib her arms were locked on her sides and her hands near her head. Not being able to manage her traumatizing environment by retreating into her head successfully, she had mounted an autoimmune attack on her nervous system resulting in MS. Interestingly Annie indicated that when she did not feel me as part of her, she felt dysregulated and that when she incorporated me, she felt that I was not in her body but her mind!

Case of Barbara

Barbara, a woman in her 40s was a highly educated and successful woman and a university professor. She was suffering from severe skin allergies that were triggered by an incident when she was in graduate school. She had developed bone

cancer when she was several years old which luckily was successfully treated. Similar to Annie, she also suffered from extreme lack of contact but a little later in life. When she was a couple of months old, her parents traveled overseas for an extended vacation and left her with her grandparents who were not very attentive. Barbara, found out later in her life that they were not very attentive. The stiffening defense was not successful in managing her traumatizing environment, and as a result she mounted an autoimmune attack on her skin which was extremely severe as well as organismic resignation which resulted in cancer. Awareness of joints and skin occurs nearly at the same time for infants.

Pre- and Part-object relating character structures

The oral character

At this point, the beginning of the second month of life, which corresponds to the symbiotic stage (Mahler, 1975), or the first half of the oral stage (Lowen, 1994), the infant faces an existential anxiety and fear (primary anxiety – Freud). The infant now becomes aware of his digestive system, hunger and the need for nourishment.

Early in this stage the infant's defense is primarily that of incorporation, where the infant incorporates the unsatisfying world into his gastrointestinal system (GI system) which has now entered his awareness. During this stage the infant responds to the unsatisfying environment by stiffening his gastrointestinal system which may result in digestive problems. If stiffening is not successful, then he will wage an autoimmune attack on his GI system which may result in a multitude of GI autoimmune related disorders, such as Krohn's disease, Colitis, etc. If the autoimmune attack is not successful, then he may organismically resign and develop cancers in the GI system later in life.

Later during this stage, the infant becomes aware of the breast as a part object and incorporates it into his primitive psyche and sees it an extension of himself. At this point the infant can wage internal attacks as discussed above as well as external attacks (biting the breast). If the needs of the infant are not met, he responds by protesting first and then denying them. He stiffens his chest and reduces his breathing and then may collapse. This is the oral character structure discussed by Lowen (1994) with its concomitant physical dynamics. During this later stage, the primitive psyche of the infant is also developing, and he becomes aware of his need and dependence on his mother perceived as a part-object (the

breast) as well as his frustration by the part-object (breast). If traumatized during this stage, the infant withdraws from the part-object (breast), in search of security, to the internal world as he had done before by incorporation. As an adult, he goes in and out of relationships. He is neither in nor out (Guntrip 1968). He has equally strong needs for and fears of close personal relationships (ibid). If traumatized at this stage, the person dreads that a close relationship will involve loss of freedom and independence and consequently withdraws to his internal world.

Still later during this phase, the infant slowly transitions from relating to the breast of the mother as a part-object to the mother with a breast (oral) which is an extension of him. This is the beginning of the symbiotic phase of development (Mahler, 1975), as well as the oral stage of development (Lowen, 1994). The mother with the breast now emerges as an extension of the infant as mentioned above. The infant transitions slowly from experiencing the mother as an extension of himself to experiencing himself and his mother as being mutually dependent – symbiosis. He (mother) and the infant are now symbiotically attached. It is noteworthy to mention that due to symbiotic attachment to the mother (still a part object), any attack on it will be perceived as an attack on himself as well. The infant is now both aware of his need for the mother with a breast as well as his frustration with her. The mother must remain attuned to her infant so that the symbiosis is not interfered with.

Case of Jane

Jane came to see me because she was suffering from depression and anxiety. She was complaining of lack of energy and a general sense of malaise. She was also suffering from fibromyalgia and IBS. Even though her body was masochistic, she also showed signs of trauma during the oral phase of development, specifically during the early oral stage of development and late schizoid stage. She was the oldest of three children. She indicated that she was estranged from her mother and felt disconnected from her. Her earliest memories of her mother were of being disconnected from her. She indicated that she felt that she had to grow up by herself. She was not breast fed for long. She also had to take care of her younger siblings. Our work started very slowly. She needed to feel safe and to trust me. But over time she was able to take in the connection. We worked on her felt sense and connecting to her body. Over time, she understood the meaning of her symptoms and her fibromyalgia symptoms disappeared and her IBS got much better. She had to move out of the country, and we could not finish our work. She has stayed

in touch with me and has told me that her fibromyalgia has not returned, and her IBS continues to improve.

The late borderline organization

The symbiotic phase ends around 5 months of age. Once the symbiotic phase ends, the infant begins to differentiate between himself and his mother and begins to distance himself from her by pushing her away when held in her arms. This is Mahler's differentiation subphase (Mahler, 1975) or the second half of the oral period (Lowen, 1994). This is the borderline phase of development. At this point the infant has developed a very primitive sense of self and fears not having the object (mother) in his vicinity. At the same time, he wants to differentiate himself from her. The drives during this and subsequent periods are focused on the object for support and safety as well as exploration of the environment. If traumatized, the infant will remain fixated in this phase. Externally, he will seek a symbiotic attachment to his mother, and once attached will try hard to differentiate. Internally, due to symbiosis, he cannot distinguish between his feelings and those of his mother (and others later). This is the essence of the formation of the borderline structure. If the infant's experience during the differentiation subphase was not traumatic, but the infant did suffer from deprivation of contact and connection, then he will develop an oral character. The infant must be allowed to separate and re-attach when he needs to in order to avoid the formation of the borderline structure. In other words, the infant must develop object constancy which is the ability to perceive objects in an integrated way. In therapy, the therapist must remain a consistent figure in the client's life – that is he should not be affected by the client's changing perception of him – idealization and devaluation. The therapist must help the client integrate the conflicting aspects of himself while providing a safe holding environment.

Case of Jasmine

Jasmin, a woman in her fifties came to see me due to her marital issues. She described her relationship with her husband as very tumultuous and unstable. She and her husband both had previous marriages. She did not have children, but her husband had children from a previous marriage. She described her mood as being explosive at times and that she would go into a rage, but then at other times she

would find herself very calm and caring. She had been in therapy before, but therapy never worked with her. She felt that she was not understood by the therapists, she indicated. She mentioned early on that she hoped that I would be different and that I would understand her and her agonizing life. Her idealization of me started early in therapy followed by occasional devaluation. Her diagnosis was clearly borderline. I was able to hold the space for her when she attacked me. I remained a source of stability for her even though she was quite unstable. A few months into the therapy she came in one day and told me that she had gotten into a fight with her husband. I asked her if she could describe what had happened. She mentioned that while eating breakfast, her husband commented on her dress, saying that it was a beautiful dress that she was wearing. That made her very angry, and she went into a rage and threw dishes on the floor breaking a number of them. I told her that I was confused as her husband gave her compliments on her dress and that made her angry. I asked her why that was. She said that she had worn that same dress a few days ago and that her husband did not comment on it then. I asked her what kind of mood she was in when this all happened. She mentioned that she was in a bad mood that morning. It must be very clear to the reader she felt bad inside and displaced that to her husband. He became the bad object and received the entirety of her wrath. Her husband on occasions threatened her with divorce which initially made her feel abandoned and caused her to retreat for a short while and then her rage and aggression came to the surface. The work with her progressed slowly but in the end, she made progress toward object constancy as I remained a stable object in her life and was able to contain her spectrum of emotions.

Object relating character structures

The full object relationship starts at the end of the differentiation phase. The infant is now aware of his mother as an external object. The frustration of the infant's needs results in higher tension and uncertainty within the infant. Please recall that at the end of the differentiation subphase (Mahler, 1975) or the end of oral stage (Lowen, 1994), the infant's drives shift more toward exploration of his environment since he has developed locomotion. The child at this point moves further away from the mother and is increasingly absorbed in his own activities and less aware of his mother. This period coincides with Mahler's practicing period (Mahler, 1975) or Lowen's narcissistic stage (Lowen, 1994). At this point the infant's explorative drives may face environmental negativity and rejection. His drives may be thwarted by the mother or other caretakers (bad object), which in

turn increases his anxiety as the infant feels that his exploratory drives are blocked and that his connection with the still needed mother has weakened. Narcissism can result in this phase when the child finds himself as the exciting object, that is when his libidinal ego (LE) cathects his central ego (CE) as the exciting object to which it attaches (Celani, 2014)! This process is shown in figure 5, below. In the treatment of this character our first goal must be to decouple the libidinal ego from the central ego.

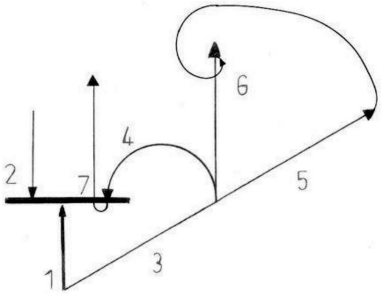

Figure 5. Narcissistic character structure

Case of James

James was a man in his late fifties when he came to see me. He was very smart and practiced as an attorney. James was a narcissist with little empathy and a sense of entitlement. He had been in therapy for many years that apparently was not of much help. He lived with his mother and on the margins. He was married for many years, but even though he was more educated and capable of making much more than his wife, ended up being dependent on her. After his divorce he had to live with his mother as he was not making enough money as an attorney. James was full of himself and thought that he deserved to be very successful. James smoked weed regularly and was also on a few psychotropic medications. The treatment of narcissism based on the object relations perspective that I presented consists of decoupling the libidinal ego from the central ego. I had to become a mirroring self-object to him so that his central ego's cathexis of his libidinal ego would cease. The work was very slow. He slowly decoupled his libidinal ego from his central ego and got in touch with his shame and his existential anxiety. Although he made great

strides as far as his narcissism was concerned, he was not able to become successful in his field. He eventually lost his insurance and could not work with me anymore.

Masochistic character structure

The child, having found his new abilities to explore and manipulate his environment, at times gets scared and runs back to his mother for safety. This is Mahler's (1975) rapprochement phase or Lowen's (1994) early masochistic stage of development. This is the time that mothers usually focus their efforts on toilette training and eating habits of the child as well as taming and controlling their child's impulses. The child, in order to conform to his environment, forms a strong antilibidinal ego which attacks the libidinal ego as well as the central ego and keeps them both under its domination. This process is shown in figure 6, below. Furthermore, the child, in an attempt to submit to the demands of his antilibidinal ego keeps his impulses and emotions in, resulting in what we know as masochism (Lowen, 1994). The immediate therapeutic goal for this character must be to weaken the punitive antilibidinal ego. For this to happen the therapist must become a good enough object for the client so that he can risk releasing the rejecting object (RO).

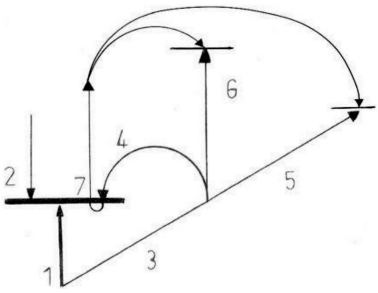

Figure 6. Masochistic character structure

Case of Mary

Mary was a woman in her early thirties who came to see me due to severe anxiety and her weight. Mary's character structure was masochistic. She had a compressed

body with a thick neck. She was a very intelligent woman but the impression that one would get from her was that nothing could go in or out, as everything was held in. In the sessions she was very agreeable and never expressed her feelings and never contradicted or disagreed with me. The work with her progressed slowly and I knew that there was a lot of anger and aggression in her. She also had accumulated guilt which kept her aggression in check. She said on occasions, in her interactions with her mother, that she could not oppose her as she did not want to make her mother upset. I asked her what she would feel in such a situation. She replied, "I feel bad and hate myself." But she still could not express how she felt to her mother nor anyone else. I first had to mobilize her stagnant energy which was very stagnant. I had her hit with a tennis racket and kick as well as throwing temper tantrums. Surprisingly she felt better after these exercises. But what had to happen beyond the exercises and getting her energy moving was for her to own her "NO". She had to own her "NO" before she could own her aggression and anger. In other words, referring to the diagram above, we had to weaken her antilibidinal ego which was attacking her central ego and her libidinal ego. This "NO" and the aggression associated with that had to be directed outward. To my surprise, she understood this and thought intellectually that it made sense and that she needed to own her "NO". I asked her to say "NO" and to do the expressive bioenergetic exercises related to the expression of "NO." I must emphasize that we had established a good therapeutic relationship, and she was able to trust the process and become, to some extent, vulnerable. She eventually was able to own her "NO" and express it. Over time, she was also able to own her anger and became more expressive. She did not hold in as much, which resulted in some weight loss.

Rigid character structure

Around the age 3, the child becomes aware of his sexuality and takes pleasure in his body and enters the family system. He becomes attracted to his opposite sex parent and sees his same sex parent as a rival. When the child's love and sexuality are rejected, he will adapt by separating his love from his sexuality. In his future, he will become an achiever where his libidinal ego supports his central ego. Or he will use sex against sexuality (Lowen, 1965; Reich, 1980). In this situation, it is the central ego that lends support to the libidinal ego. The immediate goal of therapy in both of these two situations is to separate the central ego from the libidinal ego. In either of the pathological conditions, they feed each other. Figures 7 and 8 below depict these two cases respectively.

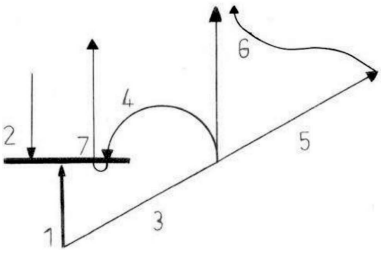

Figure 7. Rigid character structure – Achiever

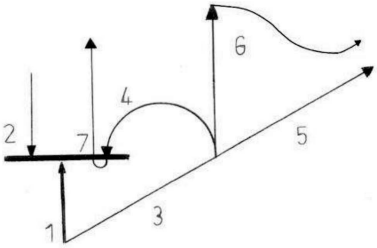

Figure 8. Rigid character structure – phallic narcissist

Case of Allen

Allen, a man in his 40's, came to see me due to anxiety related to his work situation. His body was very rigid, and he had an elevated level of anxiety which he could not manage. He wanted to get to high places in his place of work. He was a hard worker and an achiever. Allen had little pleasure in his life and despite being financially successful, he was not able to enjoy his life very much. He was constantly preoccupied with doing the "right thing" to enhance his chances of success. He was never married and had been in several unsatisfying relationships. Our work progressed slowly and was concentrated on him feeling pleasure in his body. In terms of my formulation of this structure, Allen's libidinal ego was supporting his central ego. Despite this he still had mirroring and idealizing self-object needs. I had to provide Allen with his self-object needs before he could let

himself feel pleasure. He felt if he enjoyed an activity or in a general sense had pleasure in his life then he would not be giving enough attention to his career. Once his central ego received its self-object needs, he allowed himself, albeit, very slowly, to feel pleasure in his body. In other words, now, his central ego was separated from his libidinal ego. Over time, he was able to maintain a balance between his career and his private life and to allow himself to feel pleasure and to take part in pleasurable activities. He later met a woman and became very fond of her. His relationship eventually led to marriage.

Case of Mark

Mark, a man in his late fifties came to see me due to somatic symptoms. He had very strong anal traits, in a psychoanalytic sense. He was very parsimonious, obstinate, and rigid in his ways. Mark was an educated man and relatively successful. Even though he wanted to be more financially successful, he was nonetheless satisfied with where he was. Mark was a phallic narcissist. He came into a session one day and mentioned that he had invited a female acquaintance to his house for a social get together. She agreed and went to his house. He seduced her and had sex with her. I got the sense that this was not truly what he wanted but felt that he had to perform! I asked him if he really wanted to have sex with that woman. He replied, "no"! I asked him, why then did he had had sex with her. He replied, "what would she think of me if I did not have sex with her?" She would think that I was not a man! I asked him to lie down on a mattress and asked him to bounce his pelvis saying what came to his mind. The phrase that he uttered was "fuck you". He did the exercise very diligently due to his anal traits. He came back in a couple of weeks and reported that he had invited the same woman to his house and tried to have sex with her again but lost his erection. He could not "perform"! He was terribly upset. I asked him again if he wanted to truly have sex with that woman. He responded, "no"! The exercise had resulted in some level of integration between his pelvis and his heart. It was clear that his central ego was supporting his libidinal ego. Overtime and after much work, we were able to separate his central ego from his libidinal ego. He was able to connect to women more from his heart and not his desire to conquer them. Mark's phallic narcissism was not very strong. I was aware that it was his central ego that was supporting his libidinal ego. Thus, the work with him was not very difficult as his anal traits weakened the connection between his central ego and his libidinal ego. There was a compulsiveness in his behavior which made it easier for him to progress in therapy.

Conclusion

In this paper I formulated character structures based on object relations theory. I discussed four phases of object relating, an undifferentiation phase, an incorporating phase, a pre-object (part object relations) relating phase, and finally a full object relating phase resulting in internalization. Based on this theory, I introduced the schizophrenic character, and early and late borderline organizations that were not discussed in detail in traditional bioenergetic literature. I also introduced treatment approaches, notwithstanding somatic interventions, based on object relations and the theory that I put forward in this paper. I also discussed a possible origin of certain types of auto-immune disorders which may be related to early trauma. I presented and discerned the difference between incorporation and internalization and the ramification of each in character formation as well as in auto-immune vs psychological disorders.

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Aggression: destructive impulse or life force

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Abstracts

The first part of this article retraces the evolution of the concept of aggression from the Freudian understanding of that primary impulse to the contemporary analytical authors, as well as to the Reichian and the Lowenian view of it. In a second part, it presents how today's bioenergetic therapists conceptualize the aggressive impulse and how they work with it in their clinical practice, so that they can help their patients transform what can be a destructive force into a life force sustaining self-expression and self-actualization.

Keywords: aggression, destruction, attunement, transformation, bioenergetic strategies

Agressão: Impulse Destrutivo da Força Vital (Portuguese)
A primeira parte deste artigo retoma a evolução do conceito de agressão -desde a conceituação Freudiana de impulso primário até os autores analíticos contemporâneos, e também a visão Reicheana e Loweniana. Na segunda parte, mostra como terapeutas bioenergéticos atuais conceitualizam o impulso agressivo e como trabalham com este em sua prática clínica, de modo a auxiliar seus pacientes na transformação do que pode ser uma força destrutiva numa força que sustenta a auto-expressão e a auto- atualização

Agressivité: impulsion destructrice ou force vitale (French)
La première partie de cet article retrace l'évolution du concept d'agression depuis la compréhension freudienne de cette impulsion primaire jusqu'aux auteurs analytiques contemporains, et à la vision reichienne et lowénienne de celle-ci. Dans une deuxième partie, il présente comment les thérapeutes bioénergétiques d'aujourd'hui conceptualisent l'impulsion agressive et comment ils travaillent avec elle dans la pratique clinique, afin d'aider les

patients à transformer ce qui peut être une force destructrice en une force vitale qui soutient l'expression et la réalisation de soi.

Aggressività: impulso distruttivo o forza vitale (Italian)
La prima parte di questo articolo ripercorre l'evoluzione del concetto di aggressività dalla comprensione freudiana di quell'impulso primario agli autori analitici contemporanei, e alla visione reichiana e loweniana di esso. In una seconda parte, presenta come gli odierni terapeuti bioenergetici concettualizzano l'impulso aggressivo e come lavorano con esso nella pratica clinica, in modo che possano aiutare i pazienti a trasformare quella che può essere una forza distruttiva in una forza vitale che sostiene l'autoespressione e l'autorealizzazione.

Aggression: destruktive Impulse oder Lebenskraft? (German)
Der erste Teil des Aufsatzes betrachtet den Begriff der Aggression, von dem freudschen Verständnis dieses Primärimpulses bis zu den zeitgenössischen psychoanalytischen Autoren, sowie auch die Auffassungen von Reich und Lowen. Im zweiten Teil wird dargestellt, wie die gegenwärtigen bioenergetischen Therapeuten den aggressiven Impuls verstehen und wie sie damit in ihrer klinischen Praxis arbeiten, um ihren Patienten zu helfen, eine potentiell destruktive Kraft in eine Lebenskraft zu verwandeln, die den Selbstausdruck und die Selbstverwirklichung unterstützt.

Агрессия: разрушительный импульс или жизненная сила (Russian)
В первой части этой статьи прослеживается эволюция концепции агрессии от фрейдистского понимания этого первичного импульса к современным аналитическим авторам, а также к взглядам на нее Райха и Лоуэна. Во второй части рассказывается о том, как современные биоэнергетические терапевты концептуализируют агрессивный импульс и как они работают с ним в своей клинической практике, чтобы помочь своим пациентам превратить то, что может быть разрушительной силой, в жизненную силу, поддерживающую самовыражение и самоактуализацию.

Agresión: impulso destructivo o fuerza vital (Spanish)
La primera parte de este artículo repasa la evolución del concepto de agresión, desde la comprensión freudiana de ese impulso primario hasta los autores analíticos contemporáneos, así como la visión reichiana y loweniana de la misma. En la segunda parte, se analiza cómo los terapeutas bioenergéticos que ejercen hoy en día conceptualizan el impulso agresivo y cómo lo integran en su práctica clínica. Su objetivo es guiar a los pacientes en la transformación de esta energía potencialmente destructiva en una fuerza vital, capaz de promover la autoexpresión y la autorrealización.

攻击性：破坏性冲动或生命力 (Chinese)
本文第一部分追溯了攻击性概念的演变过程，从弗洛伊德对这一原始冲动的理解到当代精神分析作者们，以及赖克派和勒温派对它的看法。文章的第二部分介绍了当今的躯体动力治疗师是如何将攻击冲动概念化的，以及他们在临床实践中是如何与攻击冲动工作的，从而帮助患者将可能具有破坏性的力量转化为维持自我表达和自我实现的生命力。

Introduction: Aggression and our bioenergetic practice in the contemporary world

> "What is certain, is that with the elimination of aggression, the *aggredi* in the original and widest sense, the tackling of a task or problem, [...] everything associated with ambition, ranking order, and countless other equally indispensable behaviour patterns would probably also disappear from human life."
>
> *(Lorenz, 2002, p. 289, original ed. 1963)*

As bioenergetic therapists, the work we do is more than precious in the times that we are living in. The predominance of screens, the pace of life, and so many distractions and anxiety-producing situations are pulling people away from their body, their sensations, and their feelings. The more people are disconnected from their body, the less capacity they have for self-regulating their emotions. Among the strong emotions one can feel is anger. In its less-controlled version, it becomes rage and hatred, the expression of which we are witnessing more and more, post-pandemic. Helping our patients learn how to self-regulate and express their anger, rage, and hatred, helping them own their aggressive energy, and "transmute" it into a life force is, in a sense, one of the alchemic tasks we face in this troubled 21st century.

In this article, I will first review a few biological observations regarding aggression, and I will address the evolution of this concept in the psychoanalytical literature, from Freud to Winnicott, and from Reich to Lowen. Then, I will discuss contemporary perspectives on aggression and our work in bioenergetic analysis related to this kind of primary impulse. Finally, I will present a few clinical vignettes as well as some exercises related to the work on aggression.

Aggression in the biological realm

In preparation for this article, I thought it might be interesting to revisit Konrad Lorenz's landmark book *On Aggression* to get a larger perspective on the subject. True, Lorenz's work has been challenged for his racially biased theories, as the following quote indicates: "Because of what Dr. Konrad Lorenz wrote on racial purity, as a professor in wartime Germany, the propriety of awarding him a Nobel Prize has been questioned in the December issue of The Sciences, organ of the New York Academy of Sciences." (Sullivan, 1973, p. 9) Nevertheless, some aspects of Lorenz's work can help us see how complex the motivations and manifestations of aggression can be. In his book, among other things, Lorenz concludes from his observation of animals, that under natural conditions, the aggressive impulse is designed to ensure the survival of the individual and the species (Lorenz, 2002, pp. 7–8, original ed. 1963). From that perspective, the aggressive drive should be considered more of a life force than a destructive instinct. Yet, in many species (fish, lizards, some birds), Lorenz reports that the relation between individual beings is impersonal, and even between mates, aggression is displayed in fights for habitat or food. In other species where there is a form of bonding, a society is held together by mutual recognition between partners. Hence, when one of the partners displays an aggressive posture toward the other, he may bypass the partner and discharge the aggression on another member of the society. Lorenz then talks about a phenomenon he calls *redirected activity* (in italics in the text), which can also be observed in human behavior when, for instance, "a man who is very angry with someone hits the table instead of the other man's jaw because inhibition prevents him from doing so." (Lorenz, 2002, p. 179 – orig. ed. 1963) Towards the end of his book, he reflects on human behavior and he concludes that "present day civilized man suffers from insufficient discharge of his aggressive drive" (Ibid., p. 253) which, as we know, can lead to destructiveness.

The psychoanalytical theory on aggression

When we consider aggression from the theoretical angle of psychoanalysis, we find different points of view as the analytical theory keeps evolving. Mizen and Morris (2007) offer an overview of that theoretical evolution. They highlight the fact that Freud initially considered aggression to be an aspect of sexuality. It is only in 1915 in his book *Instincts and their Vicissitudes* that he recognizes

the autonomous role of the aggression instinct. Then in 1920, he went further in *Beyond the Pleasure Principle*, as he "proposes aggression as a further primary instinctual basis of psyche" according to Mizen and Morris (2007, p. 40). Freud also struggled with the concept of the death instinct, as opposed to the libido (the life instinct), as he was trying to better understand the role of aggression in human nature. In the end, on the one hand, he recognized the positive aspect of aggression as a 'self-preservation instinct', while on the other hand, he maintained that there was "an inescapable, ineffable and essential destructive element in the human makeup." as reported by Mizen and Morris, (2007, p. 42), which was compatible with his death instinct theory.

Following Freud, Melanie Klein tried to deepen the understanding of the concept of the death instinct. She believed in the innate origin of aggression. Her perspective was somewhat opposed to Freud's view of the aggressive instinct as reactive to frustration or trauma or some kind of threat to the body or the psyche. Klein's perspective rather postulates that in every human being, there is an *innate* predisposition to aggression as opposed to a *reactive* one. She explains that "In phantasy, at least, all human beings are considered to have a deep well of destructiveness, murderousness, cruelty and sadism to draw upon, with the psychopath, murderer, torturer and robber to be found in every human soul." (Mizen et al., 2007, p. 44) With regards to the expression of aggression, Klein developed the concept of the split object into a good part (sustaining and nurturing, the "good breast") and a bad part (withholding, hostile, the "bad breast"). In developmental terms, Klein proposed that the infant who has attacked the "bad object" (for example, biting mother's breast) eventually realizes that: "the polarity of mother into good and bad parts is an illusion and that the attack has damaged the whole imperfect mother rather than simply the illusory bad part of her." (Ibid., p. 47). This developmental phase, as presented by Melanie Klein, opens the door to the capacity to access an integrated vision of the object, and to the possibility of gestures of reparation, in infancy as well as in adult life, whenever the aggressive impulse has created damage.

In his theory on early development issues, Winnicott for his part, attempts to combine both the Freudian and the Kleinian thinking on the role of aggression. He considers that the infant has an autonomous aggressive drive that is used to assert the boundaries of the self and the ego. In that sense, in Winnicott's perspective, aggression is used to forward an erotic drive that is at the service of the infant's development. Even actions considered to be aggressive, destructive and violent (like kicking the mother's body), are viewed as part of an erotic drive and thus, as secondary to an underlying developmental erotic instinct, or life

force. Mizen and Morris conclude that for all its positive aspects, developmentally speaking, Winnicott's view tends to ignore or to downplay "the intractable or irredeemable violence, the clinical manifestation of which, led Freud and then Klein to develop the concept of the 'death instinct' in the first place". (Ibid., p. 59)

As he was elaborating his theoretical concepts on character structure and the relationship between the psyche and the body, Reich's view on aggression was exposed as early as 1927 in his book *Die Funktion des Orgasmus* (The Function of the Orgasm). In a sub-chapter titled *Destruction, Aggression and Sadism*), Reich (1975, Orig. ed. 1927) criticizes how psychoanalysis uses interchangeably the terms aggression, sadism, destruction, and death instinct. He argues that "A living creature develops a destructive impulse when it wants to destroy a source of danger. [...] The original motive is not pleasure in destruction. Rather, the destruction serves the 'life instinct'" (Reich, 1975, p. 138 – Orig. edition 1927). He then proceeds to explain that "Aggression is always an attempt to provide the means for the gratification of a vital need" (Ibid., p. 139) As we can see, this understanding is closely related to Freud's view of aggression as reactive to a frustration or a trauma. The sexual drive being at the heart of Reich's theoretical construct, he sees the suppression of the sexual impulse as a major factor conducive to hate and to destructive tendencies. Reich (1975, p. 140) even mentions that in cases where there is an increase in sexual gratification, a decrease in sadistic perversions or sadistic fantasies can be observed.

The bioenergetic perspective on aggression

Lowen, for his part, following in the footsteps of Reich, also questions the existence of an innate death instinct. Lowen, in his book *The Language of the Body* (1974, Orig. ed. 1958), argues that "The concept of a death instinct is illogical since the word "instinct"' implies life, it is as if one said, "life equals life plus death". (Lowen, 1974, p. 86 – Orig. ed. 1958), Thus, Lowen, like Reich, basically considers instincts as oriented towards pleasure, although he explains that the "pleasure principle" is eventually tempered by the "reality principle", which enables the person to interact with external reality. In his chapter on *The Bioenergetic Concept of the Instincts* Lowen focuses on the energetic component of the instinct. In accordance with the Reichian model, he describes instinct as an impulse that can be understood as an energy movement originating from the center of the organism and moving towards the periphery, where it meets with the outer world. This movement, he explains, has two purposes: the function of charge and that of dis-

charge, the charge being associated with the taking in of food, respiration, and sexual excitement, and discharge being associated with expression and sexual discharge.

More directly related to the topic of aggression, Lowen locates the trajectory of the aggressive charge in the back of the body, as opposed to the front part of the body where tender feelings can be experienced. He argues that an aggressive component is necessary for the movement of reaching out, as both the tender and the aggressive charges move upwards in the body and find their expression through the arms, the facial expression, and the eyes. Lowen (Ibid., pp. 80–84) explains that the aggressive component is equally necessary for a sexual encounter as both the tender and aggressive charges move downwards and allow for a full sexual discharge. The aggressive charge can also be mobilized when the person needs to assert or defend herself. This is why Lowen has created typical bioenergetic exercises designed to help his patients openly own and express their anger (Lowen et al., 1977).

In the 1970s and the 1980s, the psychoanalytical community started to acknowledge the reality of violence with which caregivers sometimes treat their children. Alice Miller was one of the first analysts to challenge Freud's view that the nature of violent childhood memories reported by patients was predominantly of a phantasmatic nature. She argued in several of her books (1983, 1984a, 1984b), that the mistreatments sustained by patients in their childhood at the hands of their parents, were real and should be interpreted as such.

We cannot ignore the fact that the destructive aspect of aggression has been part of human history forever and that it still manifests itself in today's world. We can witness it in all kinds of ways: wars that are being waged in various parts of the world, social tensions resulting from migrations, political issues opposing coworkers, neighbors, and families, domestic violence, mass murders, expressions of rage through social media, etc. More recently, the #MeToo movement highlighted how widespread women's abuse still exists in our contemporary societies.

Hence, Lorenz's assertion that: "present day civilized man suffers from insufficient discharge of his aggressive drive", which can lead to repression and a distortion of this original life force into destructive behavior, seems to make a lot of sense. In Lowen's perspective, however, the problem is not merely a question of insufficient discharge of aggression. It is also a question of owning and focusing the aggressive impulse toward the appropriate object. Consequently, we can appreciate that an aggressive drive that is not channeled into a self-assertive, relational, sexual-fulfilling, and life-sustaining discharge, can be diverted, distorted, or perverted into destructive or self-destructive tendencies.

As bioenergetic therapists whose basic principles rest on Reichian and Lowenian concepts, we consider the original aggressive drive of the organism to be associated with a life instinct. Robert Hilton (2007, p. 167), who is one of our early masters in bioenergetic analysis, explains how, very early in life, a baby's original aggressive reactions resulting from unmet primary needs, can be repressed and turned against oneself as the young organism's aggressive manifestations of protest encounter negative reactions from the environment. He illustrates his point of view in the following diagram:

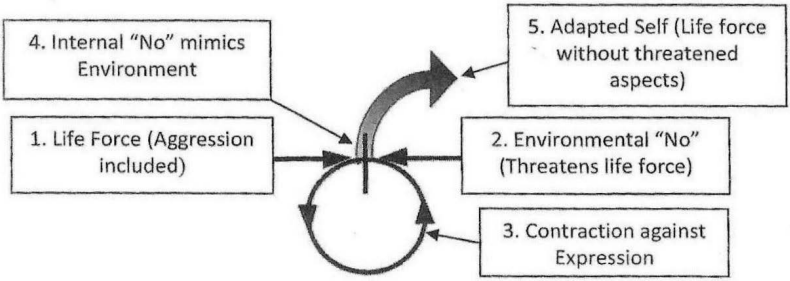

Diagram 1. Self-expression encountering a negative response from the environment (Hilton, 2007, p. 167)

> "(1) Natural organismic expressions of life emerge at different intervals and in different situations. This life force or expression consists of a need (for appropriate contact/consummation) and anger/aggressive impulses to affirm and defend the expression of the need in the world. Somewhere in the environment (2), there comes a very strong, (threatening) 'No' to this expression. A contraction develops within the individual (3) that stops self expressive movement and also begins to block healthy aggression. A freezing or pulling in develops as (4) part of this energy moves against itself to re-enforce this 'No' from the environment. What's left of the original life force (5) confronts the environment in a different ('safer') way." (Hilton, 2007, p. 168)

This explanation illustrates how most human beings initially repress their aggressive impulses and develop more acceptable behavior to survive. According to the theoretical concepts of bioenergetic analysis, this process eventually leads to the elaboration of a character structure, which is a complex defensive system made up of psychic defense mechanisms that are somatically reflected in the body through

various muscular tension patterns. The five character types developed by Lowen (the schizoid, the oral, the psychopathic, the masochistic, and the rigid) were elaborated in an era during which patients who came to therapy tended to repress their expression and needed to be helped to open up to their feelings and express them, including their aggressive feelings. This is why during the 1970's and the 1980's, emphasis was often put on a kind of work in which cathartic discharge of aggression was encouraged in bioenergetic analysis.

Contemporary perspective on aggression and bioenergetic analysis

As contemporary psychology continued to develop, groundbreaking works were published on the topic of early development. Works like Heinz Kohut's *The Analysis of the Self* (1971), Bowlby's *Attachment* (1969), Daniel Stern's *The Interpersonal World of the Infant* (1985), and Allan Schore's *Affect Regulation and the Repair of the Self* (2003), helped turn the focus from theories organized around the concept of sexual drive to theories organized around the concept of the Self as well as that of attachment and early relationships. Thanks to these developments, the nature of aggression was no longer considered to be primarily the frustration of an erotic, sexual drive. Early faulty attunement and interpersonal connection were also understood as important sources of frustration, conducive to aggressive responses. As bioenergetic therapists, we started to integrate these views into our theoretical construct as well as in our clinical practice. For instance, we developed a more refined understanding of the borderline organization as well as that of the narcissistic organization, which were not part of Lowen's original character types, although he later devoted a book to narcissistic issues (Lowen, 1985).

Another source that contributed to our knowledge with regards to our understanding of aggression, and more specifically to how we can work therapeutically with this kind of energy, is the contribution of neuroscience. In this respect, the works of Bessel van der Kolk, *The Body Keeps the Score* (2014) and Stephen Porges' *Polyvagal Theory* (2011) have helped us gain a better understanding of our neurological system with regards to the impact of trauma. Other approaches to working with trauma, like that of Peter Levine (2005) on somatic experiencing, and Pat Ogden (2006, 2015) on the sensorimotor approach, introduced different ways of working with the body. All these contributions helped emphasize the importance of titration and self-regulation when working with trauma. They are particularly useful since the manifestations of destructive aggression can often

be the result of early traumatic experiences that may lead to a poor capacity for containment and self-regulation of the aggressive drive. These days, in a world in which we are being bombarded with all kinds of stimulations, and where so much has become in flux and uncertain, there seems to be a greater need for tools that increase the capacity for containment and self-regulation. Hence as we, bioenergetic analysts, began to integrate these new tools, we nevertheless kept the typical bioenergetic strategies in our toolbox, remaining faithful to basic foundational aspects of the Lowenian legacy, among other things, the concept of grounding, so crucial for containment and self-regulation.

A good illustration of the integration of new knowledge with the more classical bioenergetic work can be found in an article from one of our bioenergetic colleagues from Switzerland, Margit Koemeda-Lutz (2006), who revisits the concept of the unconscious from the angle of the unconscious regulatory neurological processes in the human body. She explains the role of cognition, emotion, and movement in processes of change, arguing that cognition alone cannot activate change in our automated reactions and behavior. In a part of the article where she asks: "Is there healing power in rage?" she explains the somatic and neurological impact of classical bioenergetic exercises like the "bow" and the "elephant" (bending over, grounding position). She also addresses the impact of motor activities, like the kicking exercise, on the emergence of memories and the reorganization of neural networks. In her closing remarks, she concludes that: "Empirical studies consistently demonstrate that insight and wise intention alone do not effect change, but that significant new emotional experiences are needed, i. e. that the limbic system must be "addressed" and that neuroplastic change can only occur under the condition of a certain degree of general arousal and can be facilitated by concomitant motor activity" (Koemeda-Lutz, 2006, p. 123) Her article, which is based on research, confirms the importance of the work we do as bioenergetic therapists when we encourage the active expression of anger through classical bioenergetic exercises like kicking and pounding.

Another example of the integration of new concepts and core principles in bioenergetic analysis can be found in an article on the topic of aggression, written by Anat Gihon, our bioenergetic colleague from Israel. In this article, Gihon explains why aggression is such an important component in the formation and the expression of the Self: "Aggression is the charge that supports the expression of a true, contactful self. It is also the charge that helps us push away or aside an obstacle that interferes with those actions." (Gihon, 2018, pp. 78–79) Using the concepts developed by Winnicott, Mahler, and other psychoanalytical authors, she describes the role of aggression in early development as an important factor

in the separation-individuation process and the formation of true selfhood. She also explains what are the relational conditions that affect the development of healthy aggression, particularly the possibility for the child to use the parent as a 'selfobject' in the sense in which Kohut describes it, which means that the parent is able to demonstrate empathy and let the child "deposit in her/him the difficult, painful, unbearable feelings, including those of hostility and hate." (Ibid., p. 84). She describes what can happen when this life force cannot find a healthy expression: "When the flow of aggression is blocked or being sabotaged, the charge will either turn in against the self, and will often be experienced as self-hate, shame, and guilt; and/or, it will accumulate, being expressed outwardly, in a destructive force such as rage, hate and violence." (Ibid., p. 79) This quote echoes Hilton's diagram, about the turning against the self of the aggressive charge. In addition to the theoretical aspect of her article, Gihon also presents clinical cases that illustrate how she integrates contemporary concepts in her work with aggression as an important factor in the development of the self.

As therapists, we work to help our patients become aware of, understand, and transform their destructive impulses into a constructive life force. However, our efforts may feel at times like a drop in the ocean as we watch the news and consider the state of the world. Yet, the work we do as we help some of our patients access their repressed aggressive impulses or help some others contain and regulate theirs is invaluable. Symbolically, this work is akin to the alchemist's work of transmuting vile metal into gold.

Adapting bioenergetic analysis exercises to maintain attunement

In our practice, over the years, we had to develop new strategies in addition to the classical bioenergetic exercises. We had to adapt them to each patient's process and to their capacity for accessing and expressing their aggressive energy. Two colleagues from California, Vincentia Schroeter and Barbara Thomson (2011) repertory a great number of exercises that are adapted to various types of character structures. This rich collection of exercises is complemented by insightful explanations on the various character structures and can give even seasoned therapists many ideas on how to find exercises that fit the needs of patients.

As for myself, I developed my tools in addition to being inspired by those of my colleagues. I predominantly see women in my practice, and I have observed that most of them have difficulty owning the intensity of their aggressive charge.

They tend to repress it, for fear of being labeled as "bad persons", or they have cut themselves off from even feeling their anger or their rage because the feeling is unbearable. Hence, often there is a need to de-dramatize the aggressive charge and to present it as a life force. In that respect, I like to use metaphors of wild animals that need to be tamed and befriended. Lately, when I mentioned the metaphor of the "inner dragon" to one of my schizoid patients who is terrified of her murderous rage, she said: "The inner dragon is exactly how I picture my aggressive energy!" I thought that was an interesting moment of resonance.

Adapting classical bioenergetic exercises felt necessary for me as I tried to cultivate an attitude of attunement, inspired by the works of Stern (1985) and Schore (2003). It is always important for me to try to maintain attunement with the patient as best I can, as the session unfolds. One way I found that helps me do this is to consider the patient as being part of the therapeutic "team", and to use the information the patient is giving me as she is experimenting with a bioenergetic exercise. This belief in "teamwork" usually helps me stay on the same "wavelength" with the patient. Hence, when I see that a type of intervention does not feel appropriate for a patient, I try to find another type of exercise in the moment, to facilitate the expression of anger, while keeping in mind that I may have to work on the initial resistance further down the road. Here is an example of such an adaptation.

Amy[1] was a woman in her 30's. Her early life had been spent in a country at war. As a baby, she could hear bombs explode near her house. Eventually, her family moved to Canada. She had been in therapy with me for a while when the theme of her anger towards her parents came up. She was raised in a family in which expectations to display "good behavior" were high, and where there were a lot of criticisms. She resented being criticized and she could feel her anger towards her parents. She could also express it in words in the form of a complaint, but a full-body expression of her anger was another matter. One day, I invited her to experiment with a classical bioenergetic exercise (hitting the bed with a tennis racket) and to see how it felt to her to let some of her anger out in that manner. She was willing to try. I instructed her to raise the racket high and arch back, holding the charge and breathing, before letting herself hit the bed when she felt like hitting (see Figure 1 below, my own illustration of the standard posture also shown in Lowen & Lowen book on exercises (1977, pp. 114–115.). She hit once or twice, rather hard, as far as can I remember, then said: "I can't! This is too violent! I am against violence. I can't do this.". I said: "Okay, I understand. Just

1 Fictious name

ground for a moment, and let's see if we can find another way for you to express your anger." (see grounding exercise, in Lowen & Lowen, 1977, pp. 11–12)

In my office, I have a heavy cushion. As Amy came up from the grounding position, I asked her to change position and put herself at a distance, facing the opposite wall. I gave her the cushion and I invited her to assume the same arching back posture as the one I had suggested with the tennis racket, but this time it was the cushion she was holding in her extended arms. I instructed her to throw the cushion as hard as she could against the wall, using words that meant that she was "giving back" to her parents the criticisms that she did not want to tolerate anymore. She threw the cushion, and I kept throwing it back at her several times, so she could repeat the exercise. Eventually a genuine expression of anger came through in full force in a full-body movement and with loud words. After throwing the cushion several times in a row, she stopped, saying that she felt it was enough for the day. She said she felt strong and satisfied. We had found a safe way in which she could let her anger out. We continued to use this exercise in the following sessions as she kept working on her aggression, feeling more and more at ease to openly express her anger.

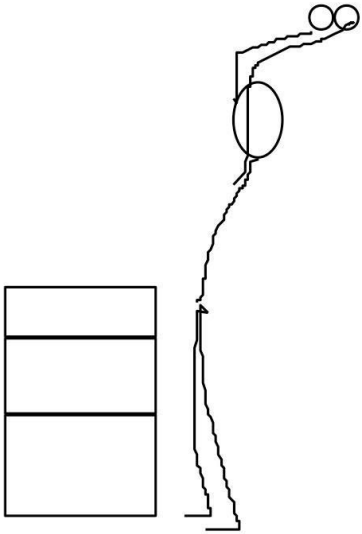

Figure 1. Positioning of the body in preparation for hitting

This kind of positioning can be used to hit with the fists, as illustrated here, hit with a tennis racket or throw a cushion. It is important to remind the patient to keep focusing her gaze on the point where she hits, or on the point where she is throwing the cushion.

I remember Lowen telling us during a workshop, that we had to transform rage into anger. He explained that rage was a type of unfocused discharge that leaves the person with a feeling of powerlessness, whereas expressing anger in a directed, focused way, leads to a feeling of empowerment.

NOTE: When working with cathartic expression of anger, I always tell my patients that they need to make sure they respect 4 basic rules when they do that kind of work on their own:

1. Make sure they don't hurt themselves
2. Make sure they don't break their belongings
3. Make sure they don't hurt anybody else
4. Make sure they don't break anybody else's belongings

I find this exercise with the cushion most useful, especially with patients who have a strong judgemental superego and with those who experience shame, due to early experiences of devaluation. I have used it with several patients who need to free themselves from parental projections and injunctions and who need to "give back to whom it belongs" the shaming and devaluating messages they have received as children. This is an exercise that generally feels satisfying and empowering to the patients. One of my present patients, who is struggling with low self-esteem issues, can reconnect with a sense of empowerment, worthiness and dignity, whenever she uses the "throwing the cushion" exercise.

Bioenergetic analysis exercises on aggression and self-regulation

As I mentioned above, literature on trauma (Levine, 2005; Ogden, 2015, 2006), as well as works on early issues (Stern, 1985; Schore, 2003), started to influence our bioenergetic theory and practice towards the end of the '90s. In particular, the notion of self-regulation became an important dimension in our work.

In that respect, in addition to the above-mentioned work, the contribution of neuropsychology, particularly that of Stephen Porges' polyvagal theory (2011, 2017), also enabled us to fine-tune our interventions with patients with trauma and early issues, whose lack of ego strength cannot tolerate an intense

discharge without risking entering into dissociated, frozen or numb states. The following diagram illustrates some of the key concepts of Porges' polyvagal theory.

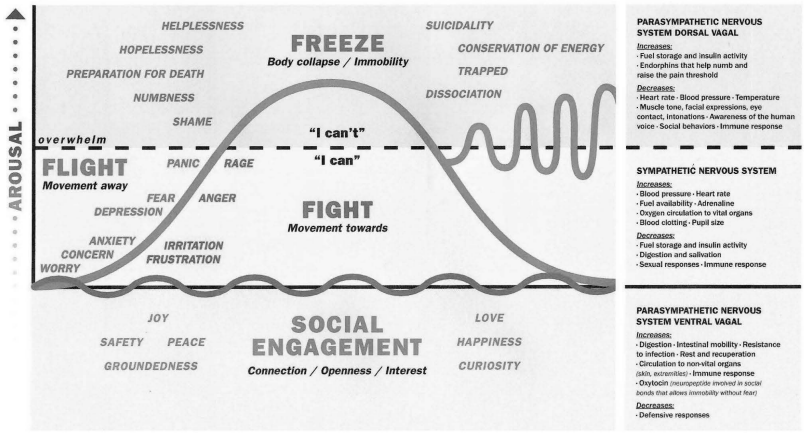

Diagram 2. Illustration of the various types of response of the autonomous nervous system, based on Porges' polyvagal theory (Slide from TRE PowerPoint. Didactic material [Berceli, 2013])

Hence, while we, bioenergetic therapists, still value cathartic release and therapeutic strategies that would facilitate the expression of various emotions, we have developed strategies that also value titration, which consists of smaller degrees of charge and intensity in the work, to make sure that the level of arousal of the patient remains within "a window of tolerance" and does not become so intense that it activates the parasympathetic dorsal vagal response (blue segment: freeze). This means that when we work on aggression with a patient, we must make sure that the degree of arousal remains manageable and self-regulated while the sympathetic nervous system (yellow segment: fight/flight) is activated during the expression of aggressive feelings. Then, once the patient has expressed her anger as fully as possible, in the present moment, she can ideally return to calmness, confidence, and openness as the parasympathetic ventral vagal state (green segment: social engagement) is activated.

Early in my career as a bioenergetic therapist, I learned the hard way by trial and error how to take into consideration what we then used to call the patient's

"capacity for containment", which is another way of talking about maintaining the patient's experience within a "window of tolerance". I still remember a session when I encouraged a borderline patient to express her anger by hitting the bed with the tennis racket. That patient, let's call her Ruth[2], was in her 30's. She had been a sexual abuse victim as a child and had had a difficult relationship with her symbiotic psychotic mother. I knew she had a lot of rage in herself, and I thought that mobilizing her anger would enable her to feel stronger and more self-possessed. Hence, in one of our sessions, I invited her to position herself to discharge some anger, pulling the racket high and arching back in preparation for hitting the bed. She had barely hit the bed two or three times when she collapsed to the floor, her legs giving from under her. Her body was literally telling us that she could not "stand" the intensity of the charge. Needless to say, I realized she had to ground and recompose herself, which fortunately I could help her do before the end of the session. But I had learned a lesson that day and from then on, I intuitively made sure I could help my patients self-regulate when doing work on aggression.

As I learned more about borderline patients and the incidence of sexual abuse in their history (Fréchette, 1987), I developed a technique that enabled them to mobilize their strength with a strong part of their body: their legs (Fréchette, 1992). I called it the pushing-back exercise. In addition to working on boundaries, this exercise reinforces grounding because the energy is directed toward the legs and the feet. In this exercise, the positioning allows for a progressive experience of mobilization. First, the patients can start with a slow push, checking how they feel as they are pushing back against an "intruder" (the therapist). The intensity can gradually grow as both therapist and patient monitor the patient's capacity to self-regulate. When the capacity to self-regulate is well established (this may take several sessions, if not weeks or months), the patient can then go into a full-throttle push, going all in to repel the intruder. The interesting feature of this exercise is its repetitiveness in a continuous pushing back motion until the patient feels "complete" with the experience. To enable continuous motion, the therapist needs to maintain the feet of the patient "glued" against a thick cushion protecting his/her chest and belly, and steadfastly hold on to the patient's ankles. This enables the therapist to move in one piece with the movement of the patient, alternately offering some pressure as the legs are bent, and letting himself/herself be pushed away, with the push of the patient. See the illustration below to have a better idea of what I am explaining here.

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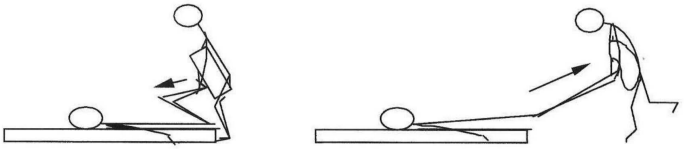
2 Fictious name



Phase 1. Applying pressure/resistance

Phase 2. Allowing the patient to push back, giving in to the push

Figure 3. The pushing back exercise

Figure 3 illustrates the full-throttle push. However, as mentioned above, a slower, gradual push, is also an interesting option to evaluate the capacity for self-regulation in the exploration of an aggressive motion to set boundaries. I found out that this exercise was an interesting one to enable borderline patients and sexual abuse victims to work on asserting their limits. For many of my borderline clients, who were also for the most part sexual abuse victims, this exercise usually gave them a sense of empowerment when they could enter into the full-throttle continuous pushing motion, using words like "back off!" or "leave me alone!" or any other self-assertive words. In this kind of exercise, even though the therapist is in the position of the "intruder", he/she should also play a supportive role, acclaiming the strength with which the patient is mobilizing her energy to set her boundary, as the physical positioning allows for eye contact and direct interaction. One of my patients even commented on how good it felt to him to have me come back towards him to apply pressure on his feet after each push because he did not feel "abandoned" after pushing me away. This says a lot about the ambivalent nature of the feelings a child can have towards an abusive parent, pushing away the abusive parent but still needing contact with the "good parent".

Note: To avoid injuries, I do not recommend using the full-throttle (hard pushing) version of this exercise unless it has been properly demonstrated by an experienced bioenergetic therapist or trainer. This is a question of safety for the therapist as well as for the patient.

Working with the "devil"

One of the manifestations of repressed and unconscious aggression is the "devil". Lowen (1975, orig. edition 1969) addresses this issue in a chapter on *Demons and*

Monsters, in his book *The Betrayal of the Body*: "The demon's voice is the voice of the rejected body taking its revenge upon the ego that denied it." (Lowen, 1975, p. 129). He pursues his explanation by saying:

> "Consciousness, associated with the ego, becomes opposed to the unconscious or the body as the repository of the dark forces. Yet the temptation cannot be removed, or the devil overcome, so long as the body is alive. In this unending struggle, the ego's illusions are constantly undermined by the activity of the repressed feelings." (Ibid., 1975, p. 130)

Everybody has a "devil", to the extent to which the original life impulse had to be repressed or suppressed and the ego had to adapt to reality (see again Hilton's diagram). When it remains unconscious, the energy of the "devil" may manifest in the form of a protective reaction, like expressing anger indirectly, or it may lash out destructively. Despite its destructive aspect, paradoxically, its aims is to protect the integrity of the person. Bennett Shapiro (1990, 1993), one of our regretted masters in bioenergetic analysis did wonderful work with the "devil" and has helped generations of bioenergetic therapists get acquainted with that type of energy. He helped us understand the importance of tapping into the powerful aggressive energy encapsulated in the "devil" and learning to use it in a constructive, life-sustaining way. He developed a powerful sequence of exercises in an article titled *Giving the Devil its Dues* (Shapiro, 1990).

I could witness the impactful result working with the devil can have, as I did a piece of work with a student of mine during one of my bioenergetic analysis training workshops. This student had volunteered to do a piece of work in front of the group. I can't recall exactly what the issue that came up was, but I believe it had to do with anger towards a significant figure in her life. She was lying on her back on the mattress, and I was bent over her, looking at her in the eyes. At one point in the work, I believe I said something like: "I suspect there is a strong devil inside of you". I challenged her to show me her devil as I invited her to seize my wrists with her hands and shake me. She started to growl, and her face became menacing. I matched her facial expression and her sounds. As the interaction between our two "devils" became more and more intense, her "devil" came out in full force and she screamed at the top of her lungs, shaking me strongly, while I contained her by offering some resistance to her shaking motion. After a full discharge, she burst out laughing with pleasure, realizing she had experienced a kind of energy that was totally new to her. She had just accessed an "ugly" but potent part of herself that had been long repressed and had owned it instead of fearing it. Here is how she

herself describes her experience to this day: "It was a most profound experience for me which I've never forgotten. It was like meeting a piece of myself for the first time. I felt so powerful and such joy in my power and no need to defend myself. I remember really looking at you and my classmates towards the end of the session with such good energy, feeling so safe and strong and no need to be aggressive."

As mentioned previously, the literature on trauma entered the mainstream, alerting us to the importance of self-regulation and the respect of the "window of tolerance". Hence, over time, Shapiro developed softer techniques designed to strengthen the person's core, which contributes to expanding a patient's "window of tolerance" and renders possible a larger range of intensity in the expression of aggression. In the above example, the student had a strong ego (core) and could sustain the intensity of her expression. However, with patients who have a weaker sense of self, it is important to help them strengthen their core through grounding and affirming their right to be who they are while acquainting them more gradually with their aggressive energy through a variety of simple exercises like alternately making fists/relaxing, breathing, sticking the jaw out, showing their teeth, twisting a towel and letting out a devilish laugh "he he he!", inviting the patient to feel how it is for her to adopt a devilish stance. Another way to work can also be to get down on all fours, therapist and patient facing each other and playfully making growling sounds. The playfulness de-dramatizes the energy of the devil, and the aggressive energy at large, and the physical posture on all fours is a more secure and protected position than standing facing each other.

Coming out of the vicious circle of negativity

Despite the work we can do to help a patient access their aggression and learn to own it so that it can be transformed into constructive energy, sometimes it may take a long time for that transformation to happen. Robert Hilton, in his article on *Anger, Aggression and the Demonic* (Hilton, 2007, pp. 163–177), recounts poignantly his journey through years of holding on to his resentment before being able to let go of it and find some peace. Indeed, even when they can express their anger in therapy, many patients remain trapped in a form of negativity towards themselves or the outside world, unable to liberate themselves from that type of energy so that it can be re-directed towards more life-giving actions.

In an excellent article titled *A Core Energetic Approach to Negativity*, inspired by the work of John Pierrakos and the work of Bennett Shapiro, Odila Weigand (2014), our bioenergetic colleague from Brazil, addresses this problem. She ar-

gues that a type of work consisting of energizing negativity and expressing its hidden meaning may free the energy consumed by negativity. Energy is not negative in itself, however, it may be distorted at the service of "survival strategies". Once survival strategies become unnecessary, this energy may be reintegrated as Life Force. In her article, Weigand explains that Pierrakos refers to Joseph Campbell's metaphor of the dragon as the image of evil, but also as the guardian of vulnerability. The dragon then represents a part of the person that can become menacing when that person is afraid to show the softness of her heart. This way of understanding the dragon is similar to that of the 'devil' as the guardian of the integrity of the self, that is evoked above. Seeing energy that is being expressed in the form of negativity from the angle of an adaptive strategy, may help the patient reframe it. Shapiro used to say that negativity should be exercised, not exorcised.

Conclusion

Working with aggression with our patients can be invigorating when timely. Not only for them but for us as well. Attunement to the patient is an essential condition to guide us as to when and how to do some aggression work with a patient, with interventions that can range from small and slow motions to more energetic ones. Another condition is obviously for the therapist to be acquainted with his or her aggression and to have worked through personal issues involving feelings like anger, contempt, hatred, sadism, resentment, negativity, violence, etc.

The therapist must also be able to see the positive potential in destructive manifestations of aggression, be it against oneself or others, and should help the patient understand them as adaptations that can be modified. As work is done to bring into the light the distorted patterns of aggression, and as the patient is encouraged to explore in an open-minded, non-judgmental way what she/he may have considered to be an "ugly" part in herself/himself, a freeing of this energy can eventually happen. It can then be transformed, and healing can occur.

Aggression is a potent impulse, and when disconnected from the heart, from the capacity for empathy, it may turn into pure evil. Evil exists, as we can see on the world scene. And it leads to destruction and immense suffering. The struggle between Good and Evil is fundamentally a struggle between forces of connection v. forces of disconnection. Dis-connection from the body, from the heart, and dis-connection from one another.

This is why the work we do, which is focused on helping our patients re-establish a connection with their body, with their sensations and feelings, is so

precious in the times that we are living in. Helping our patients express their anger and their hatred, helping them own it and transmuting it into a life force is, as I mentioned above in my text, an alchemical task like transforming vile metal into gold.

When a patient succeeds in fusing the open-hearted energy flowing through the front part of the body with the aggressive energy flowing through the back part of the body, just as described by Lowen, that person can then move through life feeling more self-possessed, whole and open, even in today's challenging world.

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Integrating Polyvagal Theory in Bioenergetic Therapy

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Abstracts

Can Polyvagal theory and BA therapy integrate? Do both point to energetic connections of trauma-process and character formation? In BA, dorsal vagal nerve (DV) is the main organ for life-energy regulation and charge/discharge, Reich viewed Solar Plexus as DVs energy regulating core and saw the Orgasm Reflex as a main regulator of vagal flow, the energetic foundation in Lowens Bioenergetic Analysis, together with grounding, energetic view on character and new techniques to restore vagal flow and pulsation. Porges pointed to a ventral vagal branch (VV) oriented to a social source of safety. Vagal – brain connections are mostly bottom-up (80%). Sensing body interior – is called interoception and involves the whole vagal system. DV activates its brake function *only* in stress; DV tunes energetic flow and proliferation of energetic resources in *normal* function. DV pulsation is needed in pleasant body feelings. VV, SNS and positive emotion join *a common synchronized process in rest, action and challenge*. In traumatic crisis, character formation happens while the dorsal vagal system is de-vitalized and the mind is over activated. Implications for therapy are offered.

Keywords: energetic regulation, social safety, crisis response, therapeutic interventions

Integrando a Teoria Polivagal à Terapia bioenergética (Portuguese)
É possível integrar a teoria Polivagal com a terapia da AB? Apontarão ambas as teorias para conexões energéticas do processo do trauma e para a formação do caráter? Na BA, o nervo Vagal Dorsal (DV) é o órgão principal para a regulação de energia vital e de carga-descarga. Reich via o Plexo Solar como o núcleo da regulação de energia do DV, e o Reflexo do Orgasmo como o principal regulador do fluxo vagal – a base energética da Análise Bioenergètica de Lowen.- juntamente com o *grounding.e a* visão energética do caráter e novas técnicas de restauração do fluxo vagal e da pulsação. Porges postulou o ramo vagal ventral

(VV) como orientado para uma fonte social de segurança. Conexões Vago-cérebro são, em sua maioria, bottom-up.(80%). A percepção do interior do corpo é chamada de Intercepção, e envolve o sistema Vagal inteiro. O DV ativa a função de freio *somente* em situações de estresse., O DV ativa o fluxo energético e a proliferação de recursos energéticos, na função *normal*. A pulsação do DV é necessária em sensações de prazer corporal. VV, SNS e emoção positiva juntam-se *num processo sincronizado comum, no descanso, na ação e no desafio*. Em crises traumáticas, a formação do caráter ocorre quando o Sistema Vagal Dorsal está desvitalizado e a mente, super-ativada. Mostramos, também, as implicações para a terapia.

Intégration de la théorie polyvagale dans la thérapie bioénergétique (French)
La théorie polyvagale et l'analyse bioénergétique peuvent-elles être intégrées? Indiquent-ils à la fois les connexions énergétiques du processus traumatique et la formation du caractère? Dans l'Analyse Bioénergétique, le nerf vague dorsal (DV) est l'organe principal pour la régulation de l'énergie vitale et la charge/décharge, Reich considérait le plexus solaire comme le noyau régulateur de l'énergie DV et voyait le réflexe orgasmique comme un régulateur principal du flux vagal, la base énergétique dans l'Analyse Bioénergétique de Lowen, ainsi que l'ancrage, la visualisation du caractère énergétique et de nouvelles techniques pour restaurer le flux vagal et la pulsation. Porges a souligné une voie vagale ventrale (VV) orientée vers une source sociale de sécurité. Les connexions vago-cérébrales sont principalement ascendantes (80%). La perception de l'intérieur du corps est appelée entéroception et implique l'ensemble du système vagal. Le DV n'active sa fonction de freinage qu'en cas de stress; La DV ajuste le flux d'énergie et la prolifération des ressources énergétiques dans des conditions normales. La pulsation DV est nécessaire dans les sensations corporelles agréables. La VV, le SNS et les émotions positives se réunissent dans un processus commun synchronisé de repos, d'action et de défi. Dans la crise traumatique, la formation du caractère se produit alors que le système vagal dorsal est dévitalisé et que l'esprit est hyperactivé. Des implications pour la thérapie sont proposées.

Integrazione della teoria polivagale nella terapia bioenergetica (Italian)
La Teoria Polivagale e l'Analisi Bioenergetica possono integrarsi? Studiano entrambe le connessioni energetiche del processo traumatico e della formazione del carattere? Nell'Analisi Bioenergetica, il nervo vago dorsale (DV) è l'organo principale per la regolazione dell'energia vitale e la carica/scarica. Reich considerava il plesso solare come nucleo regolatore dell'energia del DV e vedeva il riflesso dell'orgasmo come un regolatore principale del flusso vagale, Lowen prende in considerazione il fondamento energetico nell'Analisi Bioenergetica, insieme al grounding, alla visione energetica del carattere e alle nuove tecniche per ripristinare il flusso e la pulsazione vagale. Porges ha indicato un ramo vago ventrale (VV) orientato a una fonte sociale di sicurezza. Le connessioni vago-cerebrali sono per

lo più bottom-up (80%). La percezione dell'interno del corpo è chiamata enterocezione e coinvolge l'intero sistema vagale. Il DV attiva la sua funzione di freno solo in caso di stress; il DV sintonizza il flusso energetico e la proliferazione delle risorse energetiche in condizioni normali. La pulsazione del DV è necessaria in sensazioni corporee piacevoli. VV, SNS ed emozioni positive si uniscono in un processo sincronizzato comune in riposo, azione e sfida. Nella crisi traumatica, la formazione del carattere avviene mentre il sistema vago dorsale è devitalizzato e la mente è iperattivata. Vengono offerte implicazioni per la terapia.

Die Integration der polyvagalen Theorie in die bioenergetische Therapie (German)
Kann man die polyvagale Theorie und die bioenergetische Analyse miteinander integrieren? Sind beide auf die energetischen Bezüge des Traumaprozesses und der Herausbildung des Charakters ausgerichtet? In der bioenergetischen Analyse ist der dorsale Vagalnerv (DV) das Hauptorgan für die Regulation der Lebensenergie und der energetischen Ladung und Abfuhr. Reich betrachtete den Solarplexus als Kern der vagalen Energieregulation und sah im Orgasmusreflex den Hauptregulator des vagalen Flusses. Die energetische Ausrichtung der bioenergetischen Analyse, in Verbindungn mit dem grounding, stellt einen energetischen Blickpunkt auf den Charakter bereit sowie neue Techniken, um den vagalen Fluss und das Pulsieren wiederherzustellen. Porges hat einen ventralen vagalen Zweig (VV) als soziale Quelle von Sicherheit ausgemacht. Die vago-zerebralen Verbindungslinien laufen meist bottom-up (80%). Die Interozeption, das innere Körpergepür, bezieht das ganze Vagalsystem mit ein. Der DV aktiviert seine Bremsfunktion *nur* bei stress; unter *normalen* Bedingungen regelt er den Energiefluss und die Proliferation der energetischen Ressourcen. Für angenehme Körpergefühle ist das Pulsieren des DV notwendig. VV, SNS und positive Gefühle vereinen sich in einem *verbundenen gemeinsamen Prozess, sowohl im Zustand der Ruhe als auch beim Handeln und bei Herausforderungen*. In einer traumatischen Krise ist die Charakterformation aktiv, während das dorsale Vagalsystem devitalisiert und das Bewusstseine hyperaktiv ist. Schließlich werden Bezüge zur therapeutischen Praxis hergestellt.

Интеграция поливагальной теории в биоэнергетическую терапию (Russian)
Могут ли интегрироваться поливагальная теория и БА терапия? Указывают ли обе теории на энергетические связи травматического процесса и формирования характера? В БА дорсальный блуждающий нерв (ДБ) является главным органом регуляции жизненной энергии и заряда/разряда, Райх рассматривал солнечное сплетение как ядро регуляции энергии ДБ и считал рефлекс оргазма главным регулятором вагального потока, энергетическую основу биоэнергетического анализа Лоуэна, а также заземление, энергетический взгляд на характер

и новые техники для восстановления вагального потока и пульсации. Поржес указал на вентральную вагальную ветвь (ВВ), ориентированную на социальный источник безопасности. Вагально-мозговые связи в основном идут снизу вверх (80 %). Ощущение внутреннего пространства тела называется интероцепцией и вовлекает всю вагальную систему. ДБ активирует свою тормозную функцию *только* в состоянии стресса; *в норме* ДБ регулирует энергетический поток и распространение энергетических ресурсов. Пульсация ДБ необходима для приятных телесных ощущений. ДБ, ВНС и положительные эмоции объединяются в общий синхронизированный процесс в состоянии покоя, активности и вызова. При травматическом кризисе формирование характера происходит в то время, когда дорсальная вагальная система лишена энергии, а ум чрезмерно активизирован. Предлагаются способы применения в терапии.

Integración de la teoría polivagal en la terapia bioenergética (Spanish)

¿Es posible integrar la teoría polivagal con la terapia bioenergética? ¿Ambas teorías señalan las conexiones energéticas en los procesos de trauma y la formación del carácter? En el análisis bioenergético, el nervio vago dorsal (DV) es el órgano principal para la regulación de la energía vital y los procesos de carga/descarga. Reich identificó el plexo solar como el núcleo regulador del DV y consideró el reflejo orgásmico como un regulador esencial del flujo vagal, una base energética que Lowen incorporó en el análisis bioenergético junto con el enraizamiento, una perspectiva energética del carácter y nuevas técnicas para restaurar el flujo vagal y la pulsación. Por su parte, Porges identificó una rama ventral del nervio vago (VV) orientada hacia una fuente social de seguridad. Las conexiones entre el nervio vago y el cerebro son mayormente ascendentes (80%). La percepción del interior del cuerpo, conocida como interocepción, involucra a todo el sistema vagal. El DV activa su función de freno únicamente bajo estrés, pero en condiciones normales regula el flujo energético y la proliferación de recursos energéticos. La pulsación del DV es esencial para las sensaciones corporales placenteras. El VV, el sistema nervioso simpático (SNS) y las emociones positivas se sincronizan en procesos comunes durante el descanso, la acción y los desafíos. Durante una crisis traumática, la formación del carácter ocurre mientras el sistema vagal dorsal se desvitaliza y la mente se sobreactiva. Este análisis propone implicaciones para la terapia a partir de estas conexiones.

将多迷走神经理论融入躯体动力分析治疗 (Chinese)

Polyvagal理论与BA疗法能否整合？两者都指向创伤过程和人格形成的能量性连接吗？在躯体动力分析中，背侧迷走神经（DV）是生命能量调节和充电/放电的主要器官，赖克将太阳神经丛视为多迷走神经的能量调节核心，并将性高潮反射视为迷走神经流的主要调节器，这是勒温的躯体动力分析的能量基础，同时又包含了扎根、人格的能量观点以及修复迷走神经流和脉动的新技术。 Porges 指出，

迷走神经的腹侧分支（VV）指向了安全社交起源。迷走神经与大脑的连接大多是自下而上的（80%）。对身体内部的感知被称为“内感知”，涉及整个迷走神经系统。迷走神经只有在压力下才会启动其刹车功能；在正常功能下，迷走神经会调节能量流和能量资源的增加。愉悦的身体感受需要D V背侧迷走神经的脉动；而在休息、行动和挑战中，VV、SNS 和积极情绪共同参与一个同步过程。在创伤危机中，当背侧迷走神经系统失去活力、头脑过度活跃时，人格的形成就发生了，这对治疗具有重要意义。

Introduction

How can we integrate polyvagal theory when doing Bioenergetic therapy?

I believe we must start with looking at their common ground – where do polyvagal theory and Bioenergetic Analysis converge in understanding of human nature and human energy processes. How do they confirm and even enrich each other in the understanding of human response in ordinary life and in crisis?

There are two questions I like to ask and hopefully answer for the sake of clarifying this:

First – What is the focal connection between human energy processes in both Bioenergetic and Polyvagal perspective?

And Secondly – Does both Bioenergetic Analysis and Polyvagal Theory point to energetic connections between trauma-process and character formation?

From there, I will pick some points making sense to me in doing therapy, from both Polyvagal and Bioenergetic perspective.

What is the focal connection between human energy processes in both Bioenergetic and Polyvagal perspective?

In polyvagal literature, for instance in Porges & Dana (2018) it seems to me that therapy is depicted as a kind of drama that, as a metaphor goes like this: *The ventral vagal nerve is the hero in a plot that saves the victim in a happy end by bringing safety through social engagement. The sympathetic system is a soldier that fights boldly but cannot win the peace on its own. The dorsal vagal nerve is the helpless victim that freeze and continues to fall into collapse until the hero enters the stage and restore normal life.*

Is anything missing in the plot? – I like to suggest a first act to the drama: *Here, the dorsal vagal nerve lived a harmonious and pleasant life before the disturb-*

ing event. A daily life with little worries and low tension, very capable of regulating life through energetic flow and pulsation. It served well both in gaining life energy, everyday pleasure, work and intimate sexuality.

The point is: Polyvagal theory describes the three components of the autonomic nervous system in crisis situations. However, in science it is *untenable to generalize from the extraordinary to the ordinary*. So, we need to check: How does specifically the dorsal vagal system and the autonomic nervous system as a whole, function in normality?

The physicist Galenos who lived in the 2. century identified and named the vagal nerve – "the wanderer" and its system of innervations to the organs. Maintaining health he thought, occurred through mutual balance in organ flow. In 1732, Jacobi Winslow gave the name "sympathetic nervous system" to the chain of ganglia that connected the thoracic and the lumbar spinal cord. Otto Loewi demonstrated in 1921 that the vagal nerve transmitted signals to the organs by acetylcholine and thereby identified the first neurotransmitter to be discovered. In 1932, W. B. Cannon wrote "The wisdom of the body" a book where fight-flight response and homeostasis were introduced. Here he pointed to the important function in both branches of the autonomic system in regulating life processes in daily life and in contrast – their differential response under threats to life. *These are qualitative different modes of operation.* His groundbreaking work stimulated a strong interest in the medical world and psychology concerning autonomic nerves and its function.

Wilhelm Reich was among those who followed this development keenly. It inspired him to do his own experiments with the galvanic skin response at erogenous zones, these zones were already known to have end points of the dorsal vagal nerve in abundance.

In 1945 Reich (1982) published *"the Bioelectrical investigation of Sexuality and Anxiety"*. This book was important in introducing several new theses that is still basic in bioenergetic understanding of energetic flow. Interestingly, he came to this understanding through experimentally connecting electrodes to the erogenous zones of skin and genitals under two conditions: States of pleasure and unpleasure. So, he came to discover the relation of bio-electric energetic flow in the vagal nerve between body periphery and a body-centered core and combined it with flow through body segments, directly related to main vagal ganglions along the vertical body axis. These points, he observed clinically, are pronounced sites of tension in neurotic patients (Reich 1982).

He was able to connect flow to the periphery as corresponding to an experience of sexual pleasure *and* retraction of energy away from the world in unpleasure

or anxiety and a corresponding flow into the organismic core. Thus, he understood the movement "towards the world" in contrast with "away from the world and into the Self" as a fundamental biological antithesis (Reich 1982).

He discovered that orgasm has a role in regulating the dorsal vagal nerve itself: Relaxed calm and pleasure is a sign of restored vital function, while tension, anxiety or deadness in feeling tone is a sign of disturbed states (Reich 1996).

The dorsal vagal nerve in Reich's view became the main organ for life energy regulation through charge and discharge. Also, he suggested the solar plexus of the vagal nerve as default energy regulating core. In therapy, he observed that "the orgasm reflex[1]" had the strongest effect on restoring and regulating vagal flow.

His work with the dorsal vagal nerve, laid down the energetic foundation for Alexander Lowens *Bioenergetic Analysis.* As we know, All Lowen added *grounding, dynamic descriptions of the character types and new innovative techniques*, applied in therapy and body exercises. They too, aim at discharging tensions, deepen breathing and softening the body, and so *is a second road* to restore vagal flow and pulsation (Lowen 1994). Porges & Dana et.al (2018) re-formulation of the vagal system, through introducing the ventral vagal branch as a social engagement system that orients us towards the social source of safety, is *a third road* by providing a state of safety in the vagal nerve. Also, he introduced "neuroception": We seems enabled to feel the state of aliveness through the vagal system. For instance, I believe we all can easily detect qualities as:

Safety/unsafety; tension/relaxation; pleasure/anxiety; aliveness/deadness; strength/weakness, health/sickness (Hafstad 2008; Damasio 2018). This *sensing* may well be based on afferent vagal pathways to the brain, since it is now settled that 80 percent of the brain/vagal connections are sensory and only 20 percent are motor pathways. Such sensing of body interior is usually called interoception, a main example of bottom-up dominant processes (Hafstad 2008).

Polyvagal theory is *the new wine of these days*, opening a new avenue in our work by pointing to social safety and warm reciprocal contact as a changemaker in calming the vagal nerve. *Is Porges approach preferable or additional?*

Since neither Reich nor Lowen could know about the ventral vagal function, their mode of working with emotional disturbance had to take different roads: Reich, in removing blocks and releasing pulsating flow that involved the pelvic

1 By orgasm reflex, he referred to the clinical observation in clients to give in to organismic flow and surrender to their spontaneous movements through the body segments. It does not necessarily imply genital orgasm in vivo.

and whole-body discharge – *the new wine in the 1950's* and Lowen, by building up charge and challenge to a tipping point that more or less forced the client to surrender from a state of intolerable tension and thereby open up to rather dramatic changes. In the 1970s in Norway at least, this was *the new wine* in psychotherapy. *Porges theory is clearly a supplement, enriching our view on regulating functions, and is suited to make a stronger position for the organismic view on human nature.*

We started off with a question: *What is the focal connection between human energy processes in both Bioenergetic and Polyvagal perspective?*

In BA human energy processes has a starting point in Reichs study of the dorsal vagal nerve and its active energetic function, he was also aware of the ventral parts anatomy (Reich 1982) which he tentatively related to the throat and neck energetic segments. Porges & Dana et al. (2018) communicates about the ventral vagal with groundbreaking understanding. Concerning the dorsal vagal he seems not to differentiate between normal and disturbed function and does not focus on the energy-active side of its function. This seems a divergence that leads to different conclusions. What is of value, is certainly the focus on the ventral vagal nerve, contribution of the social engagement system, to our understanding of social, emotional, therapeutic and organismic processes. To my present knowledge, Porges does not link trauma and character formation. A possibly simplifying view on developmental matters.

The connection that strikes me most, is that Polyvagal theory, stimulates an additional dimension to the understanding of human energy regulating processes. To me, it is like a missing piece in a jigsaw puzzle has been found and the big picture is seen more clearly. Let me try to hint at what view is taking form: *The whole autonomic nervous system functions as a main regulator of organismic bioenergy. To hold this function, it must have properties of finetuned synchronization and to make mutual connections with an even broader organismic system:*

At the base of this broader system, we find the production of ATP in cell mitochondria. In contemporary cell physiology this is now called *cellular bioenergetics* (Alberts et al. 2015). How it is regulated at the organismic and behavioral levels, has remained unclear or quite mechanically described in physiology. But putting Reichs formulations together with Porges' adds to up to a grand picture:

The unmyelinated dorsal vagal nerve could have had this regulating function in organisms hundreds of millions of years ago, and this arrangement seems favored by evolution to this day: Antonio Damasio (2018) refers to development of nervous systems in early multicellular organisms in the Precambrian period 600–540 million years ago:

> "The nervous system alters the operation of tissue that receives it ... the fibers travelling in the opposite direction ... perform an operation known as interoception. The purpose of such an operation? Surveillance over the state of life" (Damasio 2018).

Later, the myelinated sympathetic system (ANS) developed in vertebrates to quickly boost and fine-regulate energy mobilization, and even later with the emergence of mammals, the myelinated ventral vagal nerves added fast fine tuning and energy supply by engaging social safety, both in daily living and in emergency. Above the ANS, the brain developed emotions, the "social brain" (Siegel 2007) and conscious awareness of body aliveness (Hafstad 2008).

I have mentioned that Reichs bioenergetic formulations, adopted by Lowen – was strongly related to ionic dynamics in the vagal nerve. Porges points to forceful retraction in the dorsal vagal nerve in crisis, i. e. its brake function, as Reich had done before him, but fails in estimating its capacity for expanding by energetic streaming "towards the world" in normal daily function.

The human autonomic nervous system as a whole is placed, with rich connections to body and brain to serve vitality functions[2]. The dorsal vagal nerve is at the organismic center – regulating the interplay between cells, tissue, organs and their energy production.

Reich shows the importance the dorsal vagal nerve in ordinary life and normal challenges: The dorsal vagal nerve is a core resource in aliveness. I suggest, we might even call it the Life Nerve, since it feels like coming alive when it is freed and it hurts like nothing else when it is deeply threatened.

In conclusion, Porges shows how the dorsal vagal functions as a brake or moving towards standstill under treats, and shows how the social-engagement system can reverse this response, but seems to omit its ability to reach out and *expand* in a contact function with the surroundings.

The vagal nerve as a whole, has an anabolic – energy building function, while the sympathetic system mobilizes energy and uses energetic resources. Its long-term effect is catabolic (Frayn & Evans 2019). Overall, they need to balance each other, but *only* when grounded in vagal expanding vitality.

We can value the ventral vagal function and hold on to the dorsal vagal nerve as the keeper of naturally balanced energy flow and pulsation. As I see it – the dorsal vagal nerve, has a need to activate its brake function only when stressed or hurt. In daily life and even from birth, its main functions are fine tuning of energetic flow and building energetic resources.

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2 By vitality functions I include energizing, regulating and adapting to environment.

Best case then – or one of our main goals, is to therapeutically facilitate dorsal vagal movements in its alive, smooth streaming standard mode – to promote a pleasant and warm body feeling – movement in ebb and flood between peaceful rest and pleasurable excitement. With that in place, the sympathetic nerves can also shift within the same window between rest and peaks of excitement, joy in play, freedom in action, challenge can be joyful.

When ventral vagal nerves join in this dance, social growth and self-development can fall into synchrony.

This is where the bioenergetic concept of energetic aliveness and polyvagal theory fits together and is a strong hint to what promotes both personal vitality and sociality: *Life streaming and pulsating from center to periphery and along the vertical body axis is enabled by the dorsal vagal system; co-regulated and supported by the ventral vagal part – giving excited intensity and peaks by the sympathetic system with its unique capacity to mobilize energy, especially in a positive emotional mode and in reaching out to fellow beings.*

Does both Bioenergetic Analysis and Polyvagal Theory point to energetic connections between trauma-process and character formation?

Trauma is like a storm of events that leaves little room for orderly response. It implies a turmoil in energetic mobilization and energetic dysregulation: Energy is first violently mobilized by a sympathetic alarm, but in a true traumatic incident it cannot be spent in an orderly sequence and direction. Metabolic Science has found that energy production in muscle cells can increase up to a thousand-fold in a second (Frayn & Evans, 2019). Therefore, if energy spending is at maximum, most of it is used up in ten seconds: *Our choice in this situation is harsh – be successful in fight or flight or get lost in chaos. Then the rest of the process is forced into lowered energy levels both because of falling energy supply and because of the instinctual response to threat is to start a conserving shut down: Combining conservation of the energy left and reduction of threat impact to the vital core.*

This time, the dorsal vagal response move energy "away from the world"; from the bodily periphery – from sensory and motor activity and conserve what is left at the organismic core. I think of the dorsal vagal system as a basically vulnerable organ. Interoceptively it can give us just that feeling when under serious treat: *Naked vulnerability*

A situation that develops slower but recurrent – as often is the case in family settings, has by repeating – about the same amount of threat to personal integrity and the safe place of the habitat. The long-term outcome is often about the same: High spending of energy first, with sensory alertness and muscular readiness to respond. But with no route for escape, normal energy resources run out. We can call this *"crisis breakdown of energy economy"*.

Sometimes repetitive incidents can take another route in the crisis: English people have an expression in crisis and hardship – "Keep calm and carry-on". One factor that is probably of relevance is the level of anxiety and dorsal vagal contraction. Another is the absence of beneficial eye witnesses or peer victims. Can I relay on anyone? Can I risk observing and wait? Can I feel enough strength in myself? Can I sooth myself? It is a possibility then that maximum crisis -energy spending starts *some* shift towards an endurance profile to recover a degree of energy rise. We may call this *"hardship-endurance energy economy"*. In any case, the incident gets into an interaction with what is already established in the development as earlier trauma; developmental deficiency and character formation: They become nested in the overall developmental process. A new trauma can therefore both influence and be influenced by all these trains of ongoing development disturbances.

Both scenarios *start* a process of short-term protective attempts, *but is not the end of it*: In the aftermath when the acute threat fades away, the victim is in a phase of recovering partial energetic equilibrium – full energy and integrity however – is hard to restore. At the same time the person is creatively searching subconsciously and highly alert for permanent protective cover: *In such a state, a split between depleted body energy and feverish mental activation can be created – often at high speed, new patterns – a modified design for future protection – can be forged. This is often a form of "one trial learning" that might constitute a lesson for life: An organismic procedural-rule followed habitually.*

I believe this furthers character formation.

Especially in childhood, trauma is a situation where the child *neither* has options, understanding nor skills to grasp what is going on *nor* options to flee or fight the perpetrator.

The energetic resources fall far short of what is needed for security. Yet, a child is driven to find its way within its limited resources, and so it does. The posttraumatic behaviors may be very maladaptive, but this is important: *It was always the best solution the child was able to find: I believe character formation happens while the dorsal vagal system is de-vitalized and contracted and still the mind forges a protective plan, creating an illusionary hope as best it can. Later still, both the plan and the de-vitalized state come into play again whenever the person meets new threat-*

ening situations. To others, this looks sometimes as re-traumatization, sometimes as acting out. For the person it is hard to see the difference because he or she is just doing what survival orders.

Residuals of the body/mind functional split that appears in the trauma crisis is an integral part of the character formation.

The clinical fact is very real: Conscious Mind flees from bodily awareness of the *naked core hurt* and takes refuge in mental processes or in the extreme, leaves the body as if it is in a remote and higher place outside the body, even travel long distance to places it has never been before – as if life is somewhere else than in the living body. Many of my clients has reported such experiences.

How does this functional split come about? What is its origin?

The feverish hype of the mind cannot be directly caused by the effector vagal pathways, since they descend from the midbrain to the body interior and do not ascend up in the brain. So, the *lucid* mind activation must be caused in other ways.

What can *partly* explain the lucid brain effect is that *sympathetic activation* brings adrenaline into circulation and activates noradrenaline pathways in the brain.

But there is another and deeper explanation available: Polyvagal theory and the literature on the vagal nerve in general, mainly focuses on the motor neurons of the vagal system, although eighty percent of the vagal fibers goes the other way – from the viscera to the brain. This bias is quite odd and begs for an explanation: Eighty percent of the vagal system sends sensory information online from body interior to the brain – here the prime end-station is a site in the cortical brain: The Right Hemisphere Insula. (Hafstad 2008)

What the Insula does, is to feel the state of life in our bodies (Damasio 2018).

What is the strongest direction of influence then – the brains influence on the vagal nerve or the vagal influence on the brain? The Insula created impression of the body is called *interoception* and was known by Sigmund Freud, but mainly ignored by him and later all of neuro-science, until *Antonio Damasio* convincingly demonstrated the following: *This sensing of body aliveness state appears to be essential to normal consciousness – if it is totally lost, as in traumatic vagal collapse – consciousness is also gone.*

In trauma response, when the body can feel numb or almost gone – the Insular cortical activity is then more or less shut down and becomes silenced.

Instead, *older brain stem nuclei* compensate by offering some fogy body impressions to keep the person awake and partially conscious. The result?

Trauma induced mental fever comes with an extremely unbalanced cortical activation that creates this odd experience: *I exist even when I have left my body*

The person is left with a very strange kind of relief.

This can explain why in a posttraumatic state, a residual feeling of unreality and chronic mental overactivation are main symptoms along with collapsed, frozen and unstable body energy.

This offers us a main therapeutic challenge: *How can the mind recover to an ordinary state were body and mind unites in an energetically mutual balance?*

Restoring "the dance of aliveness" probably needs to start with supporting a gradual return to bodily feeling. This can only happen within a combined feeling of safety and vitalization in the therapeutic process.

So, summing up a preliminary position from the two problems I departed from – the energetic dynamics between trauma and character formation, is a process from:

- *An original relatively alive state of feeling some safety, with a corresponding vagal flow and attuned exchange between body and mind in a relatively mutual balance*
- *Through a shocking experience creating lowered bodily energy and unbalanced mental overactivation, or a series of them,*
- *To a new orientation where the person holds on to a permanently protective life attitude that keeps the vitality flow and the mental operation in a certain repetitive grip, unable to surrender to full aliveness and balanced mentality.*
- *The original aliveness has become a bias towards compulsory repetition of habits and watchfulness to treats that may actively resists feeling of trust and safety.*

From a Bioenergetic perspective, combined deficiencies and character patterns adds up to keep re-traumatization risks high. The brain is alert to new treats and by that falls victims of repetition compulsion that implies feeling *at risk or even provokes new risks*.

Cultivating warm softening energetic streaming *through ventral vagal restoration and flexible sympathetic shifts*, gradually helps raising the energy level and freeing dorsal vagal pulsation. Together with bioenergetic body work, it can bring about revitalization and provide the necessary energy to change. Both approaches need to be held in a predictable and warm therapeutic relation.

Before I end this argument about the relation between trauma and character formation, there is one rather tricky outcome of character formation that we need to be aware of: The Self creates a kind of global map that we may tentatively call: *My place or fate in the world*

It can become a hidden meta pattern that keeps the character as *change resistant*. Some amount of cognitive work may be necessary to bring the therapy to a

good finish. To access this influential part of the self. We can simply ask, *"how do you see your place and fate in the world?"*.

This section started with a question: *Does both Bioenergetic Analysis and Polyvagal Theory point to energetic connections between trauma-process and character formation?*

I have not yet seen that Polyvagal therapy has a developed focus on energetic dynamics and on the conserving dynamics of trauma-character dynamics. The question remains if resistance to change therefore may be underestimated in the polyvagal modality.

What can be useful in the therapy process, based on what we have seen so far?

I like to suggest some elements, ordered into four steps.

First, I try to see the unique person and adjust to her safety seeking style.

It is quite obvious that we need to have a method and some flexible plan for adapting to the client, but just as important – is to meet the client with warm natural interest and look for both unique qualities and main hurts. Also, how do they seek safety and how does it show. The struggles they had and how they managed, is handled best when we can admire them and show it.

Being touched and let it show brings contact and safety to the relation, since they always wonder if my professionality implies distance, restriction of aliveness or even disinterest. Sensing that the therapist is as human as myself, is a big relief and sets the depth and horizon of what we can accomplish together.

Contact and safety are at the core of the process, when a safe quality of intimate contact can appear – togetherness in the heartfelt and vulnerable – then the movement becomes deeper and stronger – deep character work needs to be grounded in this kind of safety. So, the work is best done in a stable atmosphere of friendly flexible helpfulness.

Secondly, I search for how the combined trauma history and character formation makes sense and to look for a possible core hurt.

I find interest in the client's trauma history and try to notice both the bodily-nonverbal communications and the feeling in my own body that appears through the sessions.

If I can take in more, it's good if I can notice both *what is said and what is avoided*, since in the *form* of expression there are hints to what is not yet ready to be told.

We can sense how it feels to be a person in a hard-won struggle to control. Often, we find an overall quality of holding back or the opposite – like everything is thrown out disorderly when no option of regulation was possible.

Both has to be affirmed as a necessary style of handling what is overwhelming: *"This seems to me the way you have needed to handle danger; you show me how overwhelming life has been".*

Pieces of traumatic incidences and repetitive patterns are collected gradually, leaving an open space for more to come.

Characterological protections have a general gestalt form but also a network of finer aspects, where we can see traces of when and in which situations they may have been formed. Seeing this clearly may not be possible before late in the therapy.

I mentioned earlier that all people create a kind of global map that we may tentatively call: *My place or fate in the world*

Quite early or when it is possible we can ask, – (I remind you again): *"How do you see your place and fate in the world?"*

Later, it can then be used as a reference point whenever it fits.

What is of outmost importance here, is that *My place in the World* usually is connected to a core hurt or a primal scene that sets the stage for aftermath traumas and influence their course. Thirdly, I find it essential to stimulate expressed vitality, work with trauma themes through graded exposure and validating the protective response.

If within reach – *"supporting naked vulnerability"* by revisiting the traumatic scene – the therapist as a close companion, can help retuning the dorsal vagal nerve to its normal flow and pulsation.

Sometimes quite directly, sometimes gradually, we introduce small pieces of body related work and focusing body feeling. We introduce it as a possibly useful way and await the client response.

If they refuse or show reluctance or flaccid compliance without genuine interest, we should be respectful and affirmative about the response: "*Here is a sign of feeling at risk, maybe it is not safe enough yet?"*

It is useful though to be curious of *what the reluctances is about*. Later we may discover what are *their* experiential roots *and* their part in the traumatic history and characteristic protection.

Also, while expressive body work goes on, trauma and character response will appear in the *form of expression* and the *way of relating*.

We should be ready for reactions like *pushing on without feeling* or *stiffening* as a sign that the interventions are introduced too early or was too much. Then

we need to let go of the attempted intervention, and adjust to the client need for support and safety. Maybe we can say:

"Ok, I see this was not safe for you, I really need to respect that"

An experience of a special kind may appear: *We as therapists, can feel in our body or may have a vision – like we hit upon something crucial at the same time as the client. Often this is about the core hurt.*

Sensitivity to these moments may gradually develop through our life as therapists. It is like a feeling coming alive instantly – a kind of awakening of just knowing that cuts through all thinking and distance *or* like being present with the client in the original moment. We can get a vivid vision of the situation as it appeared and we can feel as a witness. At least this is my experience.

Often as a response, the client relaxes and *improves* in contact within this session. It is like we are attuned interoceptively – feeling the bodily state of the other. This can go both ways, both in the positive and negative aspect.

In such moments unreality and doubt can fall to the ground in both of us.

(Or it can be a retractive response when sensing a negative body attitude in the other)

This feeling when we touch upon something essential in the life of a client so that we are together in it – has an emotional charge in it – like unexpectedly coming upon something treasurable. This, I would say – is a response from our joint "inner field of aliveness": When coupled interoception happens between me and the other I shortly call it: *Life feeling Life*

I trust we all have it in us, also a newborn baby may have it, probably since the vagal system has already matured in the last two months before birth. I have felt it several times meeting a newborns gaze. What Porges calls neuroception is possibly the same basic sense of alive tissue to feel and respond to alive tissue. The energy that is awakened by this contact is sharply different from the feeling of what is dead, forced or disturbed.

Such moments seem crucial in change.

This sense is like an illuminating torch that can lead us wandering along with the client to suspend character, little by little. When a spark of life is lit in the therapist as a response to the client – the life in the client still looking for life may immediately recognize this, I guess – through vagal interoception.

the compensatory habitual responses that cover up lively responses, the mechanical substitutions can fall to the ground when life awakens and "just knowing" appears in this mutual field. A client finally daring to look into my eyes after several years of therapy, started to cry and said: *Now I see I am really human,*

Her illusion of being intolerable, seemed to fall to the ground, like the spell we hear of in fairytales has lost its power.

A short glimpse of truth counts. It is preciously felt and can make a shift at the core of being – a freeing of dorsal vagal function.

Fourthly, Integration of a vital state is most opening when both client and therapist can tolerate naked vulnerability. This, along with social safety and contact is felt as intimacy.

Smooth vagal flow and attuned exchange between body, mind and others can develop from the vital core and probably needs experiences of being safe in mutual vulnerability to grow and become a stable enough state to become a part of "who I am".

Another result is *a giving in to life* by melting trauma reaction patterns and character protections into a new sense of reality. The client Self can feel both unique and ordinary. There can be a sense of ability and a right to take part in life at par with others. New feeling of a granted common ground is a basic source for safety. This amounts to a shift in "My place in the world" construct.

Now, I like to share a little from my personal therapy. My main therapist whom I owe a great shift in my life, worked with a bioenergetic character-oriented approach. Two moments of my own therapy can serve to contrast each other: He said once: *"I see you as a Texan gunslinger". I asked him: What do you mean by that? As I remember it, his answer was: "Now, you are the one to figure that out".*

Honestly, it felt as if he left me standing there, I needed him to show me the way. I felt left alone and went up in my head to figure out what he meant. Nothing much happened on that road.

My learning point is: *I needed warm alive aid – what he said of my character needed to reach into feeling my basic hurt, I needed to feel "held safely in the original pain". Instead, his statement only threw me back into the self-sufficient lonely outlaw character I needed to let go (My place in the world)*

I got fearful his formulation was a critique or worse – an accusation.

As I have attempted to demonstrate, only an alive connection in this can do it – bring life back into the core of being: Life feeling life is the ignition that awakens life and trust.

An interpretation of a general character pattern is only useful I believe, if it occurs in a moment of warm and alive mutual contact.

I like to tell you another incident where my therapist was most successful: He had identified my traumatic hurt already in my second session with him, back in 1992:

He said: *"It is rarely as clear as with you, you were a hated child"*

I felt *seen* for the first time and remember the impact: *A strong movement of bodily softening as my chronic vagal frost started to melt. Especially my feet started to boil as an unfamiliar wave of energy ran into my feet – connecting me to the ground. I had had no way of grounding and was kept in a state of unreality until this moment.*

How does a hated child adapt? The Texan gunslinger outlaw image was *on the spot*, since it was my absolutely necessary character adaptations but also one reason for me to be self-suspicious and I was afraid I was his suspect too. So, I stiffened. But now, I keep this in my heart: *Feeling the clients basic hurt in me strikes the life cord in the client and starts the process of melting the character.*

When hurt and dysregulation is residuals from preverbal stages of development, as with me – the work needs to be done over and over again through attuned preverbal exchange patterns where the impulses of the client is the point of departure. Learning to know the state of safety is provided by the client experiencing being received and responded to again and again so that a good soft feeling can be an inner homestead.

This I learned from Daniel Stern (1995): *Schemas of knowing the Self in the world builds gradually up through live acceptance of the infant needs by the caregiver. This acceptance is also welcomed when the person at hand is a therapist.*

Finaly we come to my last words: When we warmly meet vocal and facial signals from the client, *their way of being themselves* – is taken in through bodily resonance –it is felt interoceptively and therefore real.

Such moments resemble a caring mother with her newborn. The naked vagal nerve, is for me metaphorically the baby – a baby who has lost its screaming voice, how do we then know its despair if not through feeling it in our joint life nerves?

So, the best cure is feeling naked vulnerability and safety in togetherness. I feel this as real as real can be.

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Arild Hafstad was born in Oslo, Norway in 1957. He graduated in Psychology in Oslo I 1983 and became Clinical Psychologist in 1989, after work in psychiatric wards, polyclinics and prevention of small children. After a few years as Chief Psychologist, he started a private practice and still do. Met Phil Helfaer in 1992 and became involved in BA. Earned his CBT in 2004, did BA supervision and was training assistant with Heiner Steckel. Certified IMAGO Couple Therapist 2008. Was president in NFBA until it closed in 2010 and was cofounder of NIBI in 2017. Is president and local trainer in NIBI. Applicant for IIBA Faculty since 2018.

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Being discovered by the M/Other

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Abstracts

This paper delves into the intricate early stages of development through the unique perspective of experiences. It draws on a diverse range of disciplines, such as embryology, psychology, and philosophy, as well as the realms of imagination and metaphor, to seek a deeper understanding of this period. Building on Emerson and Tery's concept of the impact of pregnancy discovery on the fetus/embryo (1980, 2006), this paper emphasizes the shared nature of experience between the mother and the fetus/embryo. It claims that the process of being discovered by the m/other, can be characterized by the potential for both development and change as well as the potential for trauma. The interplay between the mother and embryo, the known and unknown, the temptation to arise versus dismissal and isolation are all central themes.

The qualities being argued for are fundamentally echoed in the therapeutic relationship, in the therapist's ethical responsibility and invitation to evolve, and in each patient's unique being.

Examining the three key aspects of the prenatal discovery experience – the mother's perspective, the fetus/embryo's experience, and the field of interaction between the two.

Keywords: mother/embryo, discovery/being discovered, known/unknown, invitation/isolation, therapeutic connection

Sendo Descoberto pela Mãe (Portuguese)
Este artigo examina os intrincados estágios de desenvolvimento através de uma perspectiva única da experiência. Ele faz uso de uma grande variedade de disciplinas, tais como embriologia, psicologia, e também do campo da imaginação e da metáfora, para buscar um entendimento mais profundo deste período. Baseando-se no conceito de Emerson e Tery de impacto da descoberta da gravidez no feto/embrião (1980, 2006), este artigo enfatiza a

natureza compartilhada da experiência entre mãe e feto/embrião. Ele afirma que o processo de ser descoberto pela mãe pode ser caracterizado, tanto pelo potencial para o desenvolvimento e transformação como para um potencial para o trauma. São temas centrais: o Inter jogo entre mãe e embrião, o conhecido e o desconhecido, a tentação para emergir versus desligamento e isolamento. As qualidades que são discutidas ecoam, fundamentalmente, na relação terapêutica, na responsabilidade ética do terapeuta, no convite para progredir e em cada paciente como sendo único. Discorremos sobre os três aspectos-chave da experiência de descoberta pré-natal – a perspectiva da mãe, a experiência do feto/embrião e o campo de interação entre os dois.

Être découvert par la mère/l'autre (French)
Cet article se penche sur les premières étapes complexes du développement à travers la perspective unique des expériences. Il s'appuie sur un large éventail de disciplines, telles que l'embryologie, la psychologie et la philosophie, ainsi que sur les domaines de l'imagination et de la métaphore, pour chercher une compréhension plus profonde de cette période. S'appuyant sur le concept d'Emerson et Tery de l'impact de la découverte d'une grossesse sur le fœtus/embryon (1980, 2006), cet article met l'accent sur la nature partagée de l'expérience entre la mère et le fœtus/embryon. Il affirme que le processus de découverte par la mère/l'autre peut être caractérisé à la fois par le potentiel de développement et de changement, ainsi que par le potentiel de traumatisme. L'interaction entre la mère et l'embryon, le connu et l'inconnu, la tentation de sortir du rejet et de l'isolement sont autant de thèmes centraux.

Les qualités défendues trouvent un écho fondamental dans la relation thérapeutique, dans la responsabilité éthique du thérapeute et dans l'invitation à évoluer, et dans l'être unique de chaque patient. Examinez les trois aspects clés de l'expérience de la découverte prénatale: le point de vue de la mère, l'expérience fœtus/embryon et le champ d'interaction entre les deux.

Essere scoperti dalla madre/altro (Italian)
Questo articolo approfondisce le intricate fasi iniziali dello sviluppo attraverso la prospettiva unica delle esperienze. Attinge a una vasta gamma di discipline, come embriologia, psicologia e filosofia, nonché ai regni dell'immaginazione e della metafora, per cercare una comprensione più profonda di questo periodo. Basandosi sul concetto di Emerson e Tery dell'impatto della scoperta della gravidanza sul feto/embrione (1980, 2006), questo articolo sottolinea la natura condivisa dell'esperienza tra la madre e il feto/embrione. Afferma che il processo di essere scoperti dalla madre/altro può essere caratterizzato dal potenziale sia di sviluppo che di cambiamento, nonché dal potenziale di trauma. L'interazione tra la madre e l'embrione, il noto e l'ignoto, la tentazione di emergere rispetto al rifiuto e all'isolamento sono tutti temi centrali.

Le qualità sostenute trovano fondamentalmente eco nella relazione terapeutica, nella responsabilità etica del terapeuta e nell'invito a evolversi, e nell'essere unico di ogni paziente. Esamino i tre aspetti chiave dell'esperienza di scoperta prenatale: la prospettiva della madre, l'esperienza del feto/embrione e il campo di interazione tra i due.

Die Entdeckung durch die Mutter/den anderen (German)
Dieser Beitrag durchmisst die verwickelten frühen Phasen der Entwicklung durch die einzigartige Perspektive der Erfahrung. Er bezieht sich dabei auf verschiedene Disziplinen wie die Embryologie, Psychologie und Philosophie sowie auch auf das Reich der Imagination und der Metapher, um zu einem vertieften Verständnis dieser Phase zu gelangen. Ausgehend von Emerson und Terys Konzept der Bedeutung der Entdeckung der Schwangerschaft auf den Fötus/Embryo, unterstreicht der Aufsatz die geteilte Natur dieser Erfahrung zwischen Mutter und Fötus/Embryo. Er betont, dass der Prozess der Entdeckung durch die Mutter bzw. den anderen als Potential sowohl für Entwicklung und Veränderung als auch für Traumata aufgefasst werden kann. Gleichermaßen zentrale Elemente sind dabei das Wechselspiel zwischen der Mutter und dem Embryo, dem Bekannten und dem Unbekannten, dem Drang zur Entstehung gegenüber Ablehnung und Isolierung. Der Gehalt, um den es hier geht, findet ein Echo in der therapeutischen Beziehung, in der ethischen Verantwortung des Therapeuten und seiner Einladung, sich zu entwickeln sowie in der Einzigartigkeit eines jeden Patienten. Der Beitrag stellt die drei zentralen Aspekte der pränatalen Entdeckungserfahrung dar: Die Perspektive der Mutter, die Erfahrung des Fötus/Embryos sowie der Bereich der Interaktion zwischen den beiden.

Быть обнаруженным матерью (Russian)
Эта статья посвящена сложным ранним стадиям развития человека с уникальной точки зрения опыта. В ней используется широкий спектр дисциплин, таких как эмбриология, психология и философия, а также области воображения и метафор, для более глубокого понимания этого периода. Основываясь на концепции Эмерсона и Тери о влиянии обнаружения беременности на плод/эмбрион (1980, 2006), в этой статье подчеркивается общий характер переживаний матери и плода/эмбриона. В нем утверждается, что процесс обнаружения себя другим человеком может характеризоваться потенциалом как для развития и изменения, так и для травмы. Взаимодействие между матерью и эмбрионом, известным и неизвестным, искушение восстать против отстранения и изоляции – все это центральные темы.

Качества, о которых идет речь, фундаментально отражаются в терапевтических отношениях, в этической ответственности терапевта и его стремлении развиваться, а также в уникальности каждого пациента.

Рассмотрим три ключевых аспекта пренатального опыта открытия – точку зрения матери, опыт плода/эмбриона и область взаимодействия между ними.

Ser descubierto por la madre/otro (Spanish)
Este artículo explora las complejas primeras etapas del desarrollo desde la perspectiva única de las experiencias vividas. Se apoya en diversas disciplinas, como la embriología, la psicología y la filosofía, y recurre también a la imaginación y la metáfora, con el fin de profundizar en la comprensión de este período. Basado en el concepto de Emerson y Tery sobre el impacto del descubrimiento del embarazo en el feto/embrión (1980, 2006), el artículo destaca la naturaleza compartida de la experiencia entre la madre y el feto/embrión. Se sostiene que el proceso de ser descubierto por la madre/otro puede implicar tanto el potencial de desarrollo y cambio como el de trauma. La interacción entre la madre y el embrión, lo conocido y lo desconocido, la tentación de emerger frente al rechazo y la separación son temas clave. Estas dinámicas también se reflejan en la relación terapéutica, en la responsabilidad ética del terapeuta y en la invitación al crecimiento y evolución del paciente. El análisis examina tres aspectos fundamentales de la experiencia prenatal: la perspectiva de la madre, la experiencia del feto/embrión y el campo de interacción entre ambos (madre/embrión, descubrimiento/ser descubierto).

被妈妈/ 他人发现 (Chinese)
本文通过体验这一独特视角，深入探讨了错综复杂的早期发展阶段。它借鉴了胚胎学、心理学、哲学等不同学科，以及想象力和隐喻领域的知识，以寻求对这一阶段更深入的理解。本文以爱默生和特里关于孕期发现对胎儿/胚胎影响的概念（1980 年，2006 年）为基础，强调母亲与胎儿/胚胎之间经验的共享性。本文认为，被母亲/他人发现的过程既有发展和变化的潜力，也有可能造成创伤。母亲与胚胎之间的相互作用、已知与未知、出现的诱惑与否定和孤立都是核心主题。在治疗关系、治疗师的伦理责任和进化的邀请，以及每位患者的独特存在，都从根本上体现了所论证的品质。本文研究了产前阶段体验的三个关键方面--母亲的视角、胎儿/胚胎的体验以及两者之间的互动领域。

Introduction

> "The life of the human being is an uninterrupted continuum rather than a sequential series of separate stages– from the inception of pregnancy, nine months before birth, through the following 120 years ... However, no distinct point connecting the start and end points can be established as the point at which this biological entity [the human organism] becomes a human being".
>
> *(Leibowitz, Medicine, and the values of life, 1977)*

Over the generations, the questions where it all began, what is the source of life, and at what stage of development an embryo can be considered a living human being, and the related ethical, religious, and legal issues have occupied philosophers, thinkers, and scholars across cultures, faiths, and disciplines.

Fetus and Embryonic development expand our thinking about the evolution of life within the m/other's body. While it may be difficult to consider the first days and weeks of embryonic development in terms of bodily, emotional, and mental being, it is the essence of the pulsating process of becoming a body within one's mother body.

Building on Emerson and Tery's concept of the impact of pregnancy discovery on the fetus (1980, 2006) I found that the time of pregnancy detection – the prenatal stage at which the mother discovers that she is pregnant – is the starting point for a complex set of processes that have an impact throughout life. Yet, the moment of discovery is not a discrete point in time but rather a moment in a continuum at which realization occurs and which involves the mother, the embryo, and the emerging space of their interrelationship.

The discovery of the pregnancy and the process the mother is going through require her to acknowledge the embryo already developing inside her body. The moment of discovery is also the moment of encounter with a complex human reality of the unknown and lack of control over the body and the processes occurring inside the body, in health or in sickness. The discovery of the pregnancy is an especially baffling experience for the mother as the encounter with the complex reality of the unknown involves the emerging awareness of the life of another human being, which is still unknown, yet is gradually coming into being.

Prenatal theory posits that at the very beginning of embryonic life, the presence of the embryo is already there, affected, and affecting. Hence, when reflecting on the experience the mother is going through as she becomes aware of the embryo developing inside her body, I also wonder about the experience of the embryo.

The presence of the embryo at the beginning of embryonic life is enigmatic – enigmatic to himself as well as to those in his immediate environment. The way the mother and through her the father respond to his presence has a lasting impact. A rejection that does not give way to acceptance during pregnancy and later on is destined to have a devastating effect on his life.

I have found that these elemental experiences of life echo and resonate in the therapeutic setting – the moment of discovery evoked and re-enacted as one of the central experiences in the therapeutic process.

As a bioenergetic therapist, I take a psychodynamic perspective which considers the body and psyche as an interrelated whole. That is an approach that sees

the biological, emotional, and mental processes as correlated and intertwined and as collectively forming the basis for development.

The experience of discovery by the m/other is echoed in the therapist's position and resonates in the invitation for discovery, which is fundamental to the relationship between therapist and patient. It is an invitation to be discovered as a living human being, in body and mind, as innately possessing a unique potential, as having meaning and value. It is an invitation to be part of humankind. Paradoxically, the invitation to life for the patient to be known and belong intertwines within the therapist embodying an essence of ignorance and unknown about who the patient is or who is invited to life. The invitation for discovery includes exploring the unknown, which is experienced by both the therapist and the patient, shaping and expanding the process between them.

The invitation to be discovered as a living human being, as a person, is invested with a special significance in the therapeutic setting as reflecting an ethical and humanistic approach. Its

underlying message is that life has value, that living is of worth. It is concerned with the virtue of human existence, with the freedom of the human being, and with the primary energetic pulsating movement of the living organism.

Discovery

> "Bioenergetic pulsation is a function completely dependent on the stimulation from and contact with the environment. The character structure of the parents forms a crucial part of this environment. Particularly that of the mother, who provides the environment from the moment the embryo is formed until the moment of birth".
>
> *(Reich, 1950/1983)*

Being discovered by and in the mind of the other – first, by one's mother – lays the ground for the psychosomatic processes of opening one's heart and reaching out. It impacts attachment to the mother during pregnancy and later on, throughout childhood. It is primarily the mother and the father who provide the energetic environment for the transformative experience of opening up to the other and the world.

The mother's reaction and feelings upon discovery can range from happiness to fear, from a peaceful state of mind to shock, from ambivalence to abortion

ideation. The intense bodily, emotional, and mental arousal upon discovery is marked in the memory of the m/other.

Abortion ideation or even unresolved ambivalence can have a lasting detrimental effect on the embryo's pure life energy – during pregnancy and long after birth.

Prenatal studies confirm that genetic patterns are shaped long before birth. The intrauterine environment and prenatal experiences play a major role in the process.

Of special interest in this context is the following observation by Anserment and Magidtrtti (2007),

> "The concept of plasticity means that experiences can be inscribed in a neuronal network. An event experienced at a given time is marked at the moment and can persist over time. The event leaves a trace ... But this trace can be reworked or put in play again in a different way by being associated with different traces. Beyond biological determinism (neuronal or genetic), and psychic determinism, the fact of plasticity thus involves a subject who actively participates in the process of his or her becoming, including that of his or her neuronal network" (p. 13).

Discovery usually happens during the first four to eight weeks of embryonic development. The mother experiences slight physical changes (breast tenderness, fatigue, nausea, and emotional swings). Embryonic development is a rapid and extraordinary transformation from a group of cells to the formation of a body. The fetal programming period is most sensitive to genetic dysfunctions and environmental contaminations (alcohol, medications). Studies on pregnancy highlight the link between the environment of embryonic and fetal development, particularly the impact of stress during pregnancy, and later vulnerabilities (Leff, 2016; Finik & Nomura, 2017)[1].

From the moment of implantation in the uterus, the third week of pregnancy, the placenta develops, whose main role is to facilitate the exchange of substances, secrete hormones, and protect against the infiltration of microorganisms. The

1 The link between intrauterine conditions and future physical and mental health has been demonstrated by research. A limited supply of nutrients at critical prenatal development periods can permanently alter structure and metabolism and thus trigger a range of diseases later on in life; malnutrition during pregnancy or exposure to toxins or viruses that may impact brain development are among the risk factors for schizophrenia.

placenta is formed from fetal cells but is not part of the fetus or the mother, and it is located on the uterine wall. From the fifth week, the umbilical cord develops in the fetus from the protein sac that serves as the initial source of nourishment. The umbilical cord connects to the placenta, which transfers substances to the maternal blood and vice versa. This mechanism prevents direct mixing of fetal blood and maternal blood. It is a biological foundation but also a paradigm for a shared space that embodies both connection and separation. (Luce Irigaray 1993, J. Rephael-Leve 1991). This system of coexistence between the embryo and the m/other constitutes a link between the two, separated in a sense, yet bound together in active participation. It supports the mother's immune system, allowing her to accept the fetus carrying genetic material from a foreign component (the genome of the sperm cells). Biology supports the mother's immune system, enabling her to hold the embryo/fetus. However, mothers with dysfunctional bodily or psychic organization are liable to perceive the embryo/fetus as actually injurious. In psychosis, the embryo may be felt as an invasive foreign body or even as a demon[2].

The potential life-long consequences of maternal rejection of the embryo are discussed at length in the prenatal literature. Fauser (2015) presented three case studies to illustrate the link between early embryonic trauma and the incidence of emotional detachment, severe depression, and chronic stress and anxiety in adulthood. Other observed conditions described by Fauser include profound feelings of worthlessness, reduced vitality, chronic pain syndrome, uncontrollable fits of aggression, and paranoid psychosis.

The life status, family history, and transgenerational projections of the mother and father upon discovery are among the prenatal factors affecting later vulnerabilities. Most significant is their representation of a baby – the baby in mind – originating in their own prenatal and early childhood experiences.

Yet, it should be noted that the life status of the parents upon pregnancy discovery is not in itself the determinant factor and that difficult life circumstances do not necessarily spell later vulnerability, whether somatic or psychic. At the same time, in order to provide a welcoming and warm environment for the embryo, the parents have to be able to contain and transform their early-life traumas. In this sense, the way parents reflect and relate their feelings and experiences during pregnancy is significant. While children are usually excited to hear

2 Such feelings and fears are described in fiction, movies, etc., notably, in Roman Polansky's 1968 psychological horror film Rosemary's Baby, which is based on Ira Levin's novel about modern-day witches and demons.

stories about the pregnancy period, exposure to accounts of ambivalent or unwelcoming responses on the part of their parents upon pregnancy discovery, e. g., abortion ideation, or disappointment at the fetus's gender, can be devastating and a recurring experience that illustrates the narrative of elimination. The following vignette illustrates the point.

Vignette 1

D., aged 4, was referred to therapy due to separation difficulties. When we first met, he was clinging to his mother, touching her body, unwilling to let her go. D. is a twin. His twin sister was born first, and he was subsequently delivered by an emergency cesarean. He was smaller than his sister in all parameters, and it was clear that his condition in the womb was stressful – lacking adequate nutrition and space for movement. His mother was shocked to discover that she had twins. Since she wished to have a baby girl, she welcomed her from the very beginning, while D. was the unwelcome "extra." This unwelcoming experience, implicitly but constantly re-lived at home, was re-enacted in therapy repeatedly. Working with D.'s parents on their fears and projections, I encouraged them to get closer to D. and to spend more time together with him. However, what D. needed most was deeply to be invited to be part, to belong. His physical and emotional holding patterns and swing between the wish to belong and the desire to keep aloof reflected his fears to emerge.

After two years of therapy, a recurring moment was taking a new shape, a vital form. I heard the tapping of steps running to the room. I felt my tension rising. D. opened the door, and instead of running in as if nobody was there, the way he used to, he paused, gazing at me, and our eyes met. I could feel my heart opening up to him, my face lighting up in a welcoming smile. For a moment, I was lost for words, unable to tell him that he was welcome, in every sense of the word. And then I could sense it in my body and just said," How good it is, D, that you came."

The Vignette expresses the invitation that began to display in the therapist – the awakening before the meeting, the openness to the sound of the steps, the encounter with the pause/delay/surprise, the modulation of breathing, and finally, the attempt to give all the layers of meaning in a simple sentence: How good it is that you came.

Along with the elemental processes of emergence into being and discovery, an interplay is set off between the inherent human experience of aloneness and

the experience of being discovered and known, which continues in infancy and throughout childhood.

The interplay between the fundamental sense of aloneness and associated withdrawal into a personal inner world and the wish to be discovered and known is often re-enacted in the therapeutic setting, as illustrated in the case of D. It is commonly reflected in the children's game of hide and seek, holding the potential for deep pleasure or alternatively, profound horror. "Here is a picture of a child establishing a private self that is not communicating, and at the same time wanting to communicate and to be found. It is a sophisticated game of hide-and-seek in which *"it is a joy to be hidden but disaster not to be found"* (Winnicott, 1965, p. 186).

The m/other gap

> "The mother's responsibility for the child is not a responsibility for a being that is already there, but for a being that is coming into being, for a being that is not yet. The mother's responsibility is not only for the child's physical well-being but for the child's very existence, for the child's becoming. The mother is responsible for the child's future, for the child's possibilities, for the child's freedom. The mother's responsibility is infinite because it is a responsibility for the other's infinite becoming."
>
> *(Emmanuel Levinas, Totality and Infinity, 1969)*

The conscious discovery of pregnancy by the mother occurs at some point following conception, once the embryo has started to develop. Endowed with the power to create life, the mother is faced at that point with the paradoxical reality of lack of control over her body, with the need to contend with and, literally and metaphorically, contain the unknown – the unknown of her body and of the embryo coming into being within.

Yet, while challenging the mother's sense of the self, the unknown opens up a new space of perception and feelings that stimulate a sense of inner familiarity.

The inner space of perception and feelings opening up upon discovery by the mother, the space between knowing and not knowing, enables her to get closer to the unknowable and the unreachable ultimate truth, the domain of O, as Bion termed it, and thus deal with an enigmatic, primeval reality that cannot be

mentalized and symbolized, a reality that can only be known about, its presence recognized and felt but not known.

The unknown challenges predictions and boundary tolerance. At the same time, the space of the unknown holds the potential for containing complexity and the possibility of change and development. It has to do with the power to create life, which is deeply associated with the sense of autonomy and freedom of choice. However, the inability to contain the complex reality of the unknown gives rise to rigidity and anxiety.

Damasio (2010) saw the sense of self as emerging from a basic awareness level, from a fundamental experience of cognition, which he described as "the feeling of what happens." Yet, as Damasio noted, "... *the feeling of what happens is not the whole story.* There is some deeper feeling to be guessed and then found in the depths of the conscious mind. It is the feeling that my own body exists, and it is present ... a rock-solid, wordless affirmation that I am alive" (p. 185). Further elaborating on introspection and its importance for understanding the conscious mind, Damasio noted its essential role in establishing "some sort of stable scaffolding for what will eventually constitute the self" (p. 193).

The capacity for self-observation and self-perception is a fundamental tenet of bioenergetic analysis. Alexander Lowen saw it as essential to mental and psychosomatic development alongside self-expression and self-possession.

From this perspective, I want to talk about the core of self in the thinking of bioenergetic analysis because it will help me discern a foundation for non-verbal patterns that will come to expression in the mother and the emerging process within her and with the fetus.

The vegetative flow in the body (Wilhelm Reich) is manifested in the fundamental movement of pulsation, the movement, and rhythm of expansion and contraction, a fundamental energetic movement of every living tissue, from the cellular level to the level of whole organism systems. It is often unconscious and accessible only in part to consciousness. Pulsation, of which the respiratory system is a complex expression, supports the sense of continuity and vitality as it deepens vitality and emotional expression. (Generally, more breath means more emotional expression). A different level of pulsation expression is the expansion and gathering of the entire organism with the environment. Expansion – the flow of energy from the body's center to the periphery of the body and even beyond to the environment, is related to the sense of pleasure, curiosity, and merging in a relationship. Gathering -the flow of energy in the opposite direction, is essential for the sense of personal boundaries and supports an integrated and grounded energetic presence. Disturbance in the environment, risk, or intrusion of the envi-

ronment, leads to contraction – a withdrawal of energy from the body's periphery to the center. In an extreme state, it led to freezing at the core. Withdrawal from the connection to the environment and reality.

These processes the first two levels, describe the energetic flow in the body as the somatopsychic organization takes shape in development in relation to the environment. The chronic characterological expressions are the blockages to potential vegetative flow that attribute to the formation of structures.

In my perception, from the outset, the mother and the fetus maintain an internal pulsation of expansion and gathering.

This is a fundamental infrastructure that resonates in the shared space. The heartbeats of the mother in this sense will resonate before the recognition of the heartbeat of the fetus that will resonate within and after birth on the mother. An energetic infrastructure of flow and rhythms. The bioenergetic pulsation of the mother and embryo/fetus constantly modulates their autonomies in a rhythmic movement of expansion and gathering, fusion, and separation. The fetuses can contain minor disturbances in the mother environment, and the mother as an environment can provide a capacity to organize effectively around anxiety related to the loss of autonomy over the body and the existence of the fetuses. Another perspective of the m/other gap was offered by Raffai (1998),

> "But while the child has got access to his mother's life and is within it the mother is expelled from the lifeworld of her child. As she has not yet accepted that the small being within her is not herself, she already must realize that she has no access to his lifeworld. It is an important aspect that the mother is excluded. The world of the child consists of differentiation and growing, the mother cannot, she remains herself" (p. 167).

Pregnancy discovery may therefore be a deep touch with goodness and potential, but it can be an anxiety-laden experience that undermines the illusion of control over the body/life. It can thus lead to the collapse of the mother's omnipotent defenses and lead to depression and stress.

It is painfully illustrated in the story, Bear Ears, by Carolina Vega.

> *"I remember that the only thing I wished was that he has a button to be turned off and on. As I held the pregnancy test in my hands, I imagined that the body forming inside my body had a little button on its chest. Something simple, like a light switch. The same color as his skin, so that the deformity wouldn't be too noticeable, I didn't want anyone else to be able to use it. Just me."*

Winnicott uses the term "primary maternal preoccupation" (1956) to explain a psychological state in which the mother, primarily after birth, is in an extreme sensory and emotional sensitivity that allows her to resonate and respond to the infant's cues. The temporary delay of "normal" presence is required for being in a shared space. I want to suggest that maternal preoccupation unfolds where there is a conscious awareness of the existence of the fetus/embryo. A beginning of a gradual familiarization. At the end of pregnancy, the mother gives birth, and the baby is born, and both share an intense process of exposing the body to the world. The ancient layer is reenacted at birth, and one can think of situations where early disruption at the discovery, resonates with traumatic birth.

Hence, when working with pregnant women, especially in situations of physical or mental distress, it would be of benefit to create a movement between the dialectical experiences the pregnant woman is going through, that of carrying a separate being within and that of sharing an emerging common space of affective interaction with the embryo coming into being inside her body.

The movement between different body states would enable her to clearly perceive her boundaries and thereby expand toward and contain the new embryonic presence, thus, in place of objectification, allowing for its humanization.

Vignette 2

S., a successful lawyer, sought therapy after discovering that she was pregnant with her third child. S. did not want to get pregnant, "not now," as she said.

However, she did not think of ending the pregnancy. In her mind, abortion was a violent, evil, murderous act, evoking memories of her family's Holocaust history.

S. felt trapped. Any indication of the embryo coming into being inside her body or symptoms of the unwelcome pregnancy increased her desperation and anger. S. felt that she lost autonomy, that "destiny" controlled her life.

I could strongly feel the presence of a mother-to-be and the expected baby in my clinic; however, I had to go along with the painful choice of S. to have the child even though against her will and accommodate her feelings of hate and rejection.

Yet, while acknowledging the unbearable feelings of anger, fear, and helplessness flooding her, I told her that although she did not feel it, her body knew how to create a space for the new life coming into being within. I offered various experiences that facilitate breathing and the sensing of the body, but it was some time before S. could feel her body. With time, I could

get closer to her and use touch to help her feel herself and relax. Only then, I discover to my surprise that she had back scoliosis. Touching her back while she lay on her side was then adopted as an effective routine throughout the therapy. Her back condition was a sensitive issue, involving shame, humiliation, fear, and anger. She was outraged at her parents, who ignored her feelings while taking care of her body. She told me that she wore a corset all through her childhood, discarding it at the age of 14. From that point on, she suffered chronic back pain, and she feared she would have to learn to live with her body dysfunction.

In the second trimester, S. seemed to calm down, her constant grievances giving way to longer moments of silence. Laying on her side, her hands touching her belly, a new motherly expression was lighting her face. Quietly observing, saying nothing, just offering my enabling and containing presence, I welcomed the transformation. A week before giving birth, she talked about her worries. She was concerned about the likely impact of her initial rejection on the baby and apprehensive of the imminent encounter with him. Trying to reassure her, I told her that she made a great effort, bodily and emotionally, to be his mother, that she could benefit from letting him be with her in their mutual effort at birth. Walking her through a guided imagination experience simulating birth, I tried to help her manage a balanced coexistence with the fetus about to be born without giving up her autonomy.

The non-judgmental support I offered her, containing and enabling her bodily and emotional experience, allowed her to use me in the therapeutic setting as a surrogate mother carrying the embryo/fetus for her until her hostility could be mitigated. Being close to her, gently touching her body, I enabled her tortured body to be discovered, her feelings of being dominated and tyrannized by the developing embryo to be relieved, and the negative emotions projected onto him alleviated

As I listened to her talking, attentively watching when she kept silent, in a rhythm of expansion and contraction, her pregnancy experience echoed and resonated in the therapeutic relationship. I paid special attention to her body states, sensations, and emotions, physically supporting her spine while she was lying on her side in an embryonic position, holding her embryo/fetus.

Supporting the bioenergetic pulsation of expansion and gathering was most significant in the therapeutic context. Beyond its relaxing effect, it enabled both fusion and individuation, allowing S. to reach out to the embryo coming into being inside her body while maintaining her autonomy.

The embryonic experience upon discovery

The experience of the fetus/embryo upon discovery encompasses two distinct dimensions. The first addresses the psychological and spiritual appearances associated with the experience of emerging into existence. The second dimension pertains to the physical development of the fetus/embryo within its earliest relational environment.

The experience of emerging into existence

The contemplation of embryonic development in the early weeks invites the exploration of the profound question of when biological development transitions become a living being with inherent value and potential.

Winnicott (1988) focusing on the earliest, pre-primitive stages of emotional development, wondered, "What is the state of the human individual as the being emerges out of not being? What is the basis of human nature in terms of individual development?" (p. 131).

Elaborating on the enigmatic embryonic experience of emergence into being, Winnicott (1988) argued that it has its origin in fundamental and inherent aloneness, noting with reference to Freud's theory of life and death instincts and the underlying idea of "the inorganic state from which each individual emerges" (p. 132) that

> "from the point of view of the individual and of individual experience (which constitutes psychology) the emergence has been not from an inorganic state but from aloneness. ... There is no capacity for the infant (or fetus) to be concerned with death. There must be, however, a capacity in every infant for concern about the aloneness of pre-dependence since this has been experienced ... The recognition of this inherent human experience of pre-dependent aloneness is of immense significance" (p. 133).

Winnicott (1988) noted the total dependence of the embryo/fetus and later, the newborn infant on the caring maternal environment, far before any dependence can be acknowledged, and the lasting impact of the early-life environment on individual development.

> "As we look towards the earliest roots of emotional development, we see more and more dependence. ... At this very early stage, it is not logical to think in terms of an

> individual, and this is not only because of the degree of dependence, and not only because the new individual has not yet the power to discern environment, but also because there is not yet an individual self-there to discriminate between ME and not-ME. Yet the germ of all future development is there, and continuity of experience of being is essential to the future health of the baby who will be an individual" (p. 131).

Following Winnicott's paradoxical ideas on the primitive mental body stats of emerging into being, it is significant to hold the meaning to all levels of experience and their implication for future strength and vulnerability.

A different perspective lies in the understanding that the fetus/embryo is suspended between being and not being, and is still enigmatic, to himself and those in his immediate environment. His enigmatic experience holds a deep-seated yearning for a mystical connection to the universe, a longing for the transcendent, embodied in his body. The idea of a primeval longing for the Divine shared by all human beings, conceived as the mystical heart of all religions, was suggested by Jung (1933)[3] in the context of his theorizing about religion, morals, ethics, spirituality, and man in search of a soul as manifestations of the collective unconscious.

In health, being welcomed, calm, and harmonious allows for a diffuse, melded existence, a shared transcendent space of connection to creativity and nature.

The yearning for transcendental awakening as a possibility and perhaps as a vague sensual memory comes from ancient psychosomatic experiences that continue to be performed all lifelong. It is an energetic quality that moves within the individual. It is part of the expansion towards a close connection, melting with the other (as in sexuality) and toward connection with the divine. The discovery of the space of the soul transcends the mere biological aspect of emergence into a subjective being. It is especially significant when biology fails to take its natural course.

Vignette 3

M. a woman in her forties who longed to have a child and struggled for years to get pregnant finally achieved pregnancy through in vitro fertilization enabled by an egg donation. Her joy upon pregnancy discovery was

3 According to Jung, the journey in search of a soul, a journey to meet the self and at the same time to meet the Divine, is a process of transformation – individuation, as he termed it – necessary for the integration of the psyche.

marred by the fact that she was not the genetic mother and by her concerns about the emotional impact on her future relationship with and attachment to the long-expected child. However, the realization that she was inviting a soul to the world, a soul that she was hosting in her body, was a liberating idea.

Energetically, it opened an inner space of underlying perception and feelings, a space for expansion that enabled her to transcend the mere biological aspect of intervention in the fertilization process, reach out to the embryo coming into being inside her body, and invite him to the world, to be part and belong in the deepest sense of the word.

Her ability to contain the unknown and, at the same time, bodily embodied space of being in the world, opened for the embryo, still suspended between being and not being in an existential state evoking a primordial trauma that has no name, an affective space of longing for unification with the mother, of vague yearning for being and belonging.

The physical development within the relational environment

Between weeks 7 and 13 of gestation, when "the motor cortex and the corticospinal tract have yet to be formed ... fetal motions are overwhelmingly guided by subcortical circuits" (Piontelli, 2010, p. 61). Research findings show that these early general movements, driven by a central pattern generator in the early spinal cord, emerge from self-organization between the early neural system, the fetal body support structures, and the uterine environment. As Piontelli (2010) noted, through general movements "fetuses constantly adapt to the changing requirements of the external and internal environment ... General movements could thus be viewed as a component of prenatal 'learning' and neural development" (Piontelli, 2010, p. 93).[4]

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4 Around week 8 of gestation, the central pattern generator produces spontaneous shock-like jerks of the entire fetal body – "startles," as termed by Piontelli (2010). Once general movements stop surfacing, fetuses begin to perform breathing movements, emerging more consistently at 12 weeks (Piontelli, 2010) Sensorimotor coordination, evidenced in fetal general movements, is demonstrated in the synchronized expansion and contraction movements of fetal breathing, involving every more adaptive, self-organized patterns.

Fetal movements, seen as a clear manifestation of the "life force" in action, were discussed by Winnicott (1988) regarding the intrauterine environment. Drawing a diagram of two concentric circles representing "the absolute isolation of the individual as part of the original unit of the individual-environment setup" *Winnicott wondered,*

> "How will contact be made? Will it be as a part of the life process of the individual, or will it be as a part of the restlessness of the environment? "The reaction to impingement detracts from the sense of real living. It can be shown that environmental influences can start at a very early age to determine whether a person will go out for experience or withdraw from the world when seeking a reassurance that life is worth living" (pp. 127–128)[5].

The bioenergetic theory holds that even single-cell organisms like the amoeba react to the environment. Based on studies of amoeboid locomotion and plasmatic flow in response to different types of stimuli, Reich (1933/1990) noted the analogy to the human body.

> "The human body, the major organs, and every cell in the body react to environmental stimuli similarly – expanding outward in response to a nutritional and nourishing environment, sensed as pleasurable while contracting inward in response to unpleasant or distressing stimuli. Start at a very early age to determine whether a person will go out for experience or withdraw from the world when seeking a reassurance that life is worth living" (pp. 127–128).

The body coming into being is affected by and responsive to the environment. Fundamentally reaching out to the environment and exhibiting spontaneous, authentic motility, the emerging embryo thrives in a well-adapted environment. However, hostility, impingement, or stress would offset the outward expanding movement, trigger premature reactivity, and reduce the primary energetic pulsating movement of the embryo emerging into life. When consistently repeated,

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5 "When that active adaptation is nearly perfect … The individual's movements (perhaps an actual physical movement of the spine or leg in the womb) discover the environment. This, repeated, becomes a pattern of relationship. In the less fortunate case, the pattern of relationship is based on a movement from the environment … The individual reacts to the impingement, which … has nothing to do with the life process of the individual." (Winnicott, pp. 127–128)

such adverse effects are liable to impair the rehabilitation ability and even cause structural changes.

The heart is one of the earliest developing organs, beginning its formation in the third week of pregnancy, the discovery time. The initial heartbeat occurs in the fifth or sixth week. Initially, the anatomical structure of the heart bears little resemblance to its final form, which is established by the eighth week. The fetal heartbeat, a vital sign, marks the boundary between life and death. This heartbeat coexists with the mother's heartbeat, initially within her body and later, following birth, on her body, and it possesses calming qualities in terms of rhythm and sound.

Pierce (2012) delves into the concept that the heart, throughout its developmental stages, is not merely a mechanical pump but serves as an organ of perception that can register the vibrations and frequencies of the surrounding environment and the world.

An unwelcome response upon discovery may be reflected later in the baby's body language – inhibiting the emotional movements of the arms and hands and the heart associated with the expressive gesture of reaching out to the mother/father and through them, to the world. Terry (n. d.) offers fresh insights on baby body language, seen as a sign language opening the door to the perinatal, birth, and postnatal physical and psycho-emotional experience of the baby, its effect on the baby and bonding, and its lasting impact throughout childhood and adulthood, reflected inter alia in adult symptom patterns, which, as noted by Emerson (n. d.), are associated with birth or prenatal experiences.[6] Reich (1933/1990) noted, elaborating on his segmental armoring theory,

> "Most of the emotional expressive movements of the arms and hands also stem from the plasmatic emotions of the organs of the chest ... The inhibition of the inner chest organs usually entails an inhibition of those arm movements that express 'desire,' 'embracing,' or 'reaching for something' ... as soon as the movement of the arms becomes associated with the expressive movement of yearning or desiring, the inhibition sets in" (pp. 376–377).

Elaborating on Reich's segmental armoring theory and character analysis, Lowen (1958/1971) explored the relationship between personality functioning and

6 As both Terry and Emerson argue and describe e at length, the non-verbal cues provided by baby body language are the key to facilitating primal therapy with infants as well as clinical intervention later, in childhood and adulthood.

patterns of bodily movement and muscular tension, demonstrating how every personality trait is reflected in the body. The body is thus the mirror of the character and the language of the body (posture/gesture, breathing, motility, expression), the key to understanding behavior and a clue to the emotional state of the individual.

Concerning the interpersonal world of the individual, Lowen (1976) discussed the role of the heart in the interaction with the environment, describing three channels of communication.

> "The primary channel of communication for the heart is through the throat and mouth. It is the infant's first channel, as it reaches with its lips and mouth for the mother's breast. However, a baby doesn't reach with lips and mouth alone, it also reaches with its heart. ... The heart's second channel of communication is through the arms and hands as they reach out to touch. ... A third channel of communication from the heart to the world is downward through the waist and pelvis to the genital organs. Sex is an act of love, but whether it is simply a gesture- or an expression of the sincere feeling is, again, a question of whether one's heart is in it" (pp. 88–89).[7]

Ferenczi (1929), based on his extensive clinical experience as a physician, in the course of his work, encountered cases of apparently somatic and physiological disorders that were "not explicable anatomically. All these symptoms fitted on occasion perfectly into the total psychic trend of the patients, who had to struggle a great deal against suicidal tendencies." Ferenczi further found that in those cases, the "patients came into the world as unwelcome guests of the family" (p. 126). In this context, Ferenczi noted,

> "I only wish to point to the probability that children who are received in a harsh and disagreeable way die easily and willingly. Either they use one of the many proffered organic possibilities for a quick exit, or if they escape this fate, they keep a streak of pessimism and aversion to life" (p. 127).

These lines by Ferenczi are a moving poetic expression of the profound impact of loneliness, rejection, broken heart, and trauma in early life, reflecting his empathetic approach in the face of the patient's suffering.

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7 The multiple layers of the heart's resonating emotional and symbolic expressions will be illustrated in case four.

Therapy

At this point, I would like to share my insights and experience as a bioenergetic therapist.

The emergence of being from an enigmatic space of inherent existential aloneness into a bodily embodied affective space of yearning for being and belonging resonated in the therapeutic setting. The patient's bodily and energetically manifested developmental history indicates whether it carried with it an invitation for life, providing the vital resources for somatic, psychic, and relational growth, or was rather imbued with ambivalent feelings or outright rejection, prefiguring a lasting devastating impact.

At the same time, the complex experience of the mother upon discovery is echoed in the therapist's position, which likewise involves the space of the unknown, as self-experienced by the therapist and as experienced by the therapist vis-à-vis his or her patient. It touches on the therapist's ability to contain vague knowledge or lack of knowledge, to acknowledge and cope with the patient's fluctuation between vitality and lack of vitality, and to be alert to the patient's bioenergetic pulsation of expansion and contraction, of reaching out for relationship or withdrawing from the world, seeking reassurance that life is worth living. The task of the therapist is even more challenging when working with patients suffering from developmental and lifelong trauma originating in ongoing neglect, abuse, or threat of destruction, mostly experiences that have not been emotionally transformed and mentalized.

Specifically in such cases, the invitation extended by the therapist to the patient to emerge from inherent existential aloneness, to be discovered as a living human being, to belong, calls for due sensitivity and creativity[8]

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8 Based on his insights, Ferenczi developed an "active" therapy on the somatic level to complement the psychoanalytic work (Lowen, 1958/1971). Noteworthy in this context is the sensitive, adaptive therapeutic approach adopted by Ferenczi (1929) in "Cases of diminished desire for life," where he relaxed his active therapy approach. As Ferenczi observed, in such cases, "Finally a situation became apparent which could only be described as one in which the patient had to be allowed for a time to have his way like a child … Through this indulgence the patient is permitted, properly speaking for the first time, to enjoy the irresponsibility of childhood, which is equivalent to the introduction of positive life-impulses and motives for his subsequent existence" (pp. 128–129). 9patient is permitted, properly speaking for the first time, to enjoy the irresponsibility of childhood, which is equivalent to the introduction of positive life impulses and motives for his subsequent existence" (pp. 128–129).

In "Elysium is Far As," (1882) Emily Dickinson delves into the profound emotional landscape of longing and uncertainty. The Elysium/room symbolizes a space of intimacy and potential connection, while the unresolved condition of a waiting friend resonates with our deepest fears and hopes. This innate desire for belonging and understanding, lights the quest for meaning, especially in the face of loss. Dickinson's concise yet evocative language invites us to engage with vulnerabilities, urging us to confront the delicate balance between hope, despair, and courage.

"Elysium is as far as to
The very nearest Room
If in that Room a Friend await
Felicity or Doom--
What fortitude the Soul contains
That it can so endure
The accent of a coming Foot--
The Opening of a Door –"

Case example

L., aged 55, a mother of five, sought therapy after her divorce. She had a heavy body and dark, sad, expressive eyes. She ended her unhappy marriage after 30 years of distress, following a violent, verbal assault by her abusive husband. She had few friends and no support on the part of her family for her decision to divorce. L. grew up in a small neighborhood of immigrants. Her childhood was marred by physical and emotional abuse, mainly from her mother and one of her sisters. She recalled her decision as a child not to cry so as not to be seen as weak. L. was an excellent student aspiring to study medicine. When she was 14, her older brother, the light of her parents, was killed in war. Her grief-stricken parents sank into deep depression. In the years that followed, her life at home became even more unbearable, all the more so in the absence of her loving brother, who appreciated her intelligence and ingenuity and used to come to her help and shield her from her mother. Humiliated and harassed, she gave up her wish to become a doctor. Eventually, L. completed her university studies in engineering and had a successful career in the field. However, after giving birth to her youngest child, she had to abandon her dreams once again and give up her career under pressure from her unsupportive husband and stay home raising the children.

It has taken L. years to be able to relate to her feelings, to her body, and to herself, as a human being in her own right rather than as a mere object that has to meet the expectations and standards of others. However, she could not break out of her cocoon and remained frozen and unreachable, steeped in a deep sense of loneliness.

Seeking to reach out to her, to get in touch with her early and enduring traumas, I offered L. several times during the four years of therapy to meet more than once a week, but she refused time and again. Then, before the two sessions described below, I offered her to meet for longer sessions of an hour and a half each (at the same price), and this time, she accepted my offer, her acceptance signifying an emerging change, subsequently reflected in the therapeutic process.

First session

L. entered the room agitated. She sat down, leaning forward, anxious to explain why she was late for the meeting. It turned out that her son forgot the keys at home, and she waited for him to come. "I could go, but I haven't seen him for two weeks now, and I just wanted to say hello ... I don't know why I am so worried. I've been extremely stressed recently ..."

L. moved uncomfortably, trying to calm down.

"And you are still feeling that way ..." I asked or actually noted.

L. was still restless but outwardly at least, the fidgety movement stopped.

It seemed to me that she was startled by what I saw.

"Let's try and see what's going on inside you," I suggested.

"What are you talking about? ..." L. instinctively replied, evidently troubled.

I invited her to feel her body, first, along the vertical back side, starting with the head, the neck, the shoulder blades, along the spinal cord, down to the tail bone, the legs, and the feet soles, and then, along the vertical front side of her body, focusing on the soft parts.

L. seemed to relax. "Your voice calms me ... but it was not easy ... I got lost."

When did I lose you? Her words resonated with my sense of losing her. I felt her detachment and perplexity.

L. seemed to be mixed up. "I felt my back, but then, I did not know ... I am a lousy student."-

"You felt your back and then got lost. These moments are so hard to catch. Go back to your back, to your shoulder blades, your spinal cord. We have time, and I am here with you," I said, reassuringly.

L. remained silent for a while, her body slightly relaxed, and then she opened her eyes. She leaned forward.

"I remember now coming home from our last meeting. I sat on the sofa for a long time. Then, I had a strange image of my body ... it looked open from the throat down to the chest and the belly. It was not a bleeding cut, but I could see deep inside. I know it sounds strange, but I felt relieved as if a heavy stone had been removed. It was an image, but it was me. I saw my heart moving. it was exciting ... but also bizarre."

She then leaned back, her energy was dropping, and she looked pale.

I leaned toward her. "You've seen your heart pulsating, ... and now I have seen you alive ..."

L. opened her eyes, looking at my eyes.

"You are alive ..."

Her body awakened and relaxed. She looked back at me and then, closing her eyes, stayed like this for a long time, breathing deeply. After a while, she opened her eyes. They were damp with tears. "Maybe it's too late for me," she said sadly.

We sat on for a while, saying nothing.

As the meeting was about to end, I encouraged her to try and sense her body while standing, as I supported her, using the grounding exercises[9].

Next session

"I want to apologize for knocking on the door a few minutes earlier than scheduled. It's raining heavily outside and cold winds are blowing ... I had to get in." L. seemed embarrassed.

"It's your time; I have been waiting for you."

"I cannot just come in." L. was still uneasy.

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9 Lowen introduced the concept and therapeutic practice of grounding. The concept implies a stable physical and emotional presence, supported by the ground, the underlying idea being that embodied emotional knowledge is expressed through physical posture. "Grounding or getting a patient in touch with reality, the ground he stands on, his body and his sexuality, has become one of the cornerstones of bioenergetics" (Lowen, 1975, p. 40). Along with other techniques such as work with body contact and boundaries, grounding is used to address the energetic aspect of the individual, including self-perception, self-expression, and self-possession, which Lowen saw as essential to mental and psychosomatic development.

"It is hard for you to feel that you are welcome, that I am waiting just for you, that it is your special time."

"It feels good to hear you saying it." L. leaned back on the sofa cushion, smiling softly.

And then she leaned forward. "I have a lot to say. I have been thinking a lot ..."

She looked into my eyes. "I never thought that it was possible. It is not the facts but the way I experience them. I told you once that I used to visit my parents with my sisters, never by myself, although I felt out of place ... I felt I didn't belong there. You said then that my parents are mine ... that I am their daughter. It was something I had never felt before. I visited them alone this week and for the first time, I felt welcome ... I felt that they wanted me to come. I never thought that it was possible."

Leaning even closer, L. went on talking, almost whispering, as if revealing a secret. "On my way, back home, it occurred to me that my mother did not want to have me ... that being pregnant with me was against her will. She touched on it indirectly, wondering why my daughter had not got pregnant. Is it because she has a problem getting pregnant or out of choice? My sister was three months old when my mother became pregnant with me. And she was in poor health at the time. She had a blood problem, and her body rejected the pregnancy. I can understand now that it was a complicated situation. Yet, her rejection of me has never given way to acceptance.

Having said this, L. leaned back, sitting upright, apparently unrelieved, the pain still lingering.

It was the first time L. talked about it. I realized that all along, we had been holding an implicit dialogue, and I wondered if all that time, L. had been conscious of my feelings, if she had been aware of my thoughts about the beginning of life, the embryonic experience upon discovery, and its lasting emotional impact. And I thought about the unspoken words, the unsaid feelings, as she leaned forward, getting closer, and then, leaning back, drifted away, overwhelmed by her enduring traumas

"Will it ever end?" L. wondered.

"My mother and me. It is deep inside me. I had a different experience with my father. I read out the Bible for him ... he is blind ..." Her voice was trembling.

I leaned forward. Then she leaned forward. Our heads almost touched, but our eyes did not meet. We were both looking down at the floor.

"I Heard your voice trembling." I moved back a little and put one hand on my chest.

"Your words have meaning and heart."

Her body relaxed. She leaned back and looked at me. She was silent for a while. Looking at her hands, she lay them on her belly. She moved her fingers as if touching a soft cloth, now and then raising her head and gazing at me.

Her body posture and finger movements reminded me of the image of the fetus trying to grasp the umbilical cord, seeking contact with the mother, and reaching out to her[10].

Case discussion

Rejection and humiliation deprived L. of beauty, sexuality, love, and compassion, leaving her dead inside. She sought to mask her pain, her loneliness was deep-rooted, embodied in every cell and tissue of her body, an inherent part of her existential experience as a human being.

Her experience resonates with the vision presented by Eigen (2006),

> "I don't think any of us survive infancy or childhood fully alive. What lives survive on graves of self that didn't make it. We leave a lot behind to be what we are now, to be what we can be. We cover not only nakedness but annihilation. We try to look better than we are, more alive, more appealing. We try to mask a sense of an annihilated self with signs of life" (p. 25).

The body story of her early developmental trauma, of being rejected and ignored, and the total vulnerability and fundamental aloneness she experienced even before being born, were evoked and re-enacted during the therapeutic process.

The appearance for our meeting described above echoed her life story – her harsh emergence into being, metaphorically driven by the forces of nature (rain and wind). Being denied a genuine invitation to belong, to be part of humankind, she could not imagine that there was a place for her in the world, that someone was waiting for her.

The early parent-child-family relationships that form people and that are at the core of chronic relational trauma were explored by Tuccillo (2013), with a focus on somatopsychic unconscious processes, such as various forms of transference, specifically somatic transference. In this context, Tuccillo noted:

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10 Terry's insights on baby body language are called to mind in this context.

> "Transference is a body experience. It isn't only cognitive and perceptual. It's also a feeling state; a set of feelings structured in the body. The transference experience brings with it a whole set of familiar visceral and muscular patterns that go together with the thoughts and emotions that define it" (p. 28).

Listening to L. describing the hallucinated image she had, of her body looking open from the throat down to the chest and the belly, which allowed her to see her heart moving deep inside, I thought of the embryo at 5–8 weeks, when the first sign of life, the pulsating heart, not yet covered by the ribs cage, is already evident – and while totally dependent on the mother, even at that early stage, is already unwelcome and rejected.

Moments of discovery shared with the therapist, are an intimate and sensual experience that involves three dimensions: the patient's psychosomatic body, the therapist's psychosomatic body, and the common psychosomatic space jointly created by the patient and therapist. This multidimensional experience is reflected in changing body postures, in the way sensations and emotions are expressed by the varying movements of the emotionally and relationally significant regions of the body, and ultimately, in the transformative process that the patient goes through – as illustrated in the case example of L.

L. was finally able to engage with my invitation. I encountered a woman with vitality, tenderness, wisdom, and beauty – a devoted mother who radiated love for her children. Yet beneath this exterior, L.'s profound anguish and isolation persisted.

A year later, she recounted a striking experience upon entering her apartment building, feeling a deep sense of alienation, as if she belonged neither there nor anywhere. I suggested that we sometimes need to ponder, from the depths of our hearts, where the very molecules of our being find their true home. Is there something beyond our personal narratives that informs our existence? In this inquiry, perhaps we might uncover a blessing waiting to be recognized.

In conclusion

The singular experiences of being hosted within another's body, of being discovered, and of being born are common to all human beings. These foundational experiences hold the deepest vulnerabilities of humankind.

This paper deals with three aspects of the prenatal experience of discovery: the mother's experience, the embryo's experience, and the common space of interaction between the two.

The mother's experience of discovery, her encounter with and acknowledgment of the unknown, with the embryo within, is experienced by the embryo and influences his being from the cell level to full body-psyche realization.

The experience of discovery by the m/other resonates in the embryo and along with the enigma of his existence, the embryo experiences the response to his presence by the mother/father/environment. Whether welcoming or rejecting, this primeval response has a lasting impact on his body, mind, and psyche.

This paper suggests that the invitation extended by the therapist to the patient to be discovered as a living human being, to take part, and to belong is vital to therapy and ultimately, to healing. The invitation for discovery is essentially an attempt to get in touch with the primeval and at the same time, enduring experiences that are still pervading the patient's life.

This is especially true in those cases where the patient is deeply scarred by the trauma of early rejection, and burdened by painful feelings of unworthiness, cannot see the value of life or the virtue of human existence.

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About the Author

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Book Reviews

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

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

Bob Lewis, a clinician artist

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

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

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

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

Opening a new perspective in Bioenergetic Analysis

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

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

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

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

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

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

Definition of "Cephalic Shock"

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

"Cephalic Shock" and "False Self"

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

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

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

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

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

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

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

How does Bob Lewis work?

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

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

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

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

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

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

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

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

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

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

Empathy (2005[8])

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

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

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

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

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

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

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

How do we receive these implicit and explicit messages empathically?

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

Intersubjective relationship

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

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

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

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

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

Projective identification (2004[13])

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

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

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

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

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

How to treat these projective identifications?

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

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

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

Touching in body psychotherapy

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

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

Trauma and the body (2000[15])

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

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

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

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

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

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

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

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

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

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

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

Guy Tonella PhD
November 2024

C. Holle & J. Tasche (Eds.). (2024). *Psychodynamische Grundlagen der Bioenergetischen Analyse*. Giessen: Psychosozial-Verlag, 536 pages, Softcover, ISBN 978-3-8379-3318-5

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www.bioenergetic-analysis.com

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

The book is organized as follows:

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

The connection between neurobiological foundations and psychoanalytic theory is explored, highlighting how neuropsychoanalysis revitalizes the mind-body connection scientifically. The therapeutic applications of body-focused interventions within psychodynamic and bioenergetic contexts are examined, with a new framework for classical concepts like grounding and catharsis, especially in relation to trauma and conflict patterns.

Further discussion emphasizes bioenergetic methods for mature clients, advocating for personal responsibility in therapy. Drawing on a character model, the therapeutic journey is likened to a medieval quest, with an emphasis on the role of serendipity in personal growth and awareness. Group dynamics in bioenergetic therapy are also explored, with a model where energetic resonance and interpersonal dynamics like power and intimacy facilitate both individual and collective growth. These contributions deepen the understanding of bioenergetic methods for therapy with individuals and groups alike.

Part 2: Core Elements of Psychodynamic Bioenergetics – This section integrates developmental psychology, psychopathology, and treatment theory into Bioenergetic Analysis (BA), aiming to address gaps in available resources for practitioners. It explores both historical and contemporary intersections of psychodynamic, structural, interpersonal, and humanistic theories essential for a fuller understanding of BA.

The discussion begins with an exploration of psychodynamic understanding in BA, advocating for a balanced yet adaptable approach that bridges psychodynamic theory and bioenergetic practice. The evolution of character structure concepts is examined, illustrating their relevance when integrated with psychodynamic perspectives, which enhance BA's theoretical foundations.

Attachment theory is connected to bioenergetic character typology, highlighting its applicability in both therapeutic and organizational contexts. Relational psychoanalysis is explored, with a focus on the intersubjective understanding necessary for effective therapeutic practice. Finally, the intersection of psychodynamic and humanistic psychology within BA is reflected upon, situating BA in the broader context of cultural and therapeutic movements, emphasizing personal growth and experiential practices. This section offers a multidimensional framework that bridges theory and practice in BA.

Part 3: Selected Application Areas of Psychodynamic Bioenergetics – This section examines the adaptability of BA in addressing a range of psychological disorders, settings, and cultural contexts. It underscores the need for tailored methodologies to treat conditions such as depression, PTSD, and psychosomatic disorders, while also considering cultural and institutional factors. This

complexity highlights the relevance of BA but also calls for interdisciplinary collaboration.

A comparative framework is provided, integrating bioenergetic, psychiatric, and psychodynamic diagnostics to facilitate effective interdisciplinary communication. Body-focused approaches are explored for complex PTSD clients, with an emphasis on empathy and the resilience of these individuals.

Psychodynamic-bioenergetic therapy is advocated for use with children and adolescents in clinical settings, addressing their unique psychological needs. Transcultural challenges are discussed, drawing on experiences in non-Western contexts, where integrating sociocultural dynamics with theoretical and experiential teachings becomes paramount. Collectively, these essays highlight BA's evolution into a cross-cultural, inclusive practice, expanding its application to diverse global contexts.

Part 4: Bioenergetic-Psychodynamic Work in the Postmodern Era – This section examines the intersection of BA, Psychoanalysis, and the postmodern world, where cultural, philosophical, and technological changes present new challenges to traditional therapeutic frameworks. The pluralistic, context-dependent views of postmodern society have reshaped societal norms, creating opportunities for growth but also introducing new psychological challenges, particularly among younger generations.

The evolution of self-actualization from enlightenment ideals to modern concepts of authenticity and corporeality is explored, with a focus on the challenges these ideas pose for BA. The transformative effects of digitalization on relationships, experiences, and therapeutic practices are discussed, urging BA to adapt to the "fourth technical revolution" in therapy.

Gender identity is examined through a body-therapeutic lens, offering insights into the formation of gendered and sexual identities. Contemporary mental health issues are contrasted with mid-20th-century disorders, proposing psychodynamic-bioenergetic strategies to address new forms of suffering. Finally, the connection between BA and spirituality is explored, offering contemplative exercises that reconnect readers with the foundational vision of grounded spirituality, emphasizing love and joy in an accelerating world. These essays situate BA within the complex realities of the postmodern era, offering a comprehensive view of its evolving role in therapy.

A central theme of the book is the integration of psychodynamics as a reference framework for modernizing bioenergetic analysis. By presenting this approach to a wider audience, the authors aim to spark a dialogue on the contemporary relevance of bioenergetics.

The authors critique bioenergetic analysis for remaining rooted in Lowen's character model, which emerged over 70 years ago, and argue that it has not sufficiently adapted to the social and cultural changes of the modern world. While this critique may seem overly harsh, it is important to note that many bioenergetic therapists and researchers have indeed embraced advances in related fields. These include attachment theory, intersubjectivity, object-relations theory, neuroscience, polyvagal theory, gender theory and spirituality, which are increasingly integrated into bioenergetic practice.

The book seeks to bridge the humanistic foundations of bioenergetics with an intersubjective understanding of therapy. It highlights how bioenergetic practice can align with the principles of relational psychoanalysis to remain relevant in today's therapeutic landscape.

One of the book's key contributions is its expansion of bioenergetics to include a psychodynamic and psychopathological perspective. This shift provides a more comprehensive understanding of the spectrum of psychological disorders observed today. The book uses work with children and adolescents, clients with complex PTSD and with gender issues as illustrative examples. While these approaches are already quite common in bioenergetics, the book underscores their significance in a modern therapeutic context.

The authors also bring innovations in teaching tools, such as the use of ChatGPT to create fictitious prefaces by Freud, Reich, and Lowen. While this experiment is presented as a playful addition and lacks the depth of authentic writings, it hints at the evolving nature of educational methods. Additionally, QR codes embedded after chapters, linking to interactive multiple-choice and open-ended questions, provide practical engagement for diligent students.

Overall, this book aspires to revitalize bioenergetics by linking its rich humanistic roots with contemporary psychodynamic insights and modern pedagogical tools, paving the way for an evolved and inclusive therapeutic approach.

The final section of the book delves into the evolution of bioenergetics in the context of postmodernism and post-postmodernism, drawing on frameworks such as performatism, based on the work of Raoul Eshelman, and digimodernism, as articulated by Alan Kirby. Whether we embrace these perspectives or not, the reality is that we live in an era shaped by postmodern and post-postmodern multimedia influences, and our theoretical frameworks and therapeutic approaches must adapt accordingly.

While the book does not offer an exhaustive exploration of this complex subject, it successfully initiates a critical discussion. It raises essential questions about how bioenergetics can and should evolve to remain relevant in the rapidly

changing cultural and societal landscapes of our time. The authors highlight the urgency of aligning bioenergetic practices with the paradigms of the current era, paving the way for further exploration and dialogue in this vital area of study.

Josette van Luytelaar & Homayoun Shahri

Editorial Board

Maria Rosaria Filoni (Italy) graduated in Philosophy and is a psychologist and psychotherapist, supervisor and local trainer. For many years she was training director for Siab. She was a member of the IIBA Board from 2013 to 2019 and IIBA's Vice President from 2016 to 2019. She has her private practice in Rome, Italy.

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The Journal, *Bioenergetic Analysis*, publishes clinical reports, theoretical analyses, empirical investigations, and book reviews pertaining to the theory and practice of Bioenergetic Analysis. Articles will be published in English. Two reviewers will evaluate the article on the basis of a blind review (all information pertaining to the author's identity will be omitted). The Editorial Board will also have a vote regarding the appropriateness of the article for inclusion in the journal. Manuscripts should not have been published previously or been submitted elsewhere concomitantly.

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For submission please email text, figures and tables to the Chief Editor. For the next edition this is Rosaria Filoni.
Her email is: mariarosaria.filoni@fastwebnet.it

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1 Original by M. Koemeda; modified 2012/10 by V. Schroeter; modified 2018/10 by G. Cockburn and L. Cardenuto: modified by G. Cockburn 2021/12.

A 1st page

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Examples: "the view of Stern et al. (2012) is that ..."; "Lowen (1958, p. 79) made a distinction ..."; or "text of quotation from an author" (Lowen, 1958, pp. 80–81).

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King, P. (2004). What has happened to psychoanalysis in the British Society? In A. Casement (Ed.), *Who Owns Psychoanalysis?* Karnac.

Lowen, A. (1988). *Love, Sex and Your Heart.* MacMillan Publishing Co. Inc.
Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the Body.* W. W. Norton.

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Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psychoanalysis, 3*, 43–47.

Resneck-Sannes, H. (2002). Psychobiology of Affects. *The Clinical J. of the IIBA, 13*(1), 111–122.

Rocque, M. (2017). Exploring school rampage shootings: Research, theory, and policy. *The Social Science Journal, 54*(3), 261–270. https://doi.org/10.1016/j.soscij.2011.11.001.

Bioenergetic Analysis will be published once a year. Articles should *only* be submitted during the summer (beginning the first of June through the first of September) of the preceding year. Authors will be sent a notification of receipt of their manuscript within two weeks and will be informed about the status of their manuscripts, as to qualified acceptance or rejection, within two months after submission.

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Maria Rosaria Filoni is a psychologist and psychotherapist, supervisor and local trainer. She was a member of the IIBA Board from 2013 to 2019 and IIBA's Vice President from 2016 to 2019.

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