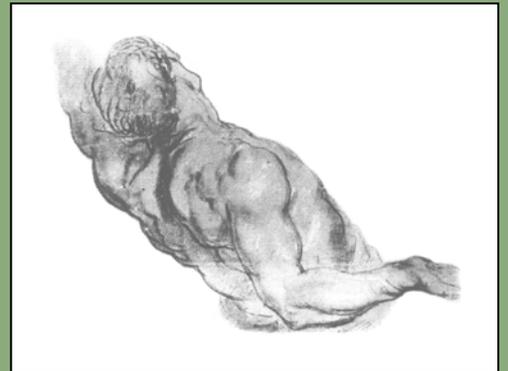


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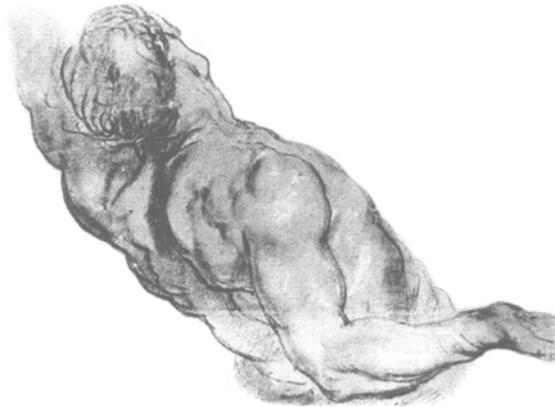


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USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

## *The USA Body Psychotherapy Journal* Editorial, Volume 10, Number 1, 2011

The two issues of this volume of the *USABPJ* mark our 10<sup>th</sup> anniversary of publication!

Beginning with Volume 11, in 2012, our Journal will be renamed The International Body Psychotherapy Journal, and will be sponsored jointly by USABP and EABP. I will remain as editor-in-chief for a few more years and will be joined in 2012 by Michael Heller, PhD, of Geneva as co-editor. I look forward to the increased energy that Michael Heller (who has been a long standing member of the USABP and attended many of our conferences) and the EABP will bring.

I have been a member of the Publications Committee of the EABP for several years and have attended the EABP Conferences regularly. I had been exploring the possibilities of joint sponsorship with the EABP for a year or so before meeting formally with the EABP Board of Directors at the EABP Conference in Vienna last November. We came to an agreement which was then ratified by the boards of directors of both organizations. Many details remain to be worked out over the course of 2011 for official publication under the new title in 2012.

We will continue to publish electronically for the foreseeable future. I really see this as the next stage in the development of the Journal and of body psychotherapy as an increasingly recognized field. A small percentage of our articles over the last 10 years have been submitted by Europeans and Latin Americans, but with Michel Heller's help, I hope to increase that number and also accept articles from other areas of the world as well. We may soon be able to publish more than two issues per year.

I have seen the contents of the *USABPJ* as well as the number of submissions evolve over the past ten years from a narrower focus on the modalities represented in the *USABPJ* to inclusion and integration of affective neuroscience, mindfulness, relational psychoanalysis and attachment and trauma theory, just to name a few. This evolution will, I am sure, be augmented by the official co-sponsorship of the EABP.

This issue, Volume 10 #1, is an example of the depth and diversity that we have achieved. Both psychoanalytic and neuroscientific literatures are frequently cited. Themes such as mirror neurons, mindfulness, the I-Thou relationship, love both unconditional and an essential part of the client-therapist relationship, the autonomic nervous system and the right brain vs. the left brain, the role of awareness, polyvagal theory, and chaos theory are utilized and integrated.

Courtenay Young, in *The Science of Body Psychotherapy Today: Part IV, New Science and Research*, leads off with the final article of his four-part series on the science of body psychotherapy. In this concluding article he surveys several key areas that are now impinging on body psychotherapy and from which we can usefully benefit. He also challenges body psychotherapists to utilize these fields, integrate them and in the case, for example, of neuroscience, begin informing them in return. A brief piece by C. Anya Hricko follows which exemplifies this integration by applying principles of both neuroscience and Somatic Experiencing to the clinical situation.

Jennifer Frank Tantia, in *Viva Las Vagus! Innervation of Embodied Clinical Intuition*, utilizes four neural correlates of corporal metaphors used in common interpersonal communication to initiate the attempt to understand intuition from an embodied epistemological point of view. She speculates that the interface between embodiment and intuition happens through metaphors, particularly of the heart and the gut that correlate interestingly with the physiology of the vagus nerve.

In *Emotions and the Organization of Experience*, Greg Johanson outlines how a mindfulness-centered, somatically inclusive therapy process allows implicit core organizers of experience to become explicit and available for modification. When traumatic activation is present, the use of mindfulness in top down processing of emotions and in bottom up processing of sensorimotor material is illustrated in clinical verbatims. As he sees it, the passive distancing aspects of mindful witnessing moves toward the sense of unity consciousness valued in the East; and active compassionate awareness can foster affect-based healing of fragmented internal parts sought in the West.

Asaf Rolef Ben-Shahar, in this second installment of a four-part series of articles on *The Relational Turn and Body Psychotherapy* entitled *Something Old, Something New, Something Borrowed, Something Blue*, deepens the marriage of relational psychoanalysis and body psychotherapy. He explores Orbach's rephrasing of Winnicott that there is no such thing as a body, only bodies in relationship. Thus, he sees the therapeutic relationship as a matrix of relationships, the dynamic of which is created by the tension among its elements. Case vignettes illustrate. A brief theoretical article by Yudit Mariah Moser entitled *The Experience of Shame in Human Development and Psychotherapy* explores follows a similar vein, exploring the relational and physiological aspects of this important topic.

Stephan Deutsch, a Gestalt therapist, utilizes both neuroscience and chaos theory in his essay entitled *The Continuum Theory of Human Development: A Theory of Life Span Development and its Application to Therapeutic Intervention*. He describes four fundamental tracks, (1) awareness, (2) envisioning, (3) communicating, and (4) loving, which he utilizes in an integrated, sequential manner in therapeutic interventions for emotional healing of his clients. Two cases illustrate the method.

Our final two articles represent and touch on, respectively, the bioenergetic tradition. In *The Somatic-Energetic Point of view: towards a Bioenergetic Character Analysis*, Philip M. Helfaer draws on his forty years of involvement in the development, practice and teaching of bioenergetic analysis. Comparing the bioenergetic paradigm with the psychoanalytic paradigm as elucidated by Fred Pine, Helfaer gently challenges and critiques both Reich and Lowen. He develops a somatic-energetic viewpoint as the foundation of bioenergetic character analysis as a functional process of identity and antithesis. And, as he stresses in all of his writings, he considers that the single most important necessity for the body psychotherapist is working energetically with one's own body, daily, year in and year out.

And finally, Daniel Hoffman, a PhD candidate at Santa Barbara Graduate Institute, explores how the roots of contemporary emotion regulation theory informed by the neurobiology of attachment can be traced back to and informed by earlier theories of patterns of emotion regulation such as those posed by Alexander Lowen. He concludes that “by integrating the understanding of both the brain-based and muscular-based methods of emotional regulation, it is possible that a more complete picture of the functioning of the human organism can be allowed to form.”

Jacqueline A. Carleton PhD  
March 2011  
New York City

# The Science of Body Psychotherapy Today: Part 4: New Science & Research

Courtenay Young

## Abstract

In the first of these four articles, I looked at the history of 'science' in body psychotherapy (mainly the work of Janet & Reich), and in the second article, I looked at what the current situation is in the science of psychotherapy and of body psychotherapy, especially mentioning what published research there is. In the third part of this series, there was a discussion about what is meant by 'appropriate science' for body psychotherapy; and in this, the fourth & final part, I make a brief and incomplete examination of some new areas of science and research that are increasingly impinging on the field of body psychotherapy – hopefully to our benefit. However, what we really need to do is to find ways to use them properly, and perhaps even to start informing neuroscience, in return.

## Keywords

Neuroscience – Body psychotherapy

## A beach of diamonds

We live in very interesting times ! After years of wandering in the desert, impoverished, abandoned, unrecognized, reviled – a little like the Bushmen of the Kalahari, we suddenly discover that there is a beach full of diamonds – as actually exists in Namibia. Whose are they? Are we going to try to pick these diamonds up, and also let everyone freely use them? The beach of diamonds is – of course – just an analogy for the relatively new branch of science called neuroscience. And it is on our doorstep. And, currently, no one is really quite sure yet how to apply all these wonderful new discoveries clinically.

If you pass a light through a ruby, you can cut steel, or perform laser eye surgery. Wow! We now know – and we have seen the evidence in MRI scans and the like – that the amygdala is definitely damaged through prolonged and unresolved trauma. Wow! Now, how do we, as primary care clinicians, really start to use that piece of information from science?

This article is an attempt at the concept of consilience (the bringing together of two different disciplines) – neuroscience and body psychotherapy. I address some of the available research in various areas of neuroscience that might be of interest to body psychotherapists.

## Autonomic Nervous System (ANS)

A proper understanding of the functioning of the autonomic nervous system (ANS) – as we understood it – was all that was essential, when I originally trained with Gerda Boyesen in Biodynamic Psychology, as we had to comprehend how the digestive system could also digest emotions (Boyesen et al., 1980). Her writings are now mostly out-of-print, somewhat unintelligible, or exist only in French. However this subtle craft of psychotherapy, whilst being gentle and effective, was also somewhat nebulous and intangible. So a need for more detail and hard facts started me off – possibly as an antidote – on the more scientific track of applied physiology, then a diploma in Psychology, and, later on, looking at these sorts of studies in psycho-neuro-biology, now mostly called neuroscience.

There had been only one interesting scientific article mentioned in the whole of our body psychotherapy training (Setekleiv, 1980: about the firing zones of smooth muscles), and then David Boadella (1981) also wrote an article about muscle firing zones and the orgasm reflex, but mostly – as was often the case in body psychotherapy trainings in those days – we focused purely on the experiential; learning and refining techniques, mainly of different types of touch; on the interpersonal relationship; and how to intuitively help the client to regulate the functioning of their ANS, working to help them re-balance it, and thus to get a better sense of their self, their life and their internal (body) functioning: we were learning a craft, not science! (Young & Heller, 2000)

What totally overturned my cozy view of the two halves of the ANS, functioning basically in opposition to each other: one nasty, the adrenaline-based sympathetic half, and one nice, the gentle, laid-back parasympathetic half; was a talk and an article by Stephen Porges (2003; 2007) on his “polyvagal” theory. This theory gave a very different appreciation of the autonomic nervous system as a properly evolved system, with an identification of neural circuits involved in the regulation of autonomic state, and an interpretation of autonomic reactivity as being adaptive:

Foremost, the polyvagal perspective emphasizes the importance of phylogenetic changes in the neural structures regulating the autonomic nervous system and how these phylogenetic shifts provide insights into the adaptive function and the neural regulation of the two vagal systems.

Porges has built up this theory over a number of years: he is currently a professor in the Department of Psychiatry and the Director of the Brain-Body Center in the College of Medicine at the University of Illinois at Chicago and holds appointments in the Departments of Psychology, Bioengineering, and Anatomy and Cell Biology (quite some set of credentials!), and he is also very nice and easy to talk to. His wife is also “*a world leader in the role of neuropeptides oxytocin and vasopressin in social cognition.*”<sup>1</sup> Anyway, here is a quick and dirty version of the polyvagal theory:

[The perception] of danger and safety or life threat triggers 3 neurological circuits. They developed at different evolutionary times. The newest one (Green traffic light) occurs when we understand that we are in a safe environment. When it's on, we have the capacity to be socially engaged, to think, to hear and understand other humans, eat and to play. The second oldest (Yellow light) is engaged when we perceive danger, but we don't think it will kill us. In this mobilized state, we attend only to cues about danger and safety. We can't connect well; we can't even really hear people. We are scanning for danger and predators. The third state and evolutionarily oldest state (Red light) is immobilization in the face of life threat. We shut down completely, can't connect, feign death, and can't/don't have protective reflexes.<sup>23</sup>

Understanding the hierarchy of response and the different functioning of these different neurological circuits, and how they are overlaid upon each other is also essential for working effectively with other things within our clients, rage, trauma, and PTSD (see later). Porges has gone on to develop a concept of “neuroception” (neurological perception) (2004): he writes:

Neuroception describes how there are neural circuits that distinguish whether situations or people are safe, dangerous, or life threatening. Neuroception explains why a baby coos at a caregiver but cries at a stranger, or why a toddler enjoys a parent's embrace but views a hug from a stranger as an assault. Faulty neuroception might also lie at the root of several psychiatric disorders, including autism, schizophrenia, anxiety disorders, depression, and Reactive Attachment Disorder.

Suddenly things began to make a bit more sense, and so I started to latch onto this new world of neuroscience; here – potentially – was the scientific proof of our somewhat fringe and disowned body psychotherapy craft.

A greater understanding of the ANS has helped me work with clients more effectively, particularly in primary care patients in the UK National Health Service (NHS) where we are often limited to 6-8 sessions for people with mild to moderate anxiety and depression, and – of course – as mentioned, such an understanding of the ANS is totally necessary for anyone working with trauma.

Incidentally, Porges has also developed a “Body Perception Questionnaire” downloadable from his website, which could be useful to many body psychotherapists (or even National Associations) to help show an improvement in their clients.<sup>4</sup>

### **The biological bases of stress, anxiety & depression**

Burijon's (2007) excellent book on *The Biological Basis of Clinical Anxiety* can serve as an introduction to the whole new set of scientifically-based concepts that we are beginning to recognize, in that mild to moderate anxiety and depression should not, repeat not, be treated psycho-pharmacologically, nor as any form of mental illness, especially in the first instance.

Modern urban life is very, very stressful: and whilst we may be able to survive, our bodies just did not evolve with the ability to cope with the constant levels of stress that we experience nowadays (especially in the West). So, as an indicator, if our Life Event Stress Index (Holmes & Rahe, 1967) goes above (say) 300 points because of events that have happened to us within an 18-month period, and we did not, or do not, take appropriate actions to reduce our physiological stress levels (essentially a combination of aerobic exercise and relaxation), then the stress hormones will inevitably build up in our system and, at some point, our bodies will react to the overload, and we end up either climbing walls (with anxiety), or disappearing under the duvet (from depression), or a combination of both. Most mild to moderate anxiety and depression is not, repeat not, endogenous; it is exogenous or reactive. Of course, it can also, of course, build up on top of inherited genetic patterns and/or psychodynamic influences.

Initial, reasonably effective and well-researched treatment usually therefore consists of: (i) telling the patient there is nothing really wrong with them, only with what went on around them; (ii) not prescribing anti-depressants too early; (iii) giving them instead some basic information and reading about life stress, and (as a body psychotherapist) I throw in a simple understanding of the ANS here; and (iv) suggesting to them a regimen of aerobic exercise (about four, 30-45 minute sessions per week.) and relaxation (about nine, 20-minute sessions per week) for at least the next 4-5 weeks, so that this pattern can become habituated (Young, 2008). Subsequent counseling or psychotherapy sessions can then happen on a very different basis

<sup>1</sup> Quoted from: [http://en.wikipedia.org/wiki/Stephen\\_Porges](http://en.wikipedia.org/wiki/Stephen_Porges): accessed 21/07/09.

<sup>3</sup> Downloaded on 21/07/09 from: [http://traumatherapy.typepad.com/trauma\\_attachment\\_therapy/stephen\\_porges/](http://traumatherapy.typepad.com/trauma_attachment_therapy/stephen_porges/)

<sup>4</sup> Accessed on 21/07/09: [http://stephenporges.com/index.php?option=com\\_content&view=article&id=21:body-perception-questionnaires&catid=10:body-scales&Itemid=17](http://stephenporges.com/index.php?option=com_content&view=article&id=21:body-perception-questionnaires&catid=10:body-scales&Itemid=17)

as the clients/patients are much more themselves, more empowered, and often considerably less anxious or depressed, so we are therefore looking at their problems quite differently. We have dealt with the basics (physiology) first.

Since most pharmacological drug treatments for anxiety happen to be quite addictive, certain anti-depressants are often prescribed for this. Much more effective is a taught course of mindfulness practice, which puts people more in touch with their bodies, calms them down through the meditative practice, brings them more into the present moment (where anxiety is not present), benefits pain relief and other conditions, and also helps them with their self-awareness.

Whilst people like Jon Kabat-Zinn (2001, 2002), and many others, have been prolific in testing the efficacy of mindfulness within the confines of modern science, and usually promoting it as an adjunct to cognitive behavioral therapy, it is really a Buddhist practice that is about 2,500 years old, so (a) I prefer recommending books like Thich Nhat Hahn's (1991) *Peace is Every Step*, and (b) I think that body psychotherapists should reclaim a bit of what they are good at, and promote this sort of practice as an excellent tool for body awareness, that has also been scientifically researched and has shown to be effective for several conditions, like anxiety, as mentioned.

More generally, body psychotherapists could benefit from an increased awareness about the biological bases of illness and disability from an evolutionary perspective (Davey, et al. 2001), and, I think, also possibly from understanding the processes of human evolution and how it has affected our bodies (Young, 2010 b). But, back to neuroscience!

Embodied self-awareness is the ability to feel our emotions and movements in the present moment, without the influence of judgmental thoughts (such as: am I doing this right?). Fogel (2009) provides some of the scientific background and understanding of this type of awareness and explores how we can prevent it from being lost. In so doing, he has "*laid a solid and comprehensive foundation for far-reaching changes in psychotherapy, medicine, and everyday life.*"

Regina Pally's (2000) book on *The Mind-Brain Relationship* attempted to do for psychoanalysts what this article attempts to do for body psychotherapists. In the forward by Mark Solms, it says:

Psychoanalysts who fail to assimilate the new knowledge will be increasingly marginalized both scientifically and professionally, and will be unable to participate in this important intellectual revolution. ... This book makes it possible for the non-specialist reader to grasp – almost in a single sitting – the main thrust of contemporary brain research on a range of topics of vital interest to psychoanalysis. Readers are bound to want to learn more about one or other of these topics and in this way they will be effortlessly inducted into this exciting new era of exploration and discovery in mental science. (Pally, 2004, iii-iv)

So too, I hope, that you will also be led. The book, somewhat predictably for its time and audience, looks at how neural circuitry develops in the infant epigenetically (as a result of early environmental influences); reviews the perceptual mechanisms; examines the structure and function of memory; looks at the embodied basis of emotion; touches on hemispherical asymmetry; and finishes off with some speculations based on research into consciousness.

### **Descartes' Error**

As has been said before, one of the fundamental problems in psychology, psychotherapy and (indeed) the whole of society, was that it largely ignored the body. Descartes' statement "*I think therefore I am,*" and Freud's reactions against the body in psychotherapy have perpetuated this trait into modern psychotherapeutic work. Antonio Damasio (1994), who was head of neurology at the University of Iowa and a prominent researcher on human brain function, was one of the first neuroscientists to challenge this premise. He wrote a fascinating and well-reasoned argument on the central role that emotion and feelings play in human rationality. According to Damasio, the same brain structures regulate both human biology *and* behavior, and both are indispensable to normal cognitive processes. He demonstrates, through a number of case histories, how patients (particularly those with prefrontal cortical damage, and there is also an interesting case study about sensory agnosia) can no longer generate the emotions necessary for effective decision-making.

This book, and Michael Gazzaniga's (1994) slightly more readable study, *Nature's Mind: Biological Roots of thinking, emotions, sexuality, language, and intelligence*, started the concept that neuroscience had something quite realistic and serious to offer psychotherapy, and also to wider society. Gazzaniga more recently presented the 2010 Gifford Lectures at the University of Edinburgh titled *Free: The Science of Mind Constraining Matter*, which explored issues of free will, mental causation, and the meanings behind patterns of our emotions, behavior, thoughts, and the choices we make, which are central to understanding the relationship between our brain and our strong sense of self. The recordings of these lectures are still available.<sup>5</sup>

### **The Emotional Brain**

A colleague in spirit of Damasio's, Joseph LeDoux's, is a neuroscientist and professor of Neuroscience and Psychology at New York University. His research interests were mainly focused on the biological underpinnings of memory and emotion, especially the mechanisms of fear. His seminal work (LeDoux, 1996) was *The Emotional Brain: The Mysterious Underpinnings of Emotional Life*, showing that, despite the hegemony of cognitive studies that ignored the emotions, we really need to understand how crucial emotions are to our evolutionary survival, as they (are designed to) cut through conscious

<sup>5</sup> Gifford Lectures 2009-10: [www.hss.ed.ac.uk/giffordexemp/ProfessorMichaelGazzaniga.htm](http://www.hss.ed.ac.uk/giffordexemp/ProfessorMichaelGazzaniga.htm)

reasoning whenever speed and rules-of-thumb are much more important and effective than logic. This approach also provided the scientific background to books such as Daniel Goleman's *Emotional Intelligence* (see below).

Much of our emotional life is lived unconsciously, and this unconscious life is far richer than our conscious feelings - for example, our conscious mind will already be reacting to situations of danger some time before we begin to be afraid. Even Socrates stated that: *The unexamined life is not worth living for a human being.*<sup>6</sup> If we - perhaps with the assistance of therapy - start to make this unconscious life conscious (through examination), then what riches can pertain? So, not only did LeDoux present a fascinating insight into how our emotions function in normal situations, but he also provided a new understanding of some of the emotional disorders. Since neuroscientists have been relatively slow to probe the biological basis for our sense of self, focusing instead on states of consciousness, his next book, *Synaptic Self: How Our Brains Become Who We Are*, (LeDoux, 2003) attempted to fill that gap.

In this book, despite the ongoing debate about the root cause(s) of psychological disorders, most people agree that the development of a healthy sense of Self is central to the distinction between normality and psychopathology. Starting with a description of a person's basic neural anatomy (including: how neurons communicate; the brain's embryological development; and some of the key neural pathways), LeDoux reviewed a mass of research and experiments, and concluded that the brain's synaptic connections provide the biological base for memory, which makes possible the sense of continuity and permanence fundamental to a normal conception of self: hence, the synaptic self. He came up with a theory: it's the neural pathways, the synaptic relationships in our brains that make us who we are. He also provided some insight into the shortcomings of psychopharmacology, and suggested new directions for research on the biology of mental illness.

Again, as we shall see, the basic assumption is that it is the brain that is key. Nevertheless, this work - and others like it - started the ball rolling in directions that we, as members of the field of body psychotherapy, probably want it to go in. LeDoux has, of course, written and edited several other books, the latest being a book on trauma and PTSD (Shiromani et al., 2009).

## Trauma work

In the field of trauma, one of the first clinicians who had done significant work in the First World War with shell-shocked soldiers (including Siegfried Sassoon and Wilfred Owens) was W.H.R. Rivers, at Craiglockhart Hospital in Edinburgh: interestingly, he had a fairly multi-disciplinary background, being an anthropologist, neurologist, ethnologist and psychiatrist. War trauma (and other severe trauma) has been known about since the time of Herodotus (who described a traumatized soldier at the Battle of Marathon in 490 BC), but Rivers brought it to modern attention and showed that it could be worked with: many soldiers, probably with PTSD, were shot in the First World War for alleged cowardice: *pour encourager les autres!*<sup>7</sup> A little clinical work was done post-WWII with Holocaust victims, but not much significant research work on severe trauma and PTSD happened until after the Vietnam War.

In a chapter in *Emotional Intelligence*, Goleman (1996) reports on findings from people who have suffered severe trauma: Holocaust victims, Vietnam War veterans, children involved in traumatic situations like school shootings or school bus kidnaps. The condition has now, relatively recently, been labelled as PTSD. There are a number of different symptoms associated with PTSD including hyper-vigilance, flashbacks, nightmares, panic attacks, etc. There is also a significant amount of evidence coming out of neuroscience (MRI scans, etc.) that show actual damage to the emotional circuitry in the limbic system of the mid-brain, particularly around the amygdala, but also including the *locus coeruleus* (a structure that regulates the production and secretion of the catecholamines, adrenaline, and noreadrenaline), the *thalamus* and *hypothalamus*, and the connections with the *pre-frontal neo cortex*. However, under the right conditions, this damage can also heal as the brain seems to have a degree of plasticity. And there are certain conditions that can facilitate (or prevent) healing: Goleman references Herman's (1992) three main stages to healing trauma and writes:

The first step, regaining a sense of safety, presumably translates to finding ways to calm the too fearful, too easily triggered emotional circuits enough to allow relearning. ... Another early step is to help patients regain some sense of control over what is happening to them, a direct unlearning of the lesson of helplessness that the trauma itself imparted. ...

Another step in healing involves retelling and reconstructing the story of the trauma in the harbor of that safety, allowing the emotional circuitry to acquire a new, more realistic understanding of and response to the traumatic memory and its triggers. As patients retell the horrific details of the trauma, the memory starts to be transformed, both in its emotional meaning and in its effects on the emotional brain. The pace of this retelling is delicate: ... (Goleman, 1996, pp. 210-211)

These findings have been replicated and reinforced by other neuroscientists (van der Kolk et al., 1996; Seigel, 2003) and by a number of clinicians (Rothschild, 2000; Ogden et al, 2006; Bremner, 2002). Ogden's book is excellent, and Bremner is

<sup>6</sup> As stated in Plato, Apology 38a: "ho de anexetastos bios ou biotos anthrōpoi — ó δὲ ἀνεξέταστος βίος οὐ βιωτὸς ἀνθρώπου"

<sup>7</sup> This is a quote from Voltaire's 'Candide' with reference to the court-martial and execution of Admiral Byng after the Battle of Minorca: Voltaire wrote, "Dans ce pays-ci, il est bon de tuer de temps en temps un amiral pour encourager les autres." ("In this country, it is wise to kill an admiral from time to time to give courage to the others.")

good (especially in his 3<sup>rd</sup> chapter) on historical and current research in PTSD, but he becomes perhaps a little bit too polemic at other places in his book.

Rothschild actually lists ten “foundations for safe trauma treatment”: creating a sense of safety; establishing a good therapeutic relationship; having the ability to slow down the process; identifying and building on the client’s internal resources; regarding defenses as resources, so that you don’t get rid of them, you create more choices; ... etc. (Rothschild, 2000, p. 98-99). However, what all of these seem to agree on is – in order for it to be absolutely necessary to overcome the fear conditioning associated with PTSD, is the formation of new neural pathways from the limbic system to the prefrontal lobes of the neo-cortex: i.e. emotional re-learning.

Left to itself, the traumatized limbic system, and in particular the amygdala, triggers the fear response again and again, which occurs every time something similar to, or vaguely reminiscent of, the original trauma happens, (and, also spontaneously, as in dreams/nightmares, perhaps in its own attempt to heal). In PTSD, there is no natural or spontaneous re-learning, as normally happens over time. Each re-triggering re-traumatizes and strengthens the fear pathways: this is the disorder. The level of traumatization can actually increase: the original phobia, possibly associated with a real traumatic incident, can get added to with a number of other associated phobias. There is, therefore, no emotional re-learning; and no healing of the trauma. This can only happen when a situation of safety and calm is created, and when the patient’s affect levels are kept well within normal bounds: what Ogden calls the “staying within the comfort zone.”

The re-telling of the trauma, which seems to be absolutely necessary to create an understanding of the affects and even an integration of the trauma into the greater scheme of things, has to be done by creating new neural pathways from the autonomic responses of the limbic system to the consciousness of the neo-cortex. Any re-triggering, or levels of increased affect, will cause too much distress and this flooding of emotion will block the person’s understanding and the process of integration. So, as one works with the traumatized person (let us de-role them from being a patient), the therapist needs to be highly aware of the emotional state (affect) of the client, on a precise moment-to-moment basis, and with a finely tuned awareness of body symptoms and emotional affect.

At any moment when the affect seems to rise too high so as to disturb the healing process, the therapist needs to have the client slow down the re-telling process, or take some time out from it with an aside or an integrative connection, or suggest that the person pauses and breathes for a moment, or really feels what’s happening within their body.

These body psychotherapeutic interventions not only calm the level of emotional reaction, and the associated affect, but also allow the neural connections from the emotional limbic system to (re)form toward the conscious cortex. The brain is surprisingly plastic in this way and emotional re-learning and the building of new neural connections and pathways can really happen. As this transpires over a number of sessions, over some time, the PTSD symptoms do diminish and become less frequent and the traumatized person can start to lead a more normal life, and integration seems to be able to happen then quite effectively.

So, to summarize, what seems to be clear is that the brain disturbance seen in PTSD patients – associated with disturbed behavior and concomitant somatic symptoms – will not, or cannot, often heal without proper therapeutic intervention; that the intervention has several pre-conditions; and that the intervention needs to be done in a particular way, and from a particular perspective – to conform with the deep understanding of the bodily processes. The key point is that the bodily symptoms are key, and the process is both a somatic and a cognitive one, **with the somatic one being paramount**. However, psychotherapy, done this way, can also be effective and long-lasting. There are, of course, some people who have been so badly traumatized and emotionally damaged that, whilst there can perhaps be some healing and improvement, it is also quite likely that significant levels of damage may remain - but then this is also true for severe physical damage.

So, in this respect, the scientific findings of neuroscience about the brain damage in people with trauma have been translated into effective clinical work, and, indeed, what is interesting is that a scientific expert, someone like Bessel van der Kolk, who has also investigated several different clinical methods of working with trauma, states clearly and forcefully, and not without controversy, that we cannot – we *absolutely* cannot – do effective work in psychotherapy, (especially with people with trauma or PTSD) *without* significantly using a number of different body psychotherapy techniques, supported by body psychotherapy awareness and training. He goes on to say, somewhat idiosyncratically:

As long as people sit on their **tochas** and simply move their tongues around, they may not be able to make enough of a difference to affect internal sensations and motor actions. People need to learn to regulate their physical states in order to get their minds to work. Once they shift their physiological patterns, their thinking can change. (Sykes Wylie, 2004)

## Psychopathology

Oliver Sachs (1986, 1991, 1996), a well-known neurologist, had also begun to show us, in his compassionate case studies, that there were wonderful people with fascinating stories and amazing talents locked up inside some quite damaged minds.

The writings of V.S. Ramachandran (e.g. Ramachandran & Blakeslee, 1999) are interesting in this context as well. Ramachandran is one of the world's leading brain researchers. He is professor and director of The Center for Brain and Cognition, University of California, San Diego and adjunct professor at the Salk Institute, La Jolla.

(He) has seen countless patients suffering from anosognosia, phantom limb pain, blindsight and other disorders, and he brings a remarkable mixture of clinical intuition and research savvy to bear on their problems. He is one of the few scientists who are able and willing to explore the personal, subjective ramifications of his work; he rehumanizes an often too-sterile field and captures the spirit of wonder so essential for true discovery.<sup>8</sup>

Another author who investigates malfunctions in brain chemistry and especially the relationship between these and brain functioning, structure and behavior is Scott Kraly, in his book, *The Unwell Brain* (Kraly, 2009). This well-written book gives a balanced account of the pros and cons of treating mental illness with an integration of psychopharmacology and psychotherapy. However, it has to be mentioned especially here, that there are also many, many studies – and much empirical evidence – of how some people with mental illness can be treated successfully without the use of any pharmacology at all (Podvoll, 1991 & 2003; Mosher, 1999).

Peter Manu's book (2004) entitled *The Psychopathology of Functional Somatic Symptoms* examines the link between mental illness and physical syndromes that lack organic disease explanations. It states that it “examines the best research work of the past 20 years to determine the association between psychopathology and functional illness”, but this book is not all that it could be or should be, at least according to one reviewer.<sup>9</sup> If this comment is accurate, then this book is a classic example of bad science.<sup>10</sup>

There have been many other studies into the psychopathology of certain conditions, and I have chosen not to delve further into this (more specialist) field, in this general, introductory article. But it should be noted that the mind-body unity that we, as body psychotherapists, hold central to our professional work has a gradually increasing number of advocates: maybe some of those psychiatrists, doctors, psychologists or scientists in white coats aren't too bad!

## Emotional Intelligence

Goleman's revolutionary book (1996), mentioned already above, covers a whole mass of other findings and research studies, told in an easily readable and instructive way. It seems that emotional intelligence is a much better predictor of success in life than IQ. He is particularly strong on what works (better) in healthcare and healing – e.g. a degree of compassion; that children who display empathy at an early age do better than those who don't; – and also he explores the roots of empathy and the studies that support his developing argument. He delves into the neurological bases of anger management, rage, toxic thinking, and the ability to calm distressing emotions in others: one told in a charming story that really sticks in the memory about how (not) to use Aikido.

He also holds, as does Stern (1987) and others, the concept that the formation of a good mother-baby attachment bond is crucial to the development of a child's emotional intelligence. He discusses the neurobiology of excellence, which could revolutionize school practices, if it were applied. He examines studies on depression that show that helping to cut the automatic pattern of rumination (which doesn't result in action), breaking isolation, scheduling in distractions, exercise, and several other strategies are extremely effective in helping to lift people out of depression for a variety of biological and emotional reasons, (and he gives indications of the research and the scientific basis behinds these strategies), and these are not all cognitive strategies as many of them tap into the emotional body and the field of neuro-psycho-biology. He is strong in suggesting the outlines for possible strategies for prevention, rather than cure, and also what makes an effective treatment. It is a well-researched and delightful scientific study that should be fairly central on any body psychotherapy training school's reading list.

## Affective Neuroscience

Jaak Panksepp (1998) is a distinguished research professor emeritus of psychobiology, and adjunct professor of psychiatry. He is a scientist, not a clinician – and he has developed a number of insights from his studies into: the neural basis of emotions; displeasure and fear systems; the sources of anger and rage; the neural control of sexuality; maternal care; social loss; social-bonding and play mechanisms in the brain, and how these can relate to childhood disorders, such as ADHD; that can significantly influence clinical work with children and adults, with sleep and arousal issues, separation, loss and grief issues, social bonding difficulties, and with sexuality. We are extremely fortunate that he, himself, has decided to make the bridge between his scientific and laboratory work and our clinical world. His work is also not without critics. He writes:

I have tried to steer a middle course between the various polar views that presently characterize different schools of psychology. My attempt at a synthesis is bound to receive some criticism from colleagues who have strong antireductionist biases, for many do not feel comfortable trying to explain complex psychological

<sup>8</sup> Review by Rob Lightner: retrieved on 21/07/09 from Amazon.com: [http://www.amazon.co.uk/Phantoms-Brain-Human-Nature-Architecture/dp/1857028953/ref=sr\\_1\\_1?ie=UTF8&s=books&qid=1248247426&sr=8-1](http://www.amazon.co.uk/Phantoms-Brain-Human-Nature-Architecture/dp/1857028953/ref=sr_1_1?ie=UTF8&s=books&qid=1248247426&sr=8-1)

<sup>9</sup> John Sayer: <http://www.sayer.abel.co.uk/MES-Nmanu.html>

<sup>10</sup> See Goldacre, B. (2008). *Bad Science*. London: HarperCollins 4<sup>th</sup> Estate.

phenomena in neurological terms. My approach may also go against the grain of a long-standing tradition in behavioural neuroscience, which mandates that we should not talk about processes that we cannot see with our eyes. (Panksepp, 1998, p. x)

I am not going to attempt to summarize the 450 pages of his book: the author index alone runs into 16 pages, each with three columns. Let me just say that, as body psychotherapists, we would be totally foolish to ignore such a massive and significant piece of work, or leave it out of the essential reading list for any trainees. In a conference presentation,<sup>11</sup> Panksepp (2004) explored his fundamental position:

A guiding premise of the affective neuroscience approach is that various emotional feelings and other affective states reflect primitive states of consciousness that emerge substantially from the neurodynamics of brain circuits that control instinctual emotional behaviours in animal brains. (p. 14)

Another neuroscientist and presenter at that conference, Mark Solms, wrote:

My aim here is briefly to summarize the emotional affect aspects of various neuropsychological equations that can lead to psychiatric disturbances. ... It is often a relief for clients to learn that they have fundamental affect generating and mood regulating systems in the brain that can be overwhelmed. By blending the neuroscientific affective and psychological cognitive knowledge, we can achieve a more robust understanding than by either alone, leading to blended disciplines such as the robust emerging synthesis known as neuropsychanalysis. (Solms & Turnbull, 2002; p.16-17)

One different aspect of affect has been summarized by Teresa Brennan (2004) in *The Transmission of Affect*. Her theory is based on the premise that there is constant communication between individuals and their physical and social environments, and that we are sensitive to atmospheres, energies and others' emotional states. Whilst this is somewhat more in the realms of belief than pure science, some effects of this are being studied scientifically.

This nicely leads me into my next topic: the psychoanalysts (or, at least, some of them) seem to be beginning to integrate neuroscience and psychoanalysis better than some of us body psychotherapists. They also seem to be walking around on this diamond beach picking up precious stones for themselves. Cognitive neuroscientists (neuropsychologists and behavioral neurologists) are doing the same thing on a different part of the beach.

Other writers (Fonagy et al., 2002) attempt to develop these sorts of findings into a more scientifically-based sense of self – to a limited degree of success. This book is perhaps a little too obtuse and psychoanalytically-oriented, but they do promote:

... a comprehensive theory for the way in which the abilities to mentalize (make and use mental representations of your own and other people's emotional states) and affect regulate (control one's own emotions as is appropriate to environment) can determine a person's successful development.<sup>12</sup>

## Neuroscience and psychoanalysis

Mark Solms (Solms & Turnbull, 2002; Kaplan-Solms & Solms, 2000) is a leading force in the development of links between psychoanalysis and neuroscience. He is both a doctor (neurosurgeon) and a psychoanalyst, so also bridges the two fields, and has written many books and articles on how these two disciplines can be integrated. Psychoanalysis rests largely on the clinical method: the methods of neuroscience are more scientific. Yet there is a method, which started to combine the two: the method of clinico-anatomical correlation, which involves making clinical observations about mental changes in a patient, following from disease or damage to a particular part of their brain. The clinical observations of how the patient's mind changed are correlated with anatomical observations with the site of the lesion in the brain. This correlation teaches us something about what the mental functions were of the part of the brain now damaged.

Although this method of study has now been supplemented by many other methods, Broca & later Wernicke formally introduced it into early neuroscience in the 1860s & 1870s, with their neurological studies on aphasia. Charcot also championed it in his studies on hysteria and neurasthenia, which influenced Freud. Pierre Janet, the first real body psychotherapist, also studied with Charcot (Boadella, 1997; Young, 2009). One of the bases of Freud's early psychoanalysis was that:

... every mental process must **somehow** be represented as a physiological process that occurs in the tissues of the brain, but he also held to the view that it was an error to localize complex mental faculties within

<sup>11</sup> UKCP Professional Conference 2004, 'About A Body', Robinson College, Cambridge, (see also Corrigan et al., 2003).

<sup>12</sup> Review by Ed Tronick, World of Books: <http://world-of-books.com/?id=EDHi3N-ebkC>: downloaded 14/9/10.

circumscribed neurological “centres.” The reasoning behind this point of view was that mental processes are complex **dynamic** entities, which therefore cannot be correlated isomorphically as static centres with the individual structures of cerebral anatomy. He concluded, therefore, that it would not be possible to understand mental phenomena in neurological terms until (1) their dynamic psychological substructure had been laid bare and (2) until neuroscience was capable of identifying the physical correlates of such **complex dynamic** entities. Freud himself then devoted his scientific energies to the former (purely psychological) task and deferred the latter, correlative (neuropsychological) task to future investigators – anticipating future methodological advances. (Kaplan-Solms & Solms, 2000, p. 60)

It is perhaps a pity that Freud did not follow this latter pathway up with Reich’s work, and so we have had to wait 100 years or so. One of the fundamental problems was that the scientific information that Freud and others had to work with was very limited. Until the relatively recent developments in brain scans, there was no hard data on the physiological side: and that limited their – and everyone’s – way of thinking about research. However, from a quite self-referential and even promotional perspective:

Neuropsychology has begun in very recent years to grapple with something that it previously excluded: the problems of personality, complex emotions and motivation. This provides a unique opportunity for psychoanalysis to build a bridge to neuroscience, because psychoanalysis has a highly elaborated theory about these very aspects of mental life, which neuroscience is now starting to grapple with. I believe that psychoanalytic theories might be of particular help to neuroscientists who are beginning to tackle these problems of human subjectivity. I align myself in this respect with the most recent winner of the Nobel Prize in Medicine, Eric Kandel, who stated in an article entitled “A new intellectual framework for psychiatry” that this is the future of cognitive neuroscience. In order to grapple with this aspect of mental life, cognitive neuroscientists need to make a bridge to psychoanalysis, which still offers, in Kandel's words, “the most coherent and intellectually satisfying view” of personality, motivation and complex emotion (p. 105). There are enormous advantages both for neuroscience and psychoanalysis. If we can find links between our psychoanalytically derived concepts on how the mind works and the concepts of neuroscience, then we can open our theory to an entirely new range of methodological possibilities, for testing hypotheses that we had previously been content only to generate. The psychoanalytic method is very useful for generating hypotheses about how the mind works and for making inferences, but psychoanalysts have historically not been very good at testing their hypotheses. There is a limit beyond which the psychoanalytical method cannot go. By making links to the neurosciences, we create the possibility of testing some of our hypotheses in ways that might make it possible to move forward in what Freud called our metapsychology, our general theory of how the mind works. (Solms, 2002)

Another very respected neurobiologist, professor, and clinician, Eric Kandel (2005) has edited a good collection of essays that cover: the mechanisms of psychotherapy and medications, showing that both work at the same level of neural circuits and synapses, and the implications of neurobiological research for psychotherapy; the ability to detect functional changes in the brain after psychotherapy, which enables us, for the first time, to objectively evaluate the effects of psychotherapy on individual patients; the need for animal models of mental disorders (for example, learned fear) to show how molecules and cellular mechanisms for learning and memory can be combined in various ways to produce a range of adaptive and maladaptive behaviors; the unification of behavioral psychology, cognitive psychology, neuroscience, and molecular biology into the new science of the mind, charted in two seminal reports; the critical role of synapses and synaptic strength in both short- and long-term learning; and the biological and social implications of the mapping of the human genome for medicine in general and for psychiatry and mental health in particular.

From the other direction, as a psychoanalyst, the ultimate goal of the cognitive sciences is to understand how the brain works - how it turns matter into imagination. In a classic book, *Imagination and the Meaningful Brain*, Arnold Modell (2003) claims that subjective human experience must be included in any scientific explanation of how the mind works. His view, supported by people such as Jan Panksepp, Walter Freeman and Mark Solms, is that the construction of meaning is not the same as information processing.

The intrapsychic complexities of human psychology, as observed through introspection and empathic knowledge of other minds, must be added to the third-person perspective of cognitive psychology and neuroscience. ... (He) emphasizes evolutionary continuities and discontinuities of emotion. The limbic system, the emotional brain, is of ancient origin, but only humans have the capacity for generative imagination. By means of metaphor, we are able to interpret, displace, and transform our feelings. ... (He also) draws on a variety of disciplines, including

psychoanalysis, cognitive psychology, neurobiology, evolutionary biology, linguistics, philosophy of language, and philosophy of mind.<sup>13</sup>

However fascinating the studies in Depth Neuropsychology or Neuropsychoanalysis may be, one difficulty for many body psychotherapists is that the fundamental mind-body split is still very apparent, as these authors tend to consider what is happening in the brain; the other difficulty is that, since they often root themselves totally within the perspective of psychoanalysis, to be of any use therefore to other psychotherapists, another degree of translation has to happen. Still, it is sometimes worthwhile to do this and one can glean something from these parallel fields.

### Science is Changing

The paradigms of modern science are changing. Whilst much of neuroscience is within traditional science, new science is causing people to think very differently about how we think, how we view the world, and what are we really seeing. Books like Michael Talbot's (1996) *The Holographic Universe*, and the work of Stephen Hawking, Richard Feynman and others are introducing radical new ways of envisioning the universe and the world we live in.

Kelly et al. (2006) try to go beyond the reductive materialism that pervades much of modern psychological science and examine phenomena that are otherwise inexplicable or unable to be accounted for.<sup>14</sup> They base themselves on the perspective of F.W.H. Myers (founder of the Society for Psychical Research) and William James and their filter theory of mind/brain relationships, modifying A.N. Whitehead's "process philosophy." It is a good analysis of many of the problems of traditional science, but they haven't found an authentic solution – yet!

The Nobel prize nominee, Ervin Lazlo (2008), takes this whole area one step further and sees the world as being in a macro-shift: in that the reality we are experiencing today is substantively a new reality. So he tries to give us a map to view phenomena such as multiple universes, sub-atomic micro levels and the interconnectedness of all things. There are many other examples of the new forms of science, but most of these take us much too far away from the topic of this article.

### Neuroplasticity

Then comes the much more relevant concept of plasticity – that maybe, just maybe, people damaged by trauma or even physiologically damaged, can actually develop new structures and pathways in the brain – and that, once we left childhood and adolescence, our brain structures were not set in stone, but remained relatively plastic, and ways around, even quite significant areas of damage, could eventually be found; that re-learning and healing could perhaps really happen. This would give us a scientific foundation for what we already know as clinicians: fundamental change can actually happen.

In the classic book, *The Neuroscience of Psychotherapy*, by Louis Cozolino (2003), another scientist demonstrates how "linkages between the theoretical domains of the self and the social brain can deepen our understanding of various psychopathologies, including trauma and severe personality disorders." As a clinician, a professor of psychotherapy and neuropsychology, he has done for mainstream psychotherapy (psychodynamic, cognitive & behavioral), rather what I am attempting to do in a very small way in this article, but for body psychotherapy. But, he again falls into the mind-body separation a little bit:

The power of psychotherapy to change the brain rests in its ability to recognize and alter unintegrated or dysregulated neural networks. ... As knowledge of neural plasticity increases, so will our ability to impact and alter the brain. The possibility exists that sensitive periods can be reinstated in the context of psychotherapy, and that stress can be used in a controlled manner to reedit emotional memories. Although the practical applications of these principles to humans remains on the distant horizon, the possibilities of psychotherapy's involvement in brain sculpting are obvious. It is not too much of a stretch to say that psychotherapists are already enhancing plasticity without the help of genetic manipulation or chemical interventions. (Cozolino, 2003, p. 320)

He therefore argues that the brain is an organ of adaptation, built by interpersonal experiences and capable of change during one's life, which encourages us to consider the activity of the brain when attempting to understand others and indeed our selves; he demonstrates cases where a two-pronged therapy really makes sense and emphasizes how psychotherapy works, and how the brain works, and the dynamic relationship between the two. However great this book is, or whatever its limitations are, the 34 pages of references make up for a lot for the lack of recognition of what also is happening in the body.

<sup>13</sup> Extract from the "Product Description": downloaded 17/09/10 [http://www.amazon.co.uk/Imagination-Meaningful-Brain-Bradford-Books/dp/0262633434/ref=sr\\_1\\_3?ie=UTF8&s=books&qid=1284763944&sr=8-3](http://www.amazon.co.uk/Imagination-Meaningful-Brain-Bradford-Books/dp/0262633434/ref=sr_1_3?ie=UTF8&s=books&qid=1284763944&sr=8-3)

<sup>14</sup> There is a good review of this book by Ulrich Morhoff in *AntiMatters*, 2007, Vol 1, No 1, pp. 161-191: downloadable (16/09/10) from: [http://anti-matters.org/ojs/index.php?journal=am&page=article&op=view&path\[\]=12&path\[\]=12](http://anti-matters.org/ojs/index.php?journal=am&page=article&op=view&path[]=12&path[]=12)

Brain development has traditionally focused on early childhood. Recently, we have learned that the brain continues to develop throughout adulthood. Cozolino (2008) has also written a neuro-scientifically based account of how our brains age and change over time, in which he explains the social brain over time, emphasizing neural plasticity and growth, and giving some skills and strategies for maintaining and enhancing a healthy brain throughout our lives.

So, the brain is no longer being viewed as a machine that is hard-wired early in life, unable to adapt and destined to wear out with age. Instead, we learn that scientists are beginning to unlock the secrets of the powerful, lifelong adaptability - or plasticity - of the brain. The implications are enormous for treating neurological conditions, for addressing the aging process, and for dramatic improvements in human performance (Dojige, 2008).

Sharon Begley (2008) takes this one step further and even engages in a dialogue with the Dalai Lama. The issue under discussion was whether we can truly change or not; i.e. by changing your thoughts (belief system), can you make a lasting and fundamental change to your brain, your body, and your being? Neuro-plasticity supports the view that that this is possible. Begley isn't a neuroscientist, but she is the author of a science column for the *Wall Street Journal* and *Newsweek*, and as such, her science awareness, along with her Buddhist sympathies, provides useful support for the *raison d'être* of psychotherapy: long-lasting change. Tim Dunne, in a recent article, writes:

Another key finding to emerge from the research on the brain is the idea of “neural plasticity”. It used to be thought (and I was certainly taught this in my psychology training course back in the 1970s) that there were a finite number of neurons that we were given at birth, and that was it. From all the CT scans, SPECT analyses, fMRI scans, EEGs and PET scans, we now know that the brain is constantly adapting to new information, threats, challenges, excitement and feelings, and that new neural networks are created with each experience. (Dunne, 2009)

Another neuroscientist and colleague of Ramachandran, Blakeslee (2007) also explores neuro-plasticity in relation to the concept of body maps, which is very close to some body psychotherapy work:

... your many body maps represent all aspects of your bodily self, inside and out. In concert, they create your physical and emotional awareness and your sense of being a whole, feeling self in a larger social world. Moreover, your body maps are profoundly elastic. Your self doesn't begin and end with your physical body but extends into the space around you. This space morphs every time you put on or take off clothes, ride a bike, or wield a tool. When you drive a car, your personal body space grows to envelop it. ... The story of body maps goes even further, providing a fresh look at the causes of anorexia, bulimia, obsessive plastic surgery, and the notorious golfer's curse “the yips.” It lends insights into culture, language, music, parenting, emotions, chronic pain, and more.

## The Molecules of Emotion

As a contrast to the above, the work of Candace Pert (1997), almost totally incorporated in the one book with the above title, tends to be a little more inspirational to body psychotherapists. In an extremely personal account, Pert, a pure neuroscientist with impeccable credentials, discovered the opiate receptor, which led to the discovery of the natural substance in the body that uses that receptor, endorphin. A receptor is the part of the cell that recognizes and binds with a particular chemical neurotransmitter. Besides discovering the various receptors, there was a big debate as to whether there are receptors in cells in various parts of the body, as well as the brain, and vice versa, for all the variety of hormones and neurotransmitters.

There are a whole variety of hormones and neurotransmitters, formed from combinations of various proteins or polypeptides, made up of various combinations of the 20 different basic amino acids. These peptides are put together in particular pairs and chains and have many functions throughout the body. The peptides that interest us here are the neuropeptides: “*small protein-like molecules used by neurons to communicate with each other*” and they “*influence the activity of the brain in specific ways and are thus involved in particular brain functions, like analgesia, reward, food intake, learning and memory.*”<sup>15</sup> Some of the commonly known ones are: adrenaline, noradrenaline (norepinephrine), endorphin (enkephalin), oxytocin, insulin, prolactin, vasopressin, gastrin, etc.<sup>16</sup>

The significance of the work on neuropeptides, particularly for psychotherapists, is that this aspect of neuroscience includes – not just the activity in the brain, composed mainly of synaptic connections – but activity throughout the whole body. Pert was the first to really point this out.

Miles (Herkenham) has estimated that, counter to the collective wisdom of the neuropharmacologists and neuroscientists, less than 2 percent of neuronal communication actually occurs at the synapse. It was so radical an idea that for several years his observation of the mismatches was ignored and attributed to artifacts of the

<sup>15</sup> Wikipedia: Neuropeptides (<http://en.wikipedia.org/wiki/Neuropeptides>, accessed 20/07/09)

<sup>16</sup> For more technical information on peptides, see: [www.neuropeptides.nl/tabel\\_neuropeptides\\_linked.htm](http://www.neuropeptides.nl/tabel_neuropeptides_linked.htm)

mapping techniques. In fact, the way in which peptides circulate through the body, finding their target receptors in regions far more distant than had ever previously been thought possible, made the brain communication system resemble the endocrine system, whose hormones can travel the length and breadth of our bodies. The brain is like a bag of hormones! Our view of the brain, and the metaphors we used to describe it, were permanently altered. ...

Frances Schmitt ... introduced the terminology of “information substances” to describe a variety of transmitters, peptides, hormones, factors, and protein ligands. Alongside the conventional model of synaptic neuronal circuitry, Schmitt proposed a parasynaptic, or secondary parallel system, where chemical information substances travel the extracellular fluids circulating throughout the body to reach their specific target-cell receptors. ...

Neuropeptides could be found not only in the rows of nerve ganglia on either side of the spine, but in the end organs themselves. ... If we accept the idea that peptides and other informational substances are the biochemicals of emotion, their distribution in the body’s nerves has all kinds of significance, which Sigmund Freud, were he alive today, would gleefully point out as the molecular confirmation of his theories. The body is the unconscious mind! Repressed traumas caused by overwhelming emotion can be stored in a body part, thereafter affecting our ability to feel that part or even move it. The new work suggests there are almost infinite pathways for the conscious mind to access – and modify – the unconscious mind and the body, and also provides an explanation for a number of phenomena that the emotional theorists have been considering. (Pert, 1979, p. 139-141)

She continues to describe hot spots or nodal points : a variety of locations where there are high concentrations of peptide receptors and these are locations where information from any of the five senses enters the nervous system.

Emotions and bodily sensations are thus intricately intertwined, in a bidirectional network in which each can alter the other. Usually this process takes place at an unconscious level, but it can also surface into consciousness under certain conditions, or be brought into consciousness by intention. (Ibid, p. 142)

This is a cue for us, body psychotherapists, if we care to take up the challenge. We are constantly dealing with emotions that we claim are present in the body ; we now have scientific evidence that this is an actuality. Emotions are not just the result of processes of the limbic system in the brain: they are chemically and neurologically embodied.

## **Oxytocin and Touch**

Another very reputable neuroscientist, Kerstin Unvas-Moberg, describes the work that she has done in her laboratories, and with animals, with one of these neuropeptides, the hormone oxytocin (2003) on which she is the world authority and she has published over 400 papers. Oxytocin is a powerful hormone involved in bonding, sex, breast-feeding, and childbirth, as well as in relaxation and feelings of calm and love: it is not exclusive to females, though there are some strong connections to the production of estrogen, just as the hormone vasopressin is linked to testosterone, but is also found in females. To an extent, oxytocin is the mirror-image of adrenaline: it calms rather than triggers the fight or flight stress response. Moberg explores the potentially beneficial applications of oxytocin and how to trigger the natural production of this hormone (without having to have a baby), so as to reduce anxiety states, stress and addictions: would you believe that this can be done by a simple type of touch, especially to the ventral area of the body?

And is this not particularly relevant to our work as body psychotherapists? Thankfully, Kerstin Moberg, like several other neuroscientists mentioned here, is really interested in the practical and clinical application of her work, and has come to a couple of body psychotherapy conferences, where she was a delightful and very welcomed speaker.

One of the foremost scientific authorities on touch is Tiffany Field, director of the Touch Research Institutes at: the University of Paris; Philippines Medical Center; UCLA and the University of Miami School of Medicine. Up to 2003, they had conducted 93 separate studies on touch and touch therapies. Her relatively small book, *Touch*, has five chapters describing “recent research on the value of touch therapies for everyone, from asthmatics to autistic children, from cancer patients to those with eating disorder.” (Field, 2003, p. x)

Given the phobic reaction towards professional touch, or indeed almost any touch, that seems to exist in the Western world (and particularly in America), it is a remarkable body of research and should be included as compulsory reading in any body psychotherapy training course. I look forward to the next volume as the research continues and can only hope that it starts to involve body psychotherapy, as well as body therapies: that would be quite something! However important this area is, we have veered slightly away from neuroscience, though Field’s book is loaded with very scientific research studies.

## Infant Development

One of Field's collaborators in the Touch Research Institutes was Ed Tronick, a developmental and clinical psychologist, an associate professor of Pediatrics at Harvard Medical School and chief of the Child Developmental Unit at the Boston Children's Hospital:

[who is] recognized internationally for his work on the neurobehavioral and social emotional development of infants and young children, parenting in the U.S. and other cultures, and infant-parent mental health. Over the course of his career, Dr. Tronick has co-authored and authored more than 150 scientific papers and chapters. [He] developed the Still-face paradigm, which has become a standard experimental paradigm for studying social emotional development in the fields of pediatrics, psychiatry, clinical and child psychology, and nursing.

<sup>17</sup>

He focuses "*on the nature of how people live in the world and how they change both themselves and their relation to the world over moments, hours, days and years.*" (Tronick, 2007, p. 1) Tronick's main book on emotional development in infants is another standard text, I hope, and follows on from the classic earlier research on separation and attachment by Bowlby (1997, 1998 & 1998) on maternal deprivation.

John Bowlby was a British psychiatrist and psychoanalyst, notable for his interest in child development and for his pioneering work in attachment theory. His original publications on maternal deprivation date back to the 1950s; especially the damaging effects on the separation of mother and child (particularly in-hospital) emphasized that children's experiences of interpersonal relationships were crucial to their psychological development. This was reinforced by the classic animal laboratory work done in the 1960s with primates on maternal deprivation by Hinde and Harlow & Harlow. Yet, children are still separated from their parents, and we, as therapists, then have to cope with the psychological disturbances that result. These people are often our clients.

Daniel Stern (1985) described, in very coherent and meaningful ways, the subjective world of the infant, yet called his book *The Interpersonal World of the Infant*, as he recognized that the two-person interaction between the caretaker and the infant creates a matrix which nurtures the inner world and psychological development of the infant. Stern's conclusions shatter some of the misconceptions of early developmental theory based on the psychoanalysis of adults and adult behavior, but he still does not go quite far enough for body psychotherapists.

Another neuroscientist of interest in this field is Feinberg (2009), who asks what dementia, delusions and other neurological disorders can teach us, and about how the brain creates personal identity and a unified sense of self.

Sue Gerhardt (2004), not a neuroscientist but a psychotherapist, has also written an important book, based on a synthesis of neuro-scientific findings, *Why Love Matters: How affection shapes a baby's brain*. One reviewer writes, "*The author trades in the hard currency of neuroscience when describing how different kinds of parenting affect brain chemistry.*"

Gerhardt admirably describes the development of the social brain in the first years of life, that part which learns how to manage feelings, our immune response, and our neurotransmitter systems, as well as the development of a person's stress response, all of which affect our future emotional life. All of this is as much physiological as emotional. The second half of the book looks at the particular conditions such as anorexia, psychosomatic illnesses, addictions, antisocial behaviors, personality disorders and depression: all from the perspective of how poor parenting can affect our brain development. She nicely links many of the people already mentioned in this article, as well as some effective body-oriented perspectives, and concludes, in the Introduction:

Ironically, what has now been discovered by these scientific processes is that "feelings come first" as the poet e.e. cummings puts it, and that our rationality, which science from its inception prized so highly, is built on emotion and cannot exist without it. It is increasingly being recognized that cognitions depend on emotions, as Damasio has argued. As he points out, the rational part of the brain does not work on its own, but only at the same time as the basic regulatory and emotional parts of the brain ... The higher parts of the cortex cannot operate independently of the more primitive gut responses. Cognitive processes elaborate emotional processes, but could not exist without them. The brain constructs representations of internal bodily states, links them to other stored representations, and then signals back to the body in a process of internal feedback, which may then trigger off further bodily feelings in a cyclical process. (Gerhardt, 2004, pp. 5-6)

Ed Tronick has a fairly radical clinical perspective, has brought a lot of this research up-to-date, and has expanded on it. He explores infant neuro-behavior; the effects of culture; infant social-emotional reactions; natural and experimental perturbations; and the expansion of consciousness and meaning-making through dyadic infant-adult interactions; the infant capacity to self-regulate and self-organize; and the effects of disturbed interactions. Whilst being very scientific, his mutual recognition model (MRM):

<sup>17</sup> Retrieved on 21/07/09 from: [www.childrenshospital.org/cfapps/research/data\\_admin/Site440/mainpageS440P0.html](http://www.childrenshospital.org/cfapps/research/data_admin/Site440/mainpageS440P0.html)

... sees humans as complex systems, as hierarchical multileveled psychobiological systems that constantly work to gain energy and meaningful information to make sense of their place in the world. This sense-of-oneself in the world equals the totality of meanings, purposes, intentions and biological goals operating in every moment on every component and process at every level of the system from molecules to awareness. ... This totality of meanings can be characterized as a psychobiological state of consciousness. (Tronick, 2007, p. 2)

Tronick was one of the researchers who have explored the emotional capacities of infants and was able to show that babies can be remarkably pro-active in one-to-one communication and that they can also be profoundly affected by their parents' emotional states and behavior. He has filmed moment-by-moment interactions between depressed mothers and their babies for years and came to see depression as a communicable disease, transferred in a vicious cycle by a mother's communication to her baby and then back from the baby to the mother. To be able to see this, using split screen films, is truly eye-opening, especially for pediatricians and other clinicians.

Another researcher who collaborates with Ed Tronick, although he is also a clinician and has been (is) a body psychotherapist, is George Downing, who is involved in various research projects in mother and baby mental health units in Salpêtrière Hospital, Paris and the University of Heidelberg (Downing, 2008; Downing et al, 2008). He has also presented his work at several body psychotherapy conferences<sup>18</sup>, using split-screen video work, often slowed down, which he uses clinically with disturbed or disadvantaged mothers to demonstrate their affect motor schemas and disturbances, so that the mothers can start to correct these and form better contact with their children. It is fascinating to see this and is obviously very valuable preventative work.

The psychotherapy profession's attention to affect is becoming increasingly popular, though Downing says he now prefers to use the phrase "baby micro-practices" as he claims the baby develops these from birth in conjunction with its caregivers. There is a lot of material now about how important affect exchange is in the first year of life (Stern, 1987; Beebe & Lachman, 2002, and others). Beebe states that this is the "*origin of relatedness and patterns of nonverbal communication that continue to operate in similar form across the life span.*" But, in the 2<sup>nd</sup> year of life, something different happens (or should happen) and Ed Tronick claims to have worked much of this out.

An important new focus appears – if there has been sufficient back-and-forth, emotional affect exchange. If there hasn't, the child has already built-up strategic ways (body micro-practices) to defend itself from the lack of contact. The new developing focus is joint attention, where the baby wants the mother to respond to something it is holding or doing, so as to give the baby cues as to whether it is nice or nasty. This is the beginning of the child's interaction with the outside world, as mediated through the mother's attention and response. Joint attention leads to new developmental pathways, a capacity for action, the capacity to retain attention, and experiment, and the ability to create an action plan: this is often referred to as executive ability and it is linked to the baby's sense of itself in time.

This 2nd pathway is practical cooperation [and] collaboration. It is interpersonal, involv[ing] a minimum of two people, and involves coordinating [activities together] to complete a task. It is fascinating to see how infants vary in building this capacity to collaborate. It does not necessarily include or exclude emotional exchange .... Collaboration is accomplished independently of emotional competence. It can be done well by infants with an avoidant attachment style (with their physiological indicators sky high). ...

If the child does not receive support to build up collaborative ability, it will have serious consequences. At age 4, 5 & 6 the child will have trouble with [their] peers. He will be at risk for lots of trouble in school [over] tasks involving cooperation. If you look at what builds up in dyads [in] the 2<sup>nd</sup> year, you see that it is important for learning [how] to deal with anger, conflict, etc. One of the causes of these difficulties may be [a] lack of [neurological & experiential] channels of collaboration.<sup>19</sup>

This area of research is obviously not only crucial for treatment of the client, who may be having severe relationship or employment difficulties, but also for the nature and dynamic of the therapeutic relationship. Exploration of what is missing in the early dyad will begin to remedy both the individual's skills as well as exploring this in the context of the dyadic therapeutic relationship.

This work leads us directly into the next main area of neuroscience and research that can impact significantly on the field of body psychotherapy.

<sup>18</sup> EABP Conference 2007, Askov, Denmark; EABP & ISC Conference 2009, Paris.

<sup>19</sup> Taken from notes by Jacqueline Carleton, on the George Downing's plenary presentation: *The Development of the Infant*, at the 2008 EABP Paris Conference: *Body Awareness – Where Body Psychotherapy, Neuroscience and Traditional Healing Meet*, reported in EABP 2009 Summer Newsletter: accessible <http://www.eabp.org/pdf/summer2009.pdf> : accessed 22/07/09.

## Affect Regulation

The work of Allan Schore, and his 3 volumes on affect, affect regulation and dysfunctions, and human development, are massive and seminal (Schore, 1999; 2003a; 2003b). He is a clinician and eminent theoretical researcher and, as such, has ventured into, and impacted a number of fields: developmental psychology, psychopathology, psychiatry, neuroscience, psychoanalysis – and also body psychotherapy as he presented at the 2004 International Biosynthesis conference in Lisbon; it is a pity there is nothing published coming out of that conference, as the 3 volumes and numerous published papers are somewhat overwhelming.

The second and third volumes definitively show the breadth of his theoretical models and the practical import of his findings. If we take these at face value, we should all be involved in *“early prevention programmes that address infant care in the prenatal and postnatal periods – the periods in which the human brain exhibits the greatest degree of plasticity.”*<sup>20</sup> However, there is still a lot to learn from his work when working with adults. Perhaps more than anyone yet mentioned, Schore emphasizes the psycho-neuro-biological perspective: a technical way of saying the emotional mind-body perspective. What is of particular interest to body psychotherapists is that he states:

The current intense interest on affect in psychoanalysis and the related sciences emphasizes the critical role of somatic, bodily-based activities in adaptive self-functions during all stages of development. In an important article, Lieberman wrote that current models of development are almost exclusively focusing on cognition. She stated, “The baby’s body, with its pleasures and struggles, has largely been missing from this picture.”<sup>21</sup> Once again, information about the development and dynamic operations of the right hemisphere is critical to a deeper understanding of the evolution of the organismic substrate of the corporal/social/emotional self.

This hemisphere is pre-eminently concerned with the analysis of direct information received from the body. Somatosensory processing and the representation of visceral and somatic states, body sense, and painful sensation are all under primary control of the “non-dominant” hemisphere. Neuroimaging research reveals that two other bodily-based drives of intense interest to Freud, sex and aggression, are also under right hemispheric control. Other studies on conversion seizures and conversion hysteria (hysterical paralysis), an area of great interest to Freud, implicate right hemisphere structures in what are now termed somatization disorders. Right hemispheric operations are thus centrally involved in allowing the individual to emotionally react to and understand bodily stimuli, to identify a corporeal image of self and its relation to the environment, and to distinguish self from nonself.

...

These neurobiological data on affective structure-function relationships have implications for clinical psychoanalysis. In treatment models, affects, including unconscious affects, are both the centre of empathic communication” and the “primary data” and “the regulation of conscious and unconscious feelings is placed in the centre of the clinical stage”. In this work, as Sander stated, “It is not the past we seek but the logic of the patient’s own state regulating strategies. ... Current psychobiological studies indicate that affects are not merely by-products of cognition – they have unique temporal and physiological characteristics that, more than thoughts, define our internal experience of self. ... Furthermore, neurobiological studies demonstrate the involvement of the right hemisphere in “implicit learning”<sup>26</sup> and “nonverbal processes”. ... According to Emde, the therapeutic context mobilizes in the patient a biologically prepared positive developmental thrust. The findings that the prefrontal limbic cortex, more than any part of the cerebral cortex, retains the plastic capacities of early development<sup>26</sup> and that the right hemisphere cycles into growth phases throughout the lifespan allows for the possibility of changes in “mind and brain” in psychotherapy. Updated, psychobiologically oriented psychoanalytic treatment models may potentiate what Kandel, in a clarion call for a paradigm shift in psychiatry, describes as “biology and the possibility of a renaissance of psychoanalytic thought.” (Schore, 2003b, p. 259 & 262-5)

I apologize slightly for the length of this quote, however it is of extreme importance. In essence, what Schore is saying is that, since most affect happens in the right hemisphere, purely cognitive (left hemisphere) models and strategies are relatively ineffective, and therefore psychoanalysis (in particular) needs to consider much more bodily-based models and treatment. Maybe we, body psychotherapists, could also learn something as well, and indeed some of our colleagues in the San Francisco Bay area have formed a Schore study-group .

<sup>20</sup> From the cover of ‘Affect Dysregulation’ (Schore, 2003a)

<sup>21</sup> The numerous references in this extract have been omitted.

## Gene Research

On the other side of the Atlantic, Joachim Bauer is a physician and psychotherapist at the University of Freiburg, Germany. He is the author of the book, *The Memory of the Body*,<sup>22</sup> about the traces of interpersonal experiences in the body and its genes. He has also written two further books (also in German) about recent developments in neurobiology. In an interview,<sup>23</sup> he states:

... information that is laid down in the coding regions of our genes has an impact on many structural and metabolic aspects of our body. However, this is just half the truth. Genes consist not only of their so-called coding regions - the latter is that part of the DNA whose text is transcribed into RNA. [But] ... Every gene is under the command of a "gene switch." That is a regulatory sequence that in most cases is situated "upstream" of the coding region of the gene. The regulatory sequence determines to which extent the gene that is under its command is activated. "Gene switches," they are also designated as "promoter regions," consist also of DNA, however, they are not transcribed into RNA. Instead, they are the target for signal factors coming "from outside." Signals that act on "gene switches" are at the end of signal cascades that may start from different sources, both inside or outside the body. One of the most important sources of signals that regulate gene activity is the interpersonal experiences that we undergo in our personal environment. ...

In fact, interpersonal experiences that, to many people, seem to be immaterial, have been proven to exert pronounced biological effects, first on our brain, and then on our whole body. The continuous inflow of psychological experiences becomes converted into bio-electrical neuronal impulses and into the release of neurotransmitters. From there, cascades of signals are initiated that end in different parts of the body where they affect biological responses including the regulation of gene activity. ...

The "fine tuning," however, is not predetermined by such an endogenous program. When it comes to the "fine tuning," there is no contradiction between genes and environments, nor between "nature" and "nurture". "Genes" only make sense with respect to the way in which they respond to their environments, thus helping the organism to adapt. "Environments" only make sense with respect to the effects they have on our body, and that includes their effects on gene regulation. Therefore, the question, "to what extent" environmental factors determine biological parameters cannot be answered because the question is wrong.

This is pretty revolutionary stuff. In the interview with Elizabeth Marshall, a body psychotherapist, Bauer, firstly briefly dismisses the concept of Richard Dawkin's "selfish gene" as ideological science fiction, and then goes on to explain, much more interestingly, how motivation has a genetic origin and yet can be influenced by emotional exchanges:

The "Motivation systems" are networks of specialized nerve cells that have the capacity to synthesize and to release certain transmitters such as dopamine, endogenous opioid, and oxytocin. These transmitters, if acting in common, may create a psychological state that we call motivation, vitality or creativity. Dopamine gives us the feeling of energy; the opioids provide that we feel fine while doing something and oxytocin motivates us to do something for or together with people we like.

Obviously, people sometimes lack any motivation. In the case of depression, the system appears to be completely shut off. Therefore, after the importance of the motivation system for vitality was recognized, the question arose what signals were necessary to activate these neurobiological systems. Recent research could show that social acceptance and sympathy we receive from others is the main stimulus of the motivation systems. (Marshall, 2010)

This is how he feels that psychology can transform biology, and vice versa: it is an interactive process. The interview is concluded by an interesting discussion about mirror neurons.

## Mirror Neurons

Another interpersonally interactive component of biology that has recently been discovered is the existence of mirror neurons. Rizzolatti & Craighero (2004) published an article about mirror neurons, which mirror the activity, body position or stance of another animal or human. Mirror neurons are adjacent to motor neurons and they activate or fire. The pattern of firing

<sup>22</sup> In German: "Das Gedächtnis des Körpers".

<sup>23</sup> Scheduled for publication in the Journal of Body, Movement & Dance in Psychotherapy: Vol. 6, No. 1, Spring 2011.

in the observer mimics the exact pattern that the observer would use if he were doing that action. V.S. Ramachandran<sup>24</sup> believes they might be very important in imitation and language acquisition. Other scientists theorize that these are involved in the development of empathy. MRI studies led to suggestions that human language evolved from a gesture performance/understanding system implemented in mirror neurons.

Some researchers also speculate that mirror systems may simulate observed actions, and thus contribute to theory of mind skills. They may also be involved in developing a theory of mind, which refers to our ability to infer another person's mental state from their behavior and thus something of their experiences. In studies, apparently females exhibit stronger motor resonances than males.

## Proxemics

Michael Heller is a scientist, body psychotherapist and colleague. At the 2004 European Association for Body Psychotherapy conference in Marathon, he presented a very interesting talk on proxemics (Heller, 2004). He uses tools forged in the analysis of non-verbal communication to illuminate some dimensions of Beatrice Beebe's case description in order to show how an awareness of postural dynamics can sharpen one's perception of long-term individual development.

Proxemics and postural dynamics extend the concept of body language, to the positioning of the client's and therapist's chair in the room, and the flexibility of the dynamics between client and therapist, that can allow the client (and therapist) to move, walk around, change position, or engage in whatever form of emotional expression is needed.

Other scientists have studied these as well (amongst them: Trout & Rosenfeld, 1980; Heller, 1991; Blatner, 2009a & 2009b). This field bridges the gap between traditional psychotherapy (two people sitting facing each other in a room) and dance-movement (psycho)therapy, about which there is much modern research, and it also follows on from the whole concept of experiential, bodily-oriented learning that is so central to our philosophy in body psychotherapy. As I have mentioned previously, Dance Movement Psychotherapy, in one aspect, transcends the somewhat static (or even supine) position of body psychotherapy, but usually doesn't go deep enough into the person's physiology.

## Memory & Language

Much work in neuroscience has been done on memory; and perhaps this is more of interest to those more cognitively-oriented amongst body psychotherapists. Kandel (2007), a Nobel prize winner, explores (very personally) some of his work in understanding learning and memory. LeDoux (2003) also explores this area of science, and in addition, one of the seminal books in this field is Gazzinga's *Cognitive Neuroscience* (Gazzinga et al., 1998), which takes a highly interdisciplinary approach to the topic and the neuroscience and neuropsychological evidence.

Other interesting works on memory include Baddeley's classic work on working memory (Baddeley, 1995; Baddeley et al., 2009); a good overview in an internet article, *The Cognitive Neuroscience of Memory*<sup>25</sup> from the prestigious University of Cambridge Inference group; Craver's work (2002) on the multi-level mechanisms of memory; and a wikibook article on Cognitive Neuroscience and Memory, explaining the different types of memory.<sup>26</sup>

Of similar interest may be Harley's (2007) *The Psychology of Language*, which is an especially good textbook on psycholinguistics and language development.

## Other research findings

Greenfield (2000) presents the basics of contemporary thought on consciousness as they relate to her own theory, which involves a continuum of experience between sensual, emotional grounding in the surrounding world and rational, cognitive withdrawal into mental life. Arguing from a wide range of animal and human research, and drawing on the work of philosophers John Searle and Daniel Dennett, she makes her case compellingly but gently, granting that other theories might also hold in this still-uncharted territory. Looking in depth at depression, drug use, and fear, Greenfield shows how each is explained by her continuum theory and how each relates to the life of the human organism as a whole.<sup>27</sup>

There is more and more of this sort of compilation.

Hass-Cohen & Carr (2009) give an account of the latest developments in neuroscience and its impact on art therapy. They explore the complex relationship between art and creativity and neurological functions such as stress response, immune functioning, child developmental phases, gender difference, the processing of imagery, attachment, and trauma. Maybe we can learn from some of this.

<sup>24</sup> Retrieved on 22/07/09 from: [http://www.edge.org/3rd\\_culture/ramachandran/ramachandran\\_p1.html](http://www.edge.org/3rd_culture/ramachandran/ramachandran_p1.html).

<sup>25</sup> Downloaded 17/09/10: <http://www.inference.phy.cam.ac.uk/jmb86/memory.pdf>.

<sup>26</sup> Downloaded 15/9/10: [http://en.wikibooks.org/wiki/Cognitive\\_Psychology\\_and\\_Cognitive\\_Neuroscience/Memory](http://en.wikibooks.org/wiki/Cognitive_Psychology_and_Cognitive_Neuroscience/Memory)

<sup>27</sup> Extract from Rob Lightner, Amazon.com review: [http://www.amazon.com/Private-Life-Brain-Emotions-Consciousness/dp/0471399752/ref=sr\\_1\\_1?ie=UTF8&s=books&qid=1295389987&sr=8-1](http://www.amazon.com/Private-Life-Brain-Emotions-Consciousness/dp/0471399752/ref=sr_1_1?ie=UTF8&s=books&qid=1295389987&sr=8-1): downloaded 15/9/10.

There is also much more work around, if you look: for example, Deborah Harkin is applying neuroscience findings to clinical work with adolescents (Harkin, 2009, 2010), and Janet Treasure (and others) are applying neuroscience to treating people with eating disorders (Treasure et al., 2005); Ernest Rossi's (1989) classic book, *The Psychobiology of Mind-Body Healing*, has some very interesting perspectives on the ANS, the endocrine system and the immune system, and also on the plasticity of the brain; Rossi has also produced a book on *The New Neuroscience Of Psychotherapy, Therapeutic Hypnosis & Rehabilitation: A Creative Dialogue With Our Genes* (Rossi & Rossi, 2008) that goes into several of the points of areas mentioned in this article; there is a whole (new) field of psycho-neuro-immunology (PNI) that studies the interaction between psychological processes and the nervous and immune systems of the body (interestingly, this is an interdisciplinary approach that incorporates psychology, neuroscience, immunology, physiology, pharmacology, molecular biology, psychiatry, behavioral medicine, infectious diseases, endocrinology, and rheumatology); there are some very interesting overlaps between brain activity with the field of social psychology and social neuroscience, summarized by Harmon-Jones & Winkelman (2007); Roz Carroll writes on neuroscience and psychotherapy with reference to the impact of the human face and aspects of love (Carroll, 2005); Colwyn Trevarthen is doing lots of research on communication between mothers and babies, as well as infant intersubjectivity (Trevarthen & Aitkin, 2001); there is a useful "Somatics Therapy Research Guide" on the CIIS website<sup>28</sup>, that gives pointers to find out more; other body-oriented therapies (like craniosacral therapy<sup>29</sup>) are also investigating relevant neuroscience findings; and the forthcoming, massive English-American edition of the *Handbook of Body Psychotherapy*<sup>30</sup> has several chapters that relate many neuroscience findings that are significant to body psychotherapy. I could go on and on: enough already.

## Conclusion

We are fortunate in that many of these distinguished neuroscientists have come and presented their work at various Body Psychotherapy conferences. These people include Damasio, and Allan Schore, Steven Porges, Ed Tronick, Jan Panksepp, George Downing, Kerstin Unvas-Moberg, Bessel van der Kolk, and several others. Many of these people are not body psychotherapists, instead they are respected scientists and researchers in their own fields, but their work impacts on, informs, and can be central to our understanding of body psychotherapy and to what is happening within the psycho-neuro-biological dynamics of our patients and clients – and what has happened to them (the social dynamics) – and thus to our work, as clinicians, as they can try to help us and we try to help them with their resulting difficulties.

There are, of course, many, many other studies in neuroscience, and many of these may also have great importance for body psychotherapy. I have just indicated a small sample of studies that have been of interest to some of my body psychotherapist colleagues, or from those who have presented at body psychotherapy conferences, or who have caught my interest, as I have trolled my very individual way through this increasingly complex field. So, please believe that this is not a comprehensive survey of the field of neuroscience; it is a snap-shot, a soupçon, a taster of this new and impressive field. I am going to leave it up to you to delve further and to relate what you discover as being relevant to our work as body psychotherapists: hopefully the subject of many of your future articles.

However, useful – essential – as all this neuroscience stuff is, I further contend that we – within body psychotherapy – must also start to do some of the basic scientific research that directly pertains to our clinical work. I wrote about this need in the previous section of these series (Young, 2010 a), so I don't want to become too polemic and strident and repeat myself endlessly. However, I will continue to try to persuade the various professional body psychotherapy associations to organize properly structured effectiveness studies (see Seligman, 1998), as well as making contact with universities to try to collaborate on some duly considered efficacy studies for single conditions. I hope that you too will assist the science of body psychotherapy in this direction.

So, we must all find ways to apply – to use – these precious diamonds – all this new and wonderful research coming from neuroscience, and we must also find ways to demonstrate the findings of the neuroscientists in our own clinical work. It is a both ... and situation. As we begin to do our own research, we may even be able to inform neuroscience about aspects that they are not aware of, as they are not clinicians, in contact with the deeper aspects of the clients' psyche and soma. As clinicians, we need to be dictating what we need to have researched, rather than just picking up the crumbs of other people's research.

So, having made what I hope has been a useful survey of this topic, and the research in this field,<sup>31</sup> in this series of four articles on "The Science of Body Psychotherapy Today", I now leave it up to you.

<sup>28</sup> Retrieved 15/9/10: [http://library.ciis.edu/resources/subject/somatic\\_psychology.asp](http://library.ciis.edu/resources/subject/somatic_psychology.asp)

<sup>29</sup> Retrieved 15/9/10: <http://www.hummingbird-one.co.uk/craniosacral/links01.html>

<sup>30</sup> German edition: Marlock, G. & Weiss, H. (2006) *Handbuch der Körperpsychotherapie*. Stuttgart: Schattauer.

<sup>31</sup> I am deeply indebted to Jacqueline A. Carleton for the use of her personal 'Library List' in the field of Neuroscience. She supplied the references to a substantive portion of this article and is thus also (indirectly) somewhat responsible for its extended length.

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#### Biography

**Courtenay Young** originally trained in Body Psychotherapy about 30 years ago. He currently works as a counselor and psychotherapist in the NHS in and around Edinburgh, Scotland, as well as having a private practice. He co-edits both the *International Journal of Psychotherapy*, and the *Journal of Body, Movement and Dance in Psychotherapy*. He has completed a first book: "Help Yourself Towards Mental Health" (Karnac, 2010); his second book "First Contacts with People in Crisis and Spiritual Emergencies" will be published next month (Feb 2011) by AuthorHouse Books; and he has also started to edit the English-American edition of the massive "Handbook of Body Psychotherapy" (edited by Gustl Marlock & Halko Weiss: published in German, 2006, by Schattauer). E-mail contact: [courtenay@courtenay-young.com](mailto:courtenay@courtenay-young.com)

# Whole Brain Integration in the Clinical application of Somatic Experiencing

C. Anya Hricko

## Abstract

Traditionally neuroscience research has been influenced by researchers with left hemisphere bias. Drawing from current affective neuroscience we can begin to understand how the brain processes emotion. The importance of right hemisphere communication in a clinical context is reviewed as a way to foster attunement and nervous system regulation. Effective touch and containment in the practice of Somatic Experiencing (SE) derives from the right brain literacy of the practitioner in sensing tissue, creating a resonant container and encouraging coherence. Beneficial right hemisphere skills can be cultivated with mindfulness and awareness based practices. Ultimately, the most benefit can be achieved clinically by utilizing both sides of the brain to further integration and resolution.

## Keyword

Neuroscience – Trauma – Somatic Experiencing – Nervous system regulation - Embodiment

## Whole Brain Integration in the Clinical Application of Somatic Experiencing

Panksepp (1998, 2001) contends that in order for neuroscience to progress, it needs to go beyond behavioral and cognitive approaches and deal with the “relatively invisible neurodynamic underbelly of the mind addressed through the domain of affective neuroscience” (Panksepp, 2001, p. 3). His contention that neuroscience research has traditionally been biased by researchers strong in left hemisphere skills and weak in right hemisphere skills warrants serious consideration. The need for validation and empirically based research has kept our understanding of emotional terrain confusing regarding deep affective states, given our inability to manipulate or measure the neuronal activity associated with internal feelings. In addition, consensus regarding empirical observation was not possible before developing an ability to observe the neural activity accompanying emotions. Panksepp argues that this limitation has contributed to a longstanding conservative approach in behavioral psychology research and has kept the field intellectually sterile.

## The Importance of Right Brain Communication in Clinical Practice

An affective revolution in contemporary neuroscience has produced much research supporting increased understanding in the biology of emotions. In particular, much is now known about the importance of early experiences on brain development. According to Schore (2003) our brains learn how to organize our experiences through relationship with another brain. Schore speaks to the importance of resonant affective communication on the development of the right brain for modulating emotions, coping with stress, and processing social, emotional and bodily input.

Research has demonstrated that it is the right hemisphere, not the left hemisphere that processes unconscious emotions and contributes to emotion regulation (Schore, 2003). Siegel (2001) suggests that attuned communication through right brain to right brain resonance and non-verbal communication between mother and infant in the early years has a significant impact on the infant’s developing mental integration and subsequent ability to emotionally self-regulate.

Moreover, van der Kolk (2001), in addressing the importance of understanding bodily perceptions and awareness as the foundation for self-regulation, stresses a critical need in trauma resolution to be “in touch” with oneself, able to identify and tolerate uncomfortable or distressing sensations, feelings and experiences (p. 17). In addition, he proposes that in order to heal trauma, individuals need to know that it is safe to experience emotions and sensations. In trauma or memory recall, there is an experience that time freezes, while emotions and sensations are in constant flux. Using mindfulness practices clients can learn to increase their tolerance for distressing internal sensations and begin to consciously notice as sensations shift; as they gradually subside, clients begin to differentiate between emotions and sensations. Present, focused awareness helps to create distance from prior, overwhelming experiences, reorient to the now, and open awareness to non-traumatic experiences.

Neuro-imaging studies of people with post traumatic stress disorder (PTSD) show decreased activation of the medial prefrontal cortex, a region of the brain associated with the integration of emotion and cognition that contributes to arousal dysregulation (Shin et al., 2001). According to van der Kolk, (2006) increasing the client’s ability to focus on internal sensations can activate the prefrontal cortex and enhance emotional, cognitive, and sensory motor integration of past trauma. Van der Kolk (2006) concluded that therapy for PTSD is most effective when it involves self-awareness, self-regulation, the ability to orient to the present, and explores new ways to engage with the environment.

Furthermore, Schore (2003) stresses the need for right hemisphere to right hemisphere communication between the patient and the therapist in order to effectively alter the brain and assist with affect regulation. Howes (2000, as cited in Wilkinson, 2003) agrees, suggesting that the therapist must remain “right brain limbic” to achieve the empathy necessary to communicate with the patient’s emotional brain (p. 248).

Porges's (2001) polyvagal theory further elucidates how the brain operates and provides a new perspective for furthering nervous system regulation and activation of right hemisphere communication. He proposes that there is an evolutionary hierarchical design of autonomic nervous system regulation. Rather than the previously accepted two reciprocal systems (sympathetic and parasympathetic) he delineates three sequential systems. The oldest system, dorsal vagal, is part of the parasympathetic nervous system and is associated with the immobility response in trauma. Next, the sympathetic nervous system relates to fight and flight response. Third, the ventral vagal system is unique to mammals and fosters social engagement. In the polyvagal theory of the autonomic nervous system, survival strategies will attempt a response from the more sophisticated ventral vagal system first, then sympathetic arousal will engage, and if that fails to work, the dorsal vagal immobility response is the last resort.

Porges' theory (as cited in Dykema, 2006) gives us an understanding of the unconscious motivations of the nervous system, offering more options to mediate reactions. Through the social engagement system (ventral vagal), clients can be helped to feel safer and calm hyperarousal through eye contact, voice modulation, and facial expressions. Porges notes that triggering the social engagement system turns off stress responses; it is self soothing, calming, and more metabolically efficient (p. 7).

### **Working with Right Hemisphere Skills in Somatic Experiencing**

When working with the non-verbal right hemisphere where emotion and sensation are processed, clinicians must be literate in accessing and tracking bodily and affective material. Siegel (2001) proposes that enhancing the innate tendency of the mind to move towards integration within the brain and through positive interpersonal relationships can enhance the capacity to achieve integration and self-regulation. Deep attunement between therapist and client is an essential aspect of the therapeutic relationship that makes change possible. For a therapist to be an effective conduit for transformation, it is important to create a resonant state internally that can help the client move toward healing. Empathic relationships, according to Siegel (2007), involve a connection with ISO [the internal state of the other] and NOTO [narrative of the other] (p. 290).

In Somatic Experiencing (SE), a body-based trauma resolution therapy, attuned communication is particularly important because SE speaks the language of the body using felt sense to track and integrate traumatic experiences and incomplete responses thwarted during traumatic events (Levine, 1997). In order to assist a client in tracking sensation, the therapist needs to be attuned to the client's subtle body signals. Such attunement involves empathic emotional connection and *somatic resonance* which is best described as empathic resonance that occurs body to body and includes the energetic inter-subjective space between client and therapist (Shaw, 2003). The therapist can use his or her own body to perceive shifts in energetic and somatic information. For example, when working with a client, it is helpful to mindfully pay attention to one's body. This mindfulness allows for a deeper level of self-care and regulation, as well as enhancing the ability to notice important shifts occurring with the client through somatic resonance. For example, the felt experience of the client may be mirrored in what the therapist senses somatically through her own body. Without assuming that her feelings or sensations belong to the client, she can invite further exploration by inquiring about the client's experience in the moment. Often this somatic resonance opens the door to deeper levels of attunement and information not available through language alone.

In addition, being in attunement allows the therapist to be more aware of any somatic countertransference. An example might be feeling tightening in the chest and shallowness in the breath as the client's nervous system becomes activated. Through self-reflection and awareness, the therapist has the opportunity to self-regulate and stay present with the client. In this way, she can act as an external regulator for the client, affording time for the client to become more adept at auto-regulation. If the therapist were to experience the same sensation without conscious, right brain awareness, she might instead come from a left brain perspective and move into analysis of what was happening with the client, ignore her own process, and essentially move the client's process in another direction. Steering away from somatic regulation into content might then be perceived somatically by the client as a disconnect from the therapist as they collude in discounting the non-verbal signals. At worst, such a scenario could be re-traumatizing for the client, as trauma is often experienced in the non-verbal areas of the brain; at best, it would not be useful in assisting the client to move toward affect-regulation and tolerance of sensations: functions that live in the body and are modulated by the right hemisphere.

Right hemisphere skills are essential in working with touch and containment in SE and other somatic based practices. The clinical application of touch in SE can profoundly affect nervous system regulation at times when language alone is inadequate. Touch is most appropriately used to address deep shock states held in the body and restore equilibrium in long-held physical patterns due to trauma. The practitioners hands act as a "gentle organizing force" (SE training manual, 2007, p. A 2.6), increasing capacity for containment: the overall ability to tolerate and manage intense experiences without losing stability. Through resonant touch the therapist can more directly communicate with the nervous system encouraging coherence, and re-establishing communication within the systems of the body.

In working with touch, it is important for the therapist to be conscious and aware of what she is bringing to this subtle level of communication. If she touches the client without awareness, this can inadvertently recapitulate earlier trauma. Sensitive attunement and ability to perceive somatic feedback allows the therapist to titrate (going slowly, little by little) the level of arousal, perceive shifts as the tissue constricts or expands, and provide a resonant container for furthering regulation and coherence.

Through touch we can have a more direct experience of the unfolding of the healing process and offer the client a more direct experience of what it feels like to bring attention and awareness into the body in a safe and contained way. Furthermore, the stability created by clear, present touch can assist the client to stay with an experience and learn how to modulate affect without going into an overwhelmed state or experiencing hyper-arousal of the nervous system.

As a Somatic Experiencing practitioner, I have observed the profound benefits of using conscious touch to establish a greater sense of coherence in the body and mind. Tracking the breath and paying attention to how each part of the body is responding to the gentle pulsation of the breath while working with touch is a good indicator of nervous system regulation. It is useful to track the relation of coherence through the tissue with reflections of coherence through the breath, and the rest of the body. For example, a well-regulated system will have the ability to expand and contract in a wave-like motion in response to the movement of the breath. Conversely, when the breath is rapid or constricted, tissues are braced or slack and there is a disruption in the way the breath moves throughout the body, an indication of nervous system dysregulation or activation (SE training manual, 2007). As the nervous system becomes more balanced and coherence returns there is a notable difference in the breath. The breath becomes slow and deep, spreads throughout the body creating a sense of connection and resonance between body areas. A synchrony between breath, muscle, and blood volume re-emerges as coherence re-establishes. As the system opens, it allows for more movement, re-organization and communication among body systems (Heller, 2006).

In order to perceive the language of sensation, it is essential for therapists to be right brain literate, somatically aware, and embodied. As a somatic educator, I have taught somatic awareness skills to many massage therapists and somatic therapists/practitioners. Most of the challenges presented were directly related to the therapists' ability to access right brain skills and stay present in their bodies as they worked with clients. Issues that emerged ranged from occupational injury from poor body mechanics to somatic countertransference issues that presented as accumulating and unprocessed somatic stress and vicarious trauma. When practitioners were able to directly sense their bodies through felt sensation, they were able to make necessary adjustments, discharge activation, and become clearer vehicles for attunement and healing.

### **Strengthening and Integrating Right Hemisphere Skills with Left Hemisphere Processes in Clinical Practice**

Right hemisphere communication in the therapeutic relationship is of immense importance, but it would be imprudent to discount the importance of left hemisphere communication for integration. Siegel (2007) reminds us that narrative integration involves the circuitry of the left hemisphere that helps us “sort, sequence and select neural maps to weave a story” (p. 309), helping us to more deeply understand our past, and create integration and meaning for a healing present. Wilkinson (2003) suggests that right hemisphere communication between therapist and client is an essential precursor to the left hemisphere integration which is needed to fully process traumatic experiences.

Likewise, van der Kolk (2001) asserts that an important task of therapy involves integrating the right hemisphere capacity for awareness of the body and sensation along with the left hemisphere ability to use language and symbolic representations. In this way, making more meaning out of experience and uncoupling physical sensations from emotional responses ameliorates the intense affects of past trauma.

In SE, greater integration comes with working all levels: (SE training manual in Foundation for Human Enrichment, 2007) sensation, image, behavior, affect and meaning. As SE practitioners, we are working to integrate left and right hemisphere processes. As already mentioned, being able to sense the body and provide a somatic resonant containment for the client to learn auto-regulation, involves the ability to be mindful. Mindfulness based practices can be very useful for facilitating increased right hemisphere literacy for left hemisphere dominant clinicians.

Fisher (2004), a body centered psychotherapist, cites the effectiveness of mindfulness in the practice of psychotherapy, proposing that for therapists to help clients achieve greater mindfulness, therapists need to first tune in and slow down themselves. For SE practitioners to help their clients self-regulate, it is very useful to regulate their own nervous system first. In this way, they can be a more effective conduit for somatic resonance and neural integration, as well as use their present awareness to more aptly perceive what is happening in a session.

Some of the tools Fisher (2004) proposes to assist the therapist in working with the experience of the present moment are those commonly used in SE. One of these tools is “tracking” (p.1). Fisher suggests that much of what happens in therapy sessions occurs in the non-verbal realm, and that using “tracking” to orient to the present moment increases the therapist's ability to perceive the subtleties of non-verbal communication and the inner states of their clients. This is especially true in SE when working with non-verbal touch and containment.

Siegel (2007) also advocates the practice of mindfulness in therapy. He provides not only an overview of how neuroscience can be integrated into our lives and practice but also valuable tools to shift our focus into present time, establishing a base of awareness that can bring more balance and internal integration. Skills such as these are particularly useful in developing right hemisphere strengths for clinicians to enhance attunement, coherence, and neural regulation.

Siegel (2007) maintains that when we are living on automatic pilot we are not fully engaging in our lives. In addition, we are more prone to what Siegel refers to as “top-down” constraints (p. 134). Top-down processes involve the way in which the neocortex embodies previous learning experiences which include autobiographical memories, beliefs, and mental models. In turn, these processes set up neuron circuitry with large-scale neuronal firing patterns that involve limbic, parietal and frontal regions. These habituated brain states interfere with our perceptions, thus adversely influencing our experience of the present

moment. They may often cause us to generate judgments about ourselves and others, and elicit a set of inflexible or inappropriate feelings that become immutable and overbearing. Mindfulness allows us to break free from the influence of these ingrained patterns and access what Siegel refers to as “bottom-up” (p.137) processes: our more primary, basic sensory experiences, and core self experiences.

The perspective of top-down and bottom-up processes is applicable to SE as trauma resolution involves processing of bottom-up experiences with top-down regulation. Ogden and Minton (2000) describe the interplay between top-down and bottom-up processes in the treatment of trauma, as conscious top-down regulation can be used to support bottom-up experience, together creating better regulation and integration. This is analogous to using right hemisphere capacity to access sensory experience in conjunction with left hemisphere capacity for shifting meaning and beliefs.

My own development in my practice as a clinician has been further enhanced through Porges’s (2001) polyvagal perspective. I have found it useful to bring my left hemisphere understanding of the polyvagal hierarchy to bear on better comprehending where a client is in their process (fight, flight, freeze, or social engagement). This perspective has thus complemented and enhanced my right hemisphere skills to engage and modulate affect.

According to Heller (2006), effective interventions re-establish the client’s ability to engage different aspects of the nervous system and higher functions of the brain in resolving and integrating unresolved trauma. Tracking the dominant system of a client is useful in guiding interventions. Parasympathetic nervous system (PNS) dominance often presents with symptoms of dizziness, nausea, and/or digestive disturbances. Since parasympathetic nervous system (PNS) response is about immobilization to conserve oxygen, the client may also be disconnected or dissociated with hypertonic muscle tone and low affect. Engaging mobility by accessing the sympathetic nervous system (SNS) can release the shut-down and assist the client to complete defensive responses thwarted at the time of trauma. As one comes out of chronic PNS they may go through a SNS response.

A client with SNS dominance may present with symptoms such as rapid speech, hypervigilance, agitation, rage, and hypertonic muscle activation, such as a tight jaw (Heller, 2006). Shields (2004) suggests that chronic jaw tightness creates additional emotional agitation and can kindle a stress response which keeps the SNS fired up.

As a client works through the trauma in a session, he/she will ideally shift from predominantly PNS or SNS to the more evolved ventral vagal system, re-establishing the capacity for social engagement. Parker (2004) emphasizes the importance of noting what part of the nervous system is active at the end of a session. She proposes that effective therapy requires moving the client back up the scale towards higher adaptations of the nervous system, engaging ventral vagal and the social engagement system (SES).

By tracking the different systems with a client, the therapist can assess how trauma resolution is progressing. When a client begins to engage socially, it is a sign that he/she is moving up the autonomic nervous system hierarchy. Therapists can also initiate social engagement to help modulate nervous system activation and assist the client towards nervous system regulation and integration. However, Porges (as cited in Dykema, 2006) stresses that engagement is not possible without a sense of safety. Understanding relevant physiological underpinnings allows the therapist to work more effectively with the client’s nervous system to facilitate regulation rather than forcing an interaction that could be counterproductive.

In conclusion, as a predominately right brain individual, I’ve observed that learning how to engage left brain skills has created a shift in my practice that would best be described as finding the marriage between my acute sensitivity and empathic nature, and my more linear analytical skills. This has allowed me to access specific techniques that then inform how I sequence through a session. In my case, strengthening left hemisphere skills grounded what I intuitively knew. In addition, having more range allowed me to communicate better with clients, meeting them where they were, while assisting them toward more effective self-regulation skills. Furthermore, although it is essential to develop and utilize right hemisphere skills in working with the body and in SE in general, it is also important to bring a balance of both left and right hemisphere communication to clinical work. It is the opinion of this researcher that clinical practice is ultimately most effective when practitioners are flexible, adapt to the flow of changes, and harness the strengths of both sides of their brain.

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#### Biography

**C. Anya Hricko, MA, SEP** has a broad range of experience in the somatic traditions. She is certified as a Somatic Experiencing Practitioner and Somatic Movement Therapist with extensive training in Integrative Bodywork, Process Work, and Body-Centered Coaching. She is currently a 4<sup>th</sup> year doctoral student at the Santa Barbara Graduate Institute where she is pursuing a clinical degree in Somatic Psychology. She is passionate about integrating neurobiological research and somatic approaches into trauma therapy and influencing conventional therapy to embrace the body. She trains therapists and somatic practitioners in embodiment skills, somatic interventions, and whole brain integration. She lives in Massachusetts where she teaches, writes and maintains a private practice specializing in Somatic Psychotherapy, trauma resolution, and Body-Centered Coaching. She can be reached at: [somawisdom@comcast.net](mailto:somawisdom@comcast.net).

# Viva Las Vagus! The Innervation of Embodied Clinical Intuition

Jennifer Frank Tantia, MS, BC-DMT, LCAT

## Abstract

Often called the “sixth sense,” “gut feeling” or “other way of knowing,” intuition is a phenomenon of the human condition that is frequently acknowledged but seldom explained. The body is said to house unconscious awareness that is not processed in language (Aposhyan, 2004; Levine, 1997) Body psychotherapists are the chief advocates and teachers who use non-conscious awareness, or “felt-sense” (Gendlin, 1981) as a source for knowledge and truth in healing. In embodied psychotherapeutic practice, it is quite possible that the direct experience of embodiment is evocative of the immediate and non-verbal “feeling” or “sense” of intuition. This theoretical article suggests that the interface between embodiment and intuition happens through metaphors, particularly of the “heart” and “gut” that correlate with the physiology of the vagus nerve.

## Keywords

Intuition – Embodiment – Body psychotherapy – Vagus nerve – Somatic Psychotherapy

*“Whatever dimension of the outer world one considers, it is through the body that one experiences it, and it is through the body that one distorts it to make it more comprehensible” (Dreyfus & Feinstein, 1977, p. 108).*

*As a dance/movement therapist and body psychotherapist, I have often found myself speaking with a client and suddenly seeing their eyes bulging from their heads while exclaiming, “How did you know that?” This happened often and although I felt as stunned as they, I had eventually managed to maintain the therapeutic context of integrity and honesty by simply responding, “I don’t know.” To my surprise, this has always proved to be an acceptable response to my client, yet I would continue wondering to myself **how** I knew information that was not overtly offered. The following vignette describes a situation in which intuition itself provided me with some answers to my question.*

*As a psychology intern at a day treatment program for individuals with HIV/AIDS, I led a weekly group entitled, “Body, Mind and Addiction.” The group consisted of twelve men, ages ranging from 35-65, with varying addictions from heroin to sex, and at varying levels of recovery. Physical complications from HIV were conflicting with their addictions, and in addition to finding themselves socio-economically-challenged, they were also coming to terms with the fact that using drugs was simply “not fun” anymore. This shift in attention forced them to take a keen interest in their health, both physically and mentally. As a result, their insights and supportive interactions created a beautiful healing environment in our weekly “Body, Mind and Addiction” group.*

*At the beginning of a particular session, I noticed an unusually high level of energy; the group members were laughing, talking loudly and pushing each other playfully as they entered the room. I decided to wait for the excitement to wind down before beginning the session. However, the rowdiness continued and the men proceeded to talk and laugh. Instantly and to my surprise I found myself doing something very “un-therapist-like.” I stood up and, elevating my voice over theirs, yelled, “You know...you make decisions based on four areas of your body...your HEAD, your HEART, your GUT, and your GENITALS!”*

*Silence immediately permeated the room. Stunned at my own spontaneity, and their resonance with it, I barely spoke a word for the next forty-five minutes as I witnessed the group members unwrap the ways in which they make decisions in their lives based on the four areas that I had cried out just moments before. The clients used the four areas: head, heart, gut, and genitals to describe metaphorically how those places represented different ways of connecting with others; how they can be dormant or over-used; how the four areas were sometimes in conflict within their experiences (for example, heart and genitals in romantic relationships). They also discussed other defining aspects in relation to how certain areas felt in the body at different times. Two examples that they presented were physical heaviness in the heart during depression or anxiety, and the way that their gut told them that something bad was about to happen.*

*I was used to the results of intuitive interventions like the one I mentioned above, but this one really commanded my attention due to my uncharacteristic intervention and its group-wide effect. I was not only surprised at the spontaneous words that were emitted from my mouth, coming from “out of nowhere,” (an intuitive intervention indeed!) but moreso the clients’ immediate understanding of what I had blurted out. With my curiosity activated, questions began to emerge in my mind. Are there actual neurological correlates to the metaphors of head, heart, gut and genitals? Did each of these areas hold specific meanings for human experience, or were they different for each person? Does personal meaning of the said areas only correspond to physical function or were there aspects of embodied intelligence that exist concurrently with physical function? Is intuition one of those experiences?*

*At the time of this surprising group experience, I was a second year doctoral student and had been studying Steven Porges’ Polyvagal Theory (1995) that describes the function of the vagus nerve in the relationship between self and others. On a hunch, I checked with my class notes and found that the vagus nerve has three branches that directly correspond with what my intuition already knew. The vagus nerve, which originates in the medulla oblongata (Hole, 1987) branches out into three main plexuses: the cervical plexus (at the base of the skull, or “head”), cardiac plexus (“heart”), and celiac plexus (“gut”). To add to my excitement, six months later, I met Barry Komisaruk, Associate Professor at Rutgers University who conducted a study on women with spinal cord injuries (Komisaruk, Whipple, Crawford, Grimes, Liu, Kalin, and Mosier, 2004) that reported*

*potential innervations of the vagus nerve in the pelvic plexus (“genitals”). To my astonishment, my “intuition” that I had blurted out six months prior was validated through a random chance meeting with Dr. Komisaruk.*

## Introduction

Most definitions of intuition (particularly in the cognitive sciences) include the words “unconscious,” “non-linear,” “illogical,” “non-verbal” and “irrational.” Such descriptions keep the definitions of intuition chained to a negative space that prevents a positive (i.e., existing) identity. To say that a phenomenon is identifiable solely in the absence of something else seems to negate its existence to some degree. By using logic or cognition to describe a phenomenon that is purely *non-logical* or *non-cognitive* at best sends it into an intellectual tailspin; at worst it dismisses the value of the phenomenon’s identity. To address this incongruousness, this article seeks to introduce the concept of intuition as a subjective and a positive (i.e., *existing*) phenomenon by articulating one type of intuitive recognition that is felt through the body: embodied intuition. In addition, it will offer some beginning thoughts on the congruence between common bodily metaphors used in body psychotherapy and the anatomical innervations of the vagus nerve.

The similarities between intuitive recognition and embodied experience offer the possibility that intuition and body-based experience are closer than perceived. Researchers in the field of clinical intuition have described qualities of intuitive phenomenon as immediate (Petitmengin-Peugeot, 1999), faster than cognition (Charles, 2004), and often understood as a feeling separate from a thought or emotion (Vaughn, 1979). Interestingly, similar descriptions are used for direct, bodily-based experiences in somatically-oriented psychotherapies (Gendlin, 1981; Kurtz, 2010; Levine, 1997). Further similarities are linked to the function of the vagus nerve in neuroscience and physiology. Neuroscientist Stephen Porges has suggested that the vagus nerve complex that resides in several parts of the head and torso, mediates communication between interoceptive activity and external environment (Porges, 1993). Still other scientists suggest that the vagus nerve complex connects the ventromedial prefrontal cortex, or “conscious” part of experience, with viscera or “unconscious” experience (Voltz & von Kramon, 2006; Zagon, 2001). This connection begins to shed light on the possibility that vagal nerve function helps to negotiate the environment through a system that includes another way of knowing- perhaps an *embodied* knowing- that defines the process of intuition in a more present and tangible way.

I suggest that intuition as an immediate embodied experience is also recognized through non-verbal knowledge that cannot be traced to an emotional pattern or memory. The connections between the plexuses of the vagus nerve and areas of intuitive recognition in the body via metaphor are also discussed here.

## Embodied Epistemology

Embodiment is the source from which we feel, define and contain life experiences as they happen. As a source of survival, our primitive bodies developed instinctive reflexes designed for self-preservation and survival (i.e., retracting one’s hand in reaction to touching a hot pot on a stove). The evolution of consciousness has led to awareness of these actions. In body/mind approaches, some name the practice of this type of awareness, “mindfulness” (Goenka, 2009; Kabat-Zinn, 1990; Kurtz, 2007; Weiss, 2009). Mindfulness encompasses a specific type of attention to one’s physical, emotional and cognitive process in the present moment. However, attention to oneself in the moment is but one component of the processes of body psychotherapy (Weiss, 2009) and only a beginning definition toward the concept of embodiment.

Neuroscientist Antonio Damasio names the referred inner experience of one’s sense of self in the world as a “core self” (1999, p.17) from which one makes sense of the environment. Embodied experience employs a continuous loop that circulates between internal and external awareness where one senses, feels, and makes meaning of the world. Embodiment is the present time *felt* experience of awareness in a moment as it is happening. However, sometimes our bodily-felt experience precedes cognitive awareness (McCraty, 2004; Lehrer, 2009). One way to describe this phenomenon is through the senses. Our primary senses: smell, taste, sight, hearing and touch all provide information about the environment. Consisting of over one billion nerves, the body feels, integrates, and responds to the environment in a way that functions beyond cognition. In particular, it is the autonomic nervous system that integrates the sensorial, emotional and thought processes that create an embodied perception. This is the system of the lived experience.

Maurice Merleau-Ponty (1962/2008) described embodiment as a subjective experience in which one makes sense of the environment by turning one’s attention toward it. Anthropologist and embodiment philosopher Tony Csordas (1993) extended Merleau-Ponty’s theory by delineating two ways that attention is comprehended: attending *to* and attending *with* the body (1993). Csordas describes how the former is not simply attending to experience as if the body is viewed as a separate object, but rather a “mode of attending to the intersubjective milieu” (p. 138) of a corporeal experience. Similar to the practice of mindfulness, this type of attention is also a primary technique used in body psychotherapy practice (i.e., Gendlin’s “Focusing” and Levine’s “Somatic Experiencing”). Csordas adds that feedback from the process of attending *to*, in fact, actually requires attending *with* the body, or the “internal milieu” where body and self are not separate. One example of Csordas’ modes of attention is through the process of the dance/movement therapy practice of Authentic Movement in which Whitehouse describes the feeling of “being moved and moving” (in Adler, 1999, p. 143) as well as the attending *with* (in spontaneous movement) which encompasses simultaneously witnessing that movement as it is happening.

In addition to attending *to* and attending *with* one's body, Csordas (1993) suggests that attention to others' bodies is equally important and further suggests that attending *with* is the primary mode of attention that one experiences when viewing another's body. Csordas called this "a cultural elaboration of sensory engagement" (p.139) and illustrates basic tasks of dancing, sports and other physical activity. In somatic psychotherapy practice, there are more subtle ways of assessing and engaging with another's body such as image, shape, rhythm, spatial proxemics (Hall, 1966), and even olfactory knowledge, all of which contribute to attending *with* the body interpersonally.

A more precise observation for the direct use of embodiment with another is Hervey's description of embodied ethical decision-making in dance/movement therapy practice. Hervey (2007) creates a compelling argument regarding the need for embodied knowledge as a part of ethical decision making. She writes, "Ethical conflict can create some of the most violently felt, bodily-based experiences we may have as clinicians" (p. 92). In light of the embodied nature of somatic and movement-based therapists (from both clinician and client perspectives), one can see the inherent necessity for embodied knowledge in clinical practice.

After integrating some of the more profound aspects on theories of embodiment, embodied approaches to ethics, and embodied decision-making, Hervey surmises that some ethical considerations can only be fully understood from an embodied perspective. One simple yet powerful suggestion that Hervey offers to achieve embodied ethical decision-making is "to become aware of the shifts in our bodily states when confronted with a particular situation" (Hervey, p.101). Although the specific ways in which one feels a bodily state can vary among each individual, a shift in state is also a shift in inward consciousness. The whole process might be closely akin to embodied intuitive experience.

Embodiment may provide the type of attention to vagal activity that facilitates communication between the neocortex, or "conscious" part of experience, and visceral "non-conscious" part of experience. In the vignette above, my verbal intervention of "attending to" the four neural plexuses was contrasted with my embodied experience of "attending with" my body, as I found my spontaneous movement and words (standing and raising my voice) to be non-logical, yet resonant and therefore a possible intuitive intervention. In body psychotherapy, sensorial "feelings" in the body that are connected to emotion are often found in the throat and viscera. Feeling in the body requires a particular type of attention that reaches beyond gross motor movements, and requires a subtle type of attention to internal states. By addressing only the physical, one can easily minimize a sensation, and ignore its potential messages. For instance, an "uneasy" stomach could be simplified to "something I ate." However, dance therapists and body psychotherapists attend to bodily sensations in such a way that those emotional components of an "uneasy stomach" come forth, usually discovering that there is more to it than simply one's epicurean choice.

Body to body interaction is an emerging concept in studies of attachment theory (E. Tronick, personal communication November 5, 2007; Schore, 2003) and is also a primary process in dance/movement therapy. Neuroscientist Allan Schore explains that intuition is a "right brain to right brain" activity between mother and infant, where information between the two is understood implicitly since verbal interaction is not available. Schore (2003) contends that the right frontal lobe of the brain is the area that holds unconscious emotional communication.

The discovery and investigation of mirror neurons (Di Pellegrino et al. 1992; Gallese, 2003; Rizzolatti & Craighero, 2004) describe a process of empathic resonance between primates, namely monkeys and humans. Not surprisingly, a key process in dance therapy called "mirroring" (Sandel, 1993, p. 103) is a term that dance therapists have used for over fifty years to describe attending *with* the body in order to understand and communicate with their patients non-verbally. In dance/movement therapy, the process of Authentic Movement allows the unconscious to arrive in consciousness by attention to and with the body (Adler, 1999). In Authentic Movement, the client closes his or her eyes and allows spontaneous movement to emerge from the body that is not directed by a thought or emotion. This is how intuitive knowledge can be recognized and utilized to bring attention to formerly unknown aspects of the self.

Learning to cultivate embodiment may begin to shed light on the possibility that the vagus nerve helps to negotiate the environment through a system that includes another way of knowing- perhaps a body-based knowing- that describes the direct experience of intuition.

## The Neurobiology of Intuition

Consciousness in the brain and "unconsciousness" in the body are beginning to connect in emerging neuroscientific theories of intuition, or "sixth sense" (Charles, 2004; Lieberman, 2000; Turnbull, 2003; Voltz & Von Cramon, 2006 ; Zagon, 2001). The vagus nerve, also called the tenth cranial nerve is said to be the place of affect regulation (Porges, 1993), emotional sensation and during traumatic experience (Levine, 1997). Of particular interest are the parts of the vagus nerve that branch into four plexuses, coincidentally corresponding with places in the body that somatic psychotherapists have designated as centers of emotion for decades. Those areas are: the cervical plexus (head); cardiac plexus (heart); celiac plexus (gut); and pelvic plexus (genitals), (Komisaruk, Whipple, Crawford, Grimes, Liu, Kalnin, & Mosier, 2004).

Stephen Porges, from the University of Illinois at Chicago has studied the gestures and postures of infants as they respond to their environment. Infants, who are developmentally "preverbal," instinctively develop a nonverbal system of communication, such as cries, movement, and/or eye contact, to negotiate their environment. They develop this in response to sensory input such as touch, smell, sound, taste and vision. Porges, (1993) suggests that our current verbal language negates descriptive words that can communicate somatic/emotional experience.

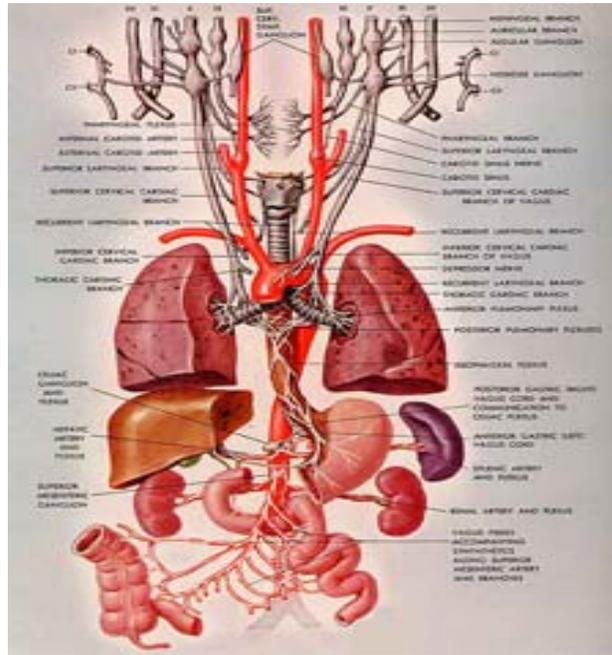


Figure 1: Vagus Nerve Innervation

Note: <http://www.ncrf.org/illustrations.html> (National Cancer Research Foundation) Reprinted with permission.

Beyond the five primary sense modalities - smell, vision, hearing, taste, and touch, Porges introduces what he calls the “sixth” sensory system, also known as *interoception*, located in the organs of the body, and mediated through the vagus nerve. Interoception is a process by which the body informs the mind of what is going on from an individual’s internal visceral environment. “Interoception is a global concept which includes both our conscious feelings and unconscious monitoring of bodily processes,” (Porges, 1993, p. 12). Porges suggests that afferent or ascending neural pathways do not always reach cognition, yet play an important role in the body’s physiological functioning. “This unconscious awareness fosters stability (i.e. homeostasis) in the internal physiology by rapidly adjusting to support specific motor behaviors and psychological processes,” (Porges, 1993, p. 12). The interoceptive system communicates unconscious processes that maintain homeostasis (Porges, 1993) otherwise known as the physiological balance between inner and outer perception. In addition to homeostasis, there is another system that responds to stimuli that emanates from within the body (Zagon, 2001) and communicates in a cyclical loop of information, as opposed to a one-way street. That system is the vagal system.

The vagus nerve (Fig 1) originates in the medulla oblongata at the base of the brain (cervical plexus), and crosses to the front of the body at the base of the neck. From there it runs down the front of the spine and branches out to the neural plexus of the heart (cardiac plexus) and gut (celiac plexus). Recent research on afferent nerve stimulation proposes that the genitals (part of the pelvic plexus) might be a fourth area of vagal innervation. Komisaruk, et al., (2004) discovered that the vagus nerve might provide an alternate afferent pathway for communication between the genitals and brain under conditions in which the CNS is severed.

Like Porges, (1993, 1995) Zagon, (2001) also supports the vagal system as a means of “feeling” in the body. Zagon proposes that the vagus nerve, “the largest visceral sensory nerve in the body” (2001, p. 671) not only regulates emotion, perception and cognition, but also might mediate a “sixth sense.” Based on the presumption that stress-related diseases in the body are regulated by the vagal activity, Zagon describes a process by which the vagus nerve connects emotion and cognition via sensorial symptoms, and suggests that a new neural pathway can be constructed at the tip of the vagus at the locus coeruleus (Fig 2), located in the brain stem.

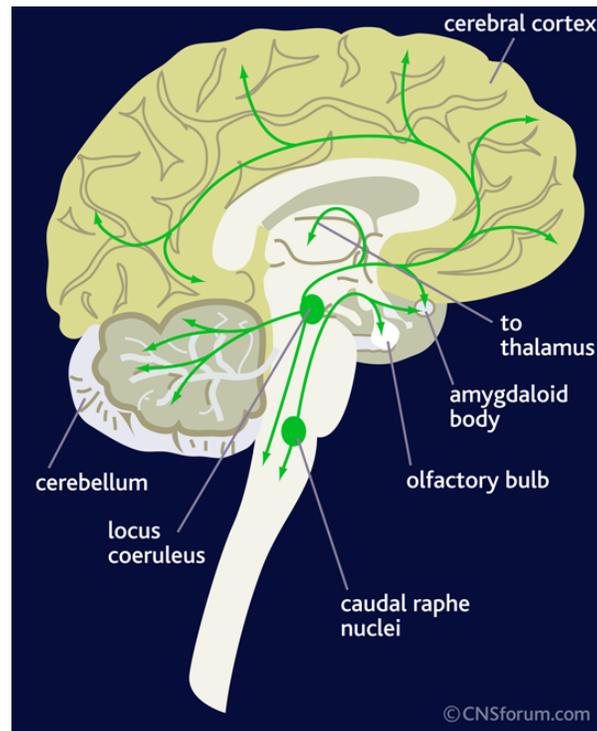


Figure 2: Locus Coeruleus

Note: From <http://www.cnsforum.com/educationalresources/>. Permission to reprint not required.

Zagon suggests that by manipulating the vagus nerve in the brain stem, one can shift a patient's perception of somatic symptoms, thereby altering emotional and mental experience of a physical condition. Zagon's study concludes by questioning whether the inter-related mental, emotional and physical experience is similar to an altered state of perceiving one's environment, or is a "sixth sense" that is the collaboration of physical, emotional and mental attention.

### The Four Neural Plexuses of Embodied Intuition: Head, Heart, Gut and Pelvis

Studies have suggested that intuition resides on other parts of the body, namely the heart (McCraty, Atkinson, & Bradley, 2004) and gut, or enteric nervous system (Gershon, 1998). Both studies have found that areas in the body can perceive information separately from cognition. In physiology, there are afferent nerves, which travel from the viscera to the brain, and efferent nerves that travel from the brain to the viscera. Most body-based healing practices work with a "top-down" (Ogden, Minton & Payne, 2006) process that begins with thinking and proceeds to bodily-felt sensation for the purpose of using a thought as a first step toward integrating body and mind. In physiological terms, it's the efferent (brain to viscera) intervention that begins with thought followed by emotion and sensation. Conversely, "bottom up" process begins with sensation followed by emotion and cognition. Many trauma therapies (Levine, 1997; Ogden, Minton & Pain, 2006; Rothschild, 2001) work in both directions for the purpose of creating a fully integrated and embodied experience. Siegel, (2006) calls this "vertical integration" (p. 251).

#### The head

Lieberman (2000) creates connections between implicit learning and intuitive process based on experiments with two types of brain stem damage. The author suggests that the basal ganglia, which is part of the brain stem that governs implicit learning and instinct, is also the place that immediately precedes intuitive decision-making. Lieberman describes "social intuitions" as spontaneous physical gestures such as blinking, twitching, or cocking one's head to the side during a conversation. While observing learning and movement deficits of patients with two types of degenerative diseases in the basal ganglia, Parkinson's disease (PD), and Huntington's disease (HD), Lieberman observed that impairment in the basal ganglia inhibited spontaneous unconscious physical gestures. He concluded that difficulty in spontaneous movement also slowed decision-making in PD and HD patients. Lieberman's findings seem to support involuntary movement as a source of bodily-felt intuitive knowledge by making the connection between spontaneous movement and its role in decision-making.

## The heart

Based on the hypothesis that the body can perceive and respond to emotionally stimulating information prior to conscious awareness, McCraty, Atkinson, & Bradley (2004) conducted a study to test the body's physiological system as a receptor of intuitive knowledge. The authors define intuition as "a process by which information normally outside the range of cognitive process is immediately sensed and perceived in the body and mind as certainty of knowledge or feeling about the totality of a thing distant or yet to happen," (p. 134). Results were threefold: a) the heart appears to respond to stimuli preceding cognitive awareness b) the heart shows a greater response to future emotional stimuli than to future calm stimuli, c) women appear to have greater physiological response than men during an intuitive experience. The experiment was based on observations of the heart's electromagnetic field, and serves as a potential forerunner for testing other areas of the body to detect the body's perception and attention toward environmental stimuli, as well as to what degree it might feel about its environment.

## The gut

Much debate persists over the ability of the gut, or enteric nervous system (ENS) to receive and respond to the environment without communicating with the brain. In his persuasive book, *The Second Brain* (1998), gastroenterologist Michael Gershon describes a history of studies dating back to the 19<sup>th</sup> century that support his hypothesis that the ENS can function independently from the brain. In a study by Bayliss & Starling (as cited in Gershon, 1998) the authors tested dogs by severing the ENS from two primary parts of the nervous system: the spinal cord and the vagus nerve. They found that the ENS continued to function fully despite the separation which altered common knowledge that the spinal cord and vagus nerve functions as a communicator between brain and internal organs of the heart and gut. Despite subsequent contradictory findings (Powley, 2000), Gershon's "second brain" persists as the common understanding of intestinal independence. Gershon's theory seems to metaphorically describe how one can have a "gut instinct" about something without cognitive reasoning to back it up.

## The pelvis

Although there is no anatomical correlate to the vagus nerve and pelvic plexus stated in anatomical text, recent research in afferent vagal communication proposes that the genitals (part of the pelvic plexus) might be a fourth area of vagal innervation. Komisaruk, Whipple, Crawford, Grimes, Liu, Kalnin, & Mosier (2004) discovered the potential for vagal innervation of the genitals and pelvis while testing female subjects who claimed to be able to experience orgasm, despite having severed spinal cords.

## Embodied Intuitive Decision-Making

In the field of neuroscience, much research on intuition focuses on the ways in which intuition is processed in the brain for decision-making (Bechara, Damasio, A., Damasio, H., & Anderson, 1994; Lieberman, 2000; Turnbull, 2003; Volz & von Cramon, 2006). From a psychobiological perspective, other researchers (Schore, 1994, 2003; Siegel, 1999, 2006) postulate that intuitive phenomena are interpersonal phenomena, resulting from empathic attunement between two people. It is suggested that intuition is the process of gathering information and responding to a situation completely spontaneously without any means of recognizing a pattern or ability to trace the origin of the information. The suggestion that intuition might be grounded in non-verbal communication, such as symbolic forms (images) and sub-symbolic forms, such as sensory, motor or visceral information systems of the body (Bucci, 2007), is an exciting proposition for both clinicians and researchers in body-based psychotherapeutic fields. Practices of embodiment might hold the key to intuitive recognition as it is still in symbolic form, rather than in the aftermath of cognitive processing.

## Intuition in Psychotherapy

In the therapeutic session, the unconscious is ever-present even if it is not ready to be discussed. Williams & Irving (1996) state that "the belief that intuitive knowing is incapable of being verbally (and in cognitive terms) communicated is widespread in counseling" (p. 223). Contrasting with Williams & Irving's statement, Ignatow (2007) proposes that there is an evolving "intuitionist" style of psychotherapy steeped in Freudian thought of primary (instinctive) and secondary (conscious) process, and refers to the psychological shift from knowledge and reasoning toward an integrated style of bodily and emotional processing. Not surprisingly, Ignatow's description correlates with the *unconscious-to-conscious* intuitive process offered above by Vaughn (1979).

Psychology research has documented that the body "feels" intuitive experience (Charles, 2004; Eisengart, 1996; Pettimengen-Pettigrew, 1999). Charles (2004), in her study of intuition in psychotherapy, categorized participants based on

Jung's four psychological types: "Thinking, Feeling, Intuition, and Sensation" (p. 42). Charles found that Intuitive and Sensing types had greater body awareness than their counterparts during intuitive experience. In addition, Charles found that senses were important to intuitive experience because sensation was the only way that participants reported awareness. Ultimately Charles, like Williams & Irving (1996) dismissed the potential for sensorial knowledge, and despite sensorial findings, concluded that sensation accompanying intuition was nothing more than a reaction to a client's body language.

Vaughn (1979) defined four types of intuitive experience: "physical, emotional, mental, and spiritual" (p.40), and defined physical intuition as "a strong body response to a situation where there is no reason to think that anything unusual is going on" (p.66). Although I do not hypothesize that embodied intuition is limited to the physical, I suggest that recording sensation is the most pragmatic way to describe intuitive phenomenon.

In an attempt to create a cohesive model to describe the multi-faceted aspects of intuition in psychotherapy, Petitmengin-Peugeot (1999) conducted a study that set out to identify the extent to which intuition affects a therapist's "whole being" through sensorial and emotional experience. The author's findings were threefold: 1) insight into the physical or emotional state of another person; 2) feeling spontaneous "gestures" such as "'letting go,' 'slowing down,' and 'listening with a panoramic sense,'" and 3) "providing the solution to a problem that did not have all information for logical processing" (p.18). All three findings support the proposed study's exploration into embodied intuition in psychotherapeutic practice.

## A Case for Body Psychotherapists

Somatic psychotherapy uses the identification of sensorial experience as a source of knowledge in the psychotherapeutic process, and recognizes the integration of the lived body, mind, and emotions as a measure of experience in healing. Due to the various ways in which the client subjectively experiences the therapeutic process, body psychotherapists must also use modes of attention during a therapy session that extend outside of training and experience, namely intuition. Arvidson (1997) describes intuition as a type of awareness. From a phenomenological perspective, he writes, "The most revealing way to respond to...a question like- 'What is intuition?' is to simply describe what is happening in consciousness when an intuition occurs" (p. 40). Both intuition and embodiment are inherently non-verbal human traits that have potential for clarity through verbal description. Some body psychotherapists have created a vocabulary to help their clients describe somatically-based experiences. Terms such as a "felt sense" (Gendlin, 1981, p. 2) is now commonly used in body psychotherapy. In trauma work, Peter Levine (1997) has created a list of descriptive words such as "fuzzy, jagged, made of glass, wood or plastic" (p. 80) when referring to the inside of the body, to help a client to make sense of sensations that do not inherently have names. This creates the possibility that vague, dissipated experiences of intuition can also adopt a descriptive vocabulary to make clear what is felt non-verbally.

Aposhyan, (2004) speaks to the empathic gaps that result from having an inadequacy of vocabulary for intuitive interventions in psychotherapy. In doing this, she creates an excellent argument for the urgency of this proposed study. In her theory of separating emotional projection from the "raw data" of intuition, Aposhyan writes:

We have not cultivated the translation of nonverbal observations of others' bodily states into verbal consciousness. By not making this translation, we relegate this information to the realm of the subconscious, thereby losing access to the raw data and often mixing that data with emotional projection. This whole cocktail is called intuition. (p. 14)

Aposhyan's assessment speaks to the need to bring embodied intuitive recognition into consciousness and the importance of defining it separately from what is known as "Somatic Countertransference" (Bernstein, 1984), which Pallaro (2007) considers to be the therapist's own psychic material that is separate from the patient, but manifests as the "body memories, body[']s affective states and sensations" (p. 184) during sessions with clients.

Body psychotherapists focus not only on the client's body in practice, but their own body during therapeutic sessions (Field, 1989; Shaw, 2004; Stone, 2006). "Grounding and centering" (personal communication, D. Poole Heller, January 27, 2008) is one way that the therapist acts as a "container" for the client's experience. Oscillating attention between "narrow and panoramic vision" (C. Caldwell, personal communication, October 17, 2007) is another way that body psychotherapists engage in the multi-faceted aspects of the client's experience. As Stone (2006) reports, the therapist's body acts as a "tuning fork" (p. 109) to resonate with the client's experience.

A therapist's "tuning fork" can be used to connect with the client in many ways, such as instances of somatic countertransference (Dosamantes, 2007; Ogden, Minton & Pain, 2006; Pallaro, 2007; Stone, 2006). In contrast with intuitive knowledge, somatic countertransference is the therapist's somatically-based reaction to a client (Stone, 2006) that is in direct correlation to what is being transferred to the therapist emotionally by the client. Stone describes two types of countertransference: "reflective" and "embodied" (Stone, 2006, p. 210). The former describes the way in which the therapist feels a reaction in his or her body that could reflect the way that others see the client in everyday life. "Embodied" refers to the instances when the therapist feels what the client is feeling so much that the therapist cannot differentiate their own feelings from that of their client, thereby causing a potential impasse in the healing process. In my own experience as a therapist, intuitive moments with clients in treatment produce clear somatic feeling, but clearly devoid of emotional content. Thereby, I

offer the possibility that somatic countertransference may be considered different from intuitive experience with clients based on the emotional quality that the former produces.

Dance therapy pioneer Mary Whitehouse often referred to working with the body as “directly working with the unconscious” (Whitehouse, 1977, p.4). Whitehouse makes a confident statement reflecting her use of intuition as a tool in psychotherapy practice: “Intuition tells one what to do and when to do it” (Whitehouse, 1979/1999, p. 87). As a dance/movement therapist, Whitehouse engendered a tremendous trust in working with the intuition that emerges between body and mind, both in her clients’ bodies and her own. Of intuitive interventions, Whitehouse (1999) states:

The presence of what one calls a hunch in everyday language indicates a possibility that may or may not work. By acting on the things that come up within, by trusting, it is found that the more they are trusted, the more strongly they come...It becomes not as logical a process but just as orderly; a different order than that of the controlling ego that grabs onto what it already knows. (p. 87)

There is no mistaking that intuition had been used successfully by Whitehouse in therapeutic practice. It is necessary to note that Whitehouse was not primarily a researcher, but a creator and practitioner of dance/movement therapy. This reflects back to the Jungian “types” of therapist (particularly “Sensing” and “Intuiting,” as described by Charles, 2004) who is more likely to embody intuitive knowledge.

A body psychotherapist’s work involves feeling from the non-verbal body to the verbal mind, and requires flexibility and courage to embrace that which is not known in a session. To use intuition as a tool in psychotherapy requires the use of what Hathaway (1956) calls, “inferences” that may be vague clues to what is actively present in the unconscious. “Intuition is involved either when the available information seems inadequate to produce the inferences drawn by the recipient or when the integrative powers of the percipient seem to exceed ordinary rational analysis” (p. 223). Perhaps the combination of body psychotherapists’ holistic perspective and “integrative powers” best qualify them to investigate the inferences of intuitive phenomenon.

## Conclusion

The connection between four neural correlates of corporeal metaphors in interpersonal communication is just the beginning of a potential basis for understanding our intuitive knowledge from an embodied epistemological perspective. Further research into the study of personal meaning made from attending “to” and attending “with” each of the four neural plexuses can potentiate expansion of this emerging theory. One way that this might be investigated is the personal physical experience (such as “tingling,” “numbness,” or even discomfort) of each of the areas of the therapist’s body and the personal meaning that is ascribed to each, in relation to clients. Another future study might inquire into the kind of knowledge that the embodied experience that each area might produce, such as information about a client that could not be attained by deduction, diagnosis or pattern recognition. Finally, an investigation on the validity of that knowledge in relation to the client’s experience might be helpful in attaining a clearer understanding of how embodied intuition works in clinical practice. Inquiries of intuition from an embodied perspective such as these might provide a firmer ground for the use of intuition in body psychotherapy practice. Studies that might delineate embodied intuitive experience from somatic countertransference; embodied intuitive decision-making in the therapeutic setting and circumstances under which embodied intuitive phenomenon is “wrong” may also contribute to our understanding of this seemingly untapped interpersonal phenomenon.

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#### Biography

**Jennifer Frank Tantia, MS, BC-DMT, LCAT** is a board-certified Dance/movement Therapist and licensed Creative Arts Therapist in New York City. Jennifer serves on the faculty of both Pratt Institute and Adelphi University, and is the Program Director of the NY State Chapter of the American Dance Therapy Association. Jennifer works with individuals in private practice and leads Authentic Movement groups while completing her Ph.D. in Clinical and Somatic Psychology at Santa Barbara Graduate Institute. Her dissertation topic explores the embodied experiences of therapists' intuition in the clinical setting. [JFTantia@gmail.com](mailto:JFTantia@gmail.com)

# Mindfulness, Emotions, and the Organization of Experience

Gregory J. Johanson, Ph.D.

## Abstract

Originally presented at the 118th Annual Convention of the American Psychological Association at San Diego, California August 2010, this presentation will concentrate on the aspect of a mindful state of consciousness able to engage the frontal cortex in a way that allows for mindfulness of the mind (or ego states). By becoming mindful of emotions, one enters into the integrated amalgam of affect, sensations, tensions, memories, and attitudes that reflect how experience is organized. Mindfulness of emotion, in a safe compassionate context, then allows for the exploration of present experience that becomes a royal road to the unconscious or the core organizer of experience. These core beliefs are then made available for modification through inter and intra-personal affective interaction that facilitates organization in elements of life previously organized out. When trauma is present that activates lower brain functions, becoming mindful of emotions can risk stimulating a trauma vortex that spirals the patient into a dysregulated state of hyper or hypo arousal where there is more risk of re-traumatization than therapeutic integration. Here it becomes necessary to employ what Ogden, Minton, & Pain (2006) term "directed mindfulness" to sensations, while consciously separating them from affective states. This allows for sensations to successfully process through the body without becoming one link in a chain of signals that immediately moves into a habitually patterned trauma vortex of cascading effects. It then becomes possible to move mindfully toward modifying core memories or uncompleted physical tendencies. This approach to mindfulness in relation to emotions functions as a bridge between Eastern and Western perspectives on psychology. Mindful witnessing moves toward the sense of unity consciousness valued in the East, while active compassionate awareness can foster affect-based healing of fragmented internal parts sought in the West. Annotated case verbatims from both developmental issues and trauma histories are offered to illustrate the theoretical material.

## Keywords

Mindfulness – Trauma – Veterans - Emotions

## Emotions as Messy

Gendlin (1992) notes that psychological science is much more friendly with emotions today than was the case not that long ago.

A sentient body not only is, but also feels its interactions with the environment. . . . A vast amount of information is sensed - not in separated facets - but as a global, bodily sentience. . . In the history of thought, this bodily sentience is a crucial, forgotten dimension! . . . Feelings were said to be mere "reactions to" the facts - after the facts are given by the five external senses and reason. For two millennia feelings were said to contain no information about one's situational reality. How could this have been believed? (Gendlin, 1992, pp. 15-16).

Now that emotions have assumed their rightful place in psychological study, a dizzying array have found their way into the discipline. There are, of course, the categorical emotions. Fosha's (2000, 20001, 2004, 2005, 2206, 2008, 2009a, 2009b, 2010) therapeutic involvement with emotions alone include receptive affective experiences, transitional affects, heralding affects, green and red signal affects, post-breakthrough affects, mastery affects, mourning-the-self affects, tremulous affects, healing affects, relational affects, and transformational affects. She calls attention to Fredrickson (2001) who differentiates between the negative emotions for survival, and the positive emotions for expansion of capacities and growth. Sundararajan (2000) names recognition emotions, being emotions, transpersonal emotions, and egoist emotions. Ogden (2009) references the structural developmental model of Lane and Schwartz (1987) that outlines five stages of emotional development from physical sensations, to physical actions tendencies, to single emotions, to blends of emotions, and blends of blends of emotions.

Siegel notes that "clearly the term emotion does not have a precisely shared meaning even for those who use the concept in their daily work" (Siegel, 2009, p. 147).

Depending upon the larger story of the particular discipline of science, emotion can be seen as a process that links people together (anthropology, sociology), a fundamental part of the continuity that connects a person across development (attachment research, developmental psychology, developmental psychopathology), or a way that the body proper -our somatic physiology -is connected to the brain and coordinated within its various layers (neuroscience with its branches in affective and social neuroscience especially) (Siegel, 2009, p. 149).

Porges (2009) has done significant work through his Polyvagal Theory establishing that social interactions and emotion are biobehavioral processes in which varying bodily states underlie forms of behavior. "Emotions, affect regulation,

and interpersonal social behavior . . . represent a complex interplay between our psychological experience and our physiological regulation." (p. 27) In situations where normal social engagement skills fail to deal with perceived dangers, lower brain functions inducing flight, fight, or freezing automatically activate. This is one reason, van der Kolk (1994; van der Kolk, McFarlane, & Waisaeth, 1994) argues, that normal talk therapies have difficulty touching the bodily processes underlying trauma.

Porges notes that the biological-emotional response becomes activated from an interpretation of the neuroception of intentionality, something Lipton (2005) agrees with through his theory of the biology of belief. For instance, if one is standing at a train station and another person suddenly begins sprinting from six feet away and knocks one to the ground, it can be a profoundly disorienting, emotionally hurtful situation. However, if the same person is playing football, catches a ball and is knocked to the ground, the intentional context transforms the physical-emotional response. Likewise, if the person at the train station comes back and apologizes, the entire meaning and effect of the incident is changed.

Gendlin (1992), along with feminist and post-modern theorists, agree that culture and learning inform bodily sensing and mobilizing. "Emotions are not things by themselves. Emotions are only part of a story. . . . This narrow story is itself only part of the story. The wider context was involved in giving rise to the emotion" (p.20). To complicate things further, "a 'feeling' contains, or rather can generate or re-generate a number of emotions as we enter into it. Emotions are embedded within such a texture" (p. 19).

For Tronick (2009, pp. 108-109):

Emotions, and what might be thought of as emotional activation patterns (EMAPs) in the brain, are activated by a variety of internal and external events. . . . An EMAP is not a fixed form but one that changes in relation to other EMAPs, to its own reiteration, and to the overall gestalt of EMAPs in the emotion meaning-making network.

Damasio's research (1999) suggests activating signals originate in part from our life experiences that generate sensations through the emotional brain that he terms *somatic markers* that then inform us of the significance of whatever we are considering. Normally these somatic markers work on our decisions below consciousness, supplying us preverbal intuitions of "right" or "not right" about doing something. Mindfully attending to these felt bodily senses, as in Gendlin's (1996) work, can bring their messages and memories into consciousness.

However, for all the work that has been done to establish that "neural firing and mental activity mutually influence each other," Siegel (2009) concludes that "we have a nonquantifiable inner world of our subjective reality. The truth is that we actually do not know how neural firing and subjective experience create each other" (p. 146). There is mystery abundant to go around.

The mystery, of course, is predictable in terms of non-linear systems theory that says all of us perpetuate ourselves through multiple patterns that evolve over time (Piers et al, 2007). Self-organizing systems begin with many parts with large degrees of initial freedom that are then "compressed to produce more patterned behavior" (Thelen & Smith, 2002, p. 51). "In self-organization, the system selects or is attracted to one preferred configuration out of many possible states, but behavioral variability is an essential precursor" (Thelen & Smith, 2002, p. 55). Nonlinear means order out of chaos (Johanson, 2009a, b).

Under different conditions the components are free to assemble into other stable behavioral modes, and it is indeed this ability of multi-component systems to "soft-assemble" that both provides the enormous flexibility of biological systems and explains some of the most persistent puzzles of development (Thelen & Smith, 2002, p. 60).

For all the complexity we have been referencing, Tronick (2009) asserts that emotions have meaning, even if they are multiple and contextually derived. For Siegel (2009, p. 163) this is because the "mind is defined as an embodied and relational process that regulates the flow of energy and information. This energy and information flow is happening all the time, and its texture, the music of the mind, can be considered primary emotion."

Tronick emphasizes the word "flow" by arguing that emotional meaning is never fixed:

Emotions have meaning. Emotions are elements of meaning, being perhaps even the foremost and principle elements assembled in humans' state of consciousness. And though emotions are elements within the individual (the essentialist or individual psychology perspectives), I believe that they are both internally created in new emergent forms, as well as dyadically cocreated in new emergent forms with both externalized others and internalized objects. Thus, emotions are not fixed elements. They evolve over moments. Old ones change, new ones emerge, nuanced forms abound (Tronick, 2009, p. 88)

Tronick offers the following summary statement that wisely emphasizes the complexity and messiness of emotions, emotional research, and emotional work.

Emotions are elements of meaning, being perhaps even the foremost and principle elements assembled in humans' states of consciousness. . . . Meaning is biopsychological. It is made by polymorphic systems operating at multiple levels of the individual. These polymorphic systems create qualitatively different forms of meaning, what Freeman (2000) refers to as actualizations of meaning, which at best only messily fit together (Tronick, 2009 p. 88).

### Messiness & the Organization of Experience

Though it might indeed be at best messy, the above emphasis on meaning and the regulation of energy and information flow implies that living human systems embody a degree of organization that affects how individuals experience themselves emotionally, cognitively, physically, and spiritually.

This is consistent with Bateson's (1979) propositions on the nature of living organic systems that make it clear that humans are hard-wired to *organize* their experiential complexity. The system encodes, filters, or transforms signals from both internal and external sources (proposition five), and then organizes this information into a hierarchy of logical levels of organization (proposition six). This view is paralleled in the philosophical *new key methods* such as Langer's (1962) conception of the symbolic transformation of the given. Likewise, Siegel (1999), as noted above, argues that the human mind emerges from patterns in the flow that organize energy and information within the brain and between brains. Porges also agrees that psychology must pay attention to the organizing variable. "In the Polyvagal Theory, neuroception is an S-O-R model. Within this context, autonomic state is an intervening process that contributes to the transformation of the external physical stimulus to the complex internal cognitive affective processes that determine the quality of the interpersonal interaction" (Porges, 2009, p. 53).

Ogden (2009, p. 210) observes that "from interactions with attachment figures, the child forms *internal working models* (Bowlby, 1988), which are encoded in procedural memory and become non-conscious strategies of affect regulation (Schore, 1994) and relational interaction." This now commonplace assertion, in line with Gendlin's opening remarks about psychology only coming lately to appreciate emotions, was controversial within our own generation. When Bowlby reported the result of his attachment research to the United Nations in 1950, specifically that the mother-infant relationship was extremely important and that early separations can hurt growing children, many professionals scorned and ridiculed him (Karen, 1998).

Now much research, such as Tronick's (1980, 1989, 1998), makes it clear that "though we don't truly know the infant's experience, nonetheless, they gave evidence of an organized state of consciousness" (Tronick, 2009, p. 90). This means that many of the core organizers that affect us are in implicit memory (Nadel, 1994). As the emotional responses to organizers become engrained patterns of neural firing (Schoener & Kelson, 1988), Siegel (1999, p. 218) observes that they come to function as *attractor states* that "help the system organize itself and achieve stability. Attractor states lend a degree of continuity to the infinitely possible options for activation profiles." Schwartz (1995), and Rowan and Cooper (1999) add that our organization is characterized by a multiplicity of common internal attractor states, and therefore are never completely of one mind or one emotion in relation to any issue.

Since core organizers control how we experience and express ourselves before we ever perceive something or react, Kurtz (1990) understands transformational characterological level psychotherapy as dealing with the modification of what he terms *core organizing beliefs*. Since these beliefs are at the basis of what story we live in the world, they can be termed *core narrative beliefs*. Similarly, Stolorow, Brandchaft, & Atwood, (1987) title the chapter in their work on intersubjective psychoanalytic therapy "The Organization of Experience."

Transference in its essence refers neither to regression, displacement, projection, nor distortion, but rather to the assimilation of the analytic relationship into the thematic structures of the patient's personal subjective world. Thus conceived, transference is an expression of the universal psychological striving to organize experience and create meanings (Stolorow et al, 1987, pp. 45-46).

When Tronick considers the organization of experience into meaningful units, he uses the term *state of consciousness*. He writes, the

flow of meaning has to be assembled by individuals into a coherent sense of themselves in the world, into what I will call a state of consciousness. No simple task. Bruner (1990) has said that humans are meaning makers. They make meaning to gain a sense of their self in relation to their own self, and in relation to the world of things and other people. These meanings are held in the individual's state of consciousness. A state of consciousness is the in-or mostly out-of-awareness polysemic meanings made by the totality of an individual's biopsychological processes. Some meanings are known, and symbolizable, some are unknown, implicit but with "work" can become known, and some may be unknowable (Tronick, 2009, p. 87).

Tronick raises the issue here of the mind/body interface in terms of the knowable and unknowable. Often the concept of meaning is associated with verbal meaning. Certainly, as Ricoeur (1987) has stated, it is part of our identity as humans that

we know and express ourselves through symbols. At the same time Ogden's point remains that "neuroscience has taught us that emotions and the body are mutually dependent and inseparable in terms of functions (Damasio, 1994; Frijda, 1986; LeDoux, 1996; Schore, 1994) (Ogden, 2009, p. 213). Thus, psychotherapists must struggle with words in terms of how they can articulate emotionally charged meaning, and also how they can distance, and deaden one from authentic, felt-sense meaning, especially meanings rooted in implicit memory (Johanson, 1996). Here, mindfulness can be a resource.

Those who deal with religion and spirituality do not escape the dilemma of words bearing both the birth and death of meaning, but they are often clear they are dealing with core organizing belief systems.

To understand people, one must understand their unique ways of construing their worlds (Evans, 1993). . . . Every individual has a global meaning or orienting system. . . . Meaning systems provide the general framework through which individuals structure their lives and assign meanings to specific situational encounters with their environment.

Global meaning consists of three aspects-- beliefs, goals, and feelings (Park & Folkman, 1997)--and is central in determining behavior patterns in both everyday life and situations of adversity (Park, 2005; Silberman, 2005a) (Park & Slattery, 2009, p. 123).

Likewise, for Tronick, emotions are never fixed entities understood without context. Once they become integrated into a larger scheme of meaning, they in turn influence perception and expression in wide areas.

They change and develop through emotion organizing processes and through the interaction of those processes with other processes (e. g. cognitive processes). Further, when emotional means are self-created or cocreated in a state of consciousness, their creation has consequences for the formation of relationships, ongoing emotional experience, and the growth of the individual: how the individual thrusts him- or herself into the world (Freeman, 1994) (Tronick, 2009, p. 88)

### **Emotions as Integrated Ports to the Organization of Experience**

Considering that a multiplicity of experiences are organized leads to a congruent concept of integration. There is the one and the many, growth in agency and communion (Wilber, 1995). Bateson (1979) says that what makes a system organic is not just that it is a whole made of parts, but that all the parts communicate within the whole.

Likewise, Siegel (2009, p.149) concludes that the one consistent finding that has emerged from diverse scientific investigations "is that of 'connection' or 'linkage' of different elements into a functional whole. The linguistic term we use for the linkage of differentiated parts into a functional whole is the word integration. . . . emotion is integrative." Further, "emotion, clarified as integration . . . [is] the fundamental pattern of energy and information flow that is at the heart of our subjective lives" (Siegel, 2009, p.160). "The integration of consciousness involves the linkage of differentiated aspects of attention into a state of mindful awareness in the moment" (Siegel, 2009, p. 167). "Discussing emotion as integration, as we link our individual sense of self with its own unique, differentiated history to the selves of others now, in the past, and also in a future we will never directly see, we come to realize our 'emotional ties' to a much larger whole" (Siegel, 2009, p. 171).

Sundararajan (2008a) also writes about the unifying pattern that weaves together disparate elements related to emotion.

After a comprehensive review of the literature, Jams Russell (2008) concludes that the so-called emotion is perceived pattern of configuration out of multiple ingredients--brain modes, instrumental action, action tendencies, reflexes, attitudes, cognitive structures, motives, sensation feelings, facial, vocal and autonomic changes--none of which have any intrinsic connection with one another (Sundararajan, 2008a, 710-711).

Tronick deals with integration both in terms of the meaning-making mentioned above, and a principle of singularity. Seeing the "myriad biopsychological processes that make up the whole individual (the whole system and all its components) as meaning-making systems provides a unifying conceptualization that makes sense of the individual's place in the world" (Tronick, 2009, p. 111).

Meanings include anything from the linguistic, symbolic, abstract realms, which we easily think of as forms of meaning, to the bodily, physiological, behavior, and emotional structures and processes, which we find more difficult to conceptualize as forms, acts, or actualizations of meaning. . . . It is possible to comfortably integrate these ideas about meaning under a principle of singularity. . . . All systems making up the whole individual--the totality of human biopsychological processes, including, but not limited to what we call mind, brain, and behavior--operate to gain information about the world in order to act in and on the world in alignment with their intentions and goals as well as to create the individual's unique, singular purposes, intention, meanings, and sense of self in the world (Tronick, 2009, p. 88)

Infants begin this task right away according to Tronick, even though the hippocampus and the ability to have full memory are not present until around age three. "Given the precocious sophistication of infants in responding to the expressing emotions, compared to their ability to act skillfully on the world," writes Tronick (2009, p. 93), "emotions may be the foundational form of their sense making (Tronick, 1980). Perhaps too mechanistically, infants can be thought of as emotion-meaning-making devices."

Fosha, Siegel, and Solomon (2009, p. x) comment on a book chapter by Trevarthen that also emphasizes integration and interconnectedness.

Trevarthen outlines how emotions operate in all spheres of human endeavor and serve many functions. He shows them as forces for the healthy intersubjectivity that is at the core of healing not just our individual selves but also our relationships and even our culture. Reaching down into neurophysiology and evolutionary history and up toward community and culture, emotion for Trevarthen allows individuals to participate in the music and dance of interrelatedness toward establishing sympathetic companionship and transmitting the value of human community throughout the lifespan, the upper reaches of the human endeavor.

The upper reaches of the human endeavor are often talked about in terms of compassion, which depends on an experiential sense of connectedness, realizing "our 'emotional ties' to a much larger whole" as Siegel wrote above. Thomas Merton noted that compassion is a profound sense of the interdependence of all things. The Greek language translation of compassion is "being moved in the guts" by the situation of the other. It is harder to harm, or to not help another, if one is so emotionally close that their predicament moves one's core physically. Wilber argues that various therapies have been designed to deal with overcoming various levels of splitting or lack of connection in a client's world (Wilber, 1979), thereby cultivating compassion at diverse levels.

In any case, there are far reaching stakes when therapists work to enhance or repair the level of integration present. For trauma patients, Ogden (2009, p. 226) says the "overarching aim of trauma therapy is integration." Therefore, "abreaction and expression of trauma-related emotion that takes place far beyond the regulatory boundaries of the patient's window of affective tolerance is not encouraged because it does not promote integration (Van der Hart et al., 1992) (Ogden, 2009, p. 226).

The good news is that even when profound disintegration and disassociation is present, emotional material remains holographic, organized into a larger whole that can be a gateway to greater integration.

What therapists can know and trust is that important experiences in both implicit and explicit memory are embedded in emotion as Morgan (forthcoming) points out, "and emotion arises in the body. Damasio differentiates between emotion as bodily response, and feeling as conscious perception of the emotion. Emotions play out in the theatre of the body. Feelings play out in the theatre of the mind." Further:

When the client focuses on the body, in the present moment, unconscious material can surface into awareness. Implicit memory doesn't feel like memory; it is perceived in the present. Unconscious memory related to core material seems to come in packages, similar to the complexes described by Carl Jung, and COEX systems detailed by Stanislav Grof (1975). . . . Touch one aspect of the package, use mindful attention and hang out with the experience, and the rest will emerge into awareness. Often it is experiencing the somatic marker that is the doorway opening to awareness and change.

Ogden (2009, p. 214) points out that "gestures, facial expressions, and posture are not only reflections of emotion, but actively participate in the subjective experience of emotion and in our interpretation of our experiences." Clinically, bringing compassionate awareness to any of these elements can help access the core organizing beliefs that brought it into being.

Since emotions are integrated within the organization of experience in such important ways, they can be used as a royal road to the unconscious level of core organizers. Fosha (2010) teaches that each emotion, once accessed and viscerally experienced, acts as a *magnet for experiences* that are organized under its aegis and "lights up the network" (Shapiro, 2000): It draws to it and facilitates the emergence of emotion-specific constellations of memories, perceptions, fantasies, relational configurations and ways of being. It is this that allows the working-through of traumatic experience.

Gendlin talks about the unity and integration of the organism that underlies the possibility of therapy in the following ways:

Body and environment together make up one interactional process . . . Interactional information about the environment is therefore implicit in body-structure and in every bodily process (Gendlin, 1992, p. 15).

Your situation is not just what the five senses give you. . . . A situation doesn't consist of sense-bits. Nor does it consist of separate bits of any sort. You can think of a few special factors, but you cannot think all of the parts of a situation separately. But you speak and act from a sense of the whole situation. That sense guides how you act and what you say, think, and need in the situation. You would be lost without that bodily sense of the situation (Gendlin, 1992, p. 16).

## Psychotherapy, Working with the Organization of Experience

One way of conceptualizing psychotherapy is that it works with the organization of experience, often how a client's way of organizing has organized something out (Johanson, 2006b). That we organize our experience to make sense and meaning out of life is a normal necessity. However, if we have at one time organized ourselves to be self-reliant because there was not trustworthy support in our life, it could be problematic later if we have not found a way to reassess and update our core organizing beliefs.

In psychotherapy today, one could argue that all therapies that recognize constructivist principles deal with the organization of experience. While there is ongoing dialogue about how things get organized, the agreement of Kurtz (1990) in the humanistic world, Schwartz (1995) in the family therapy world, White and Epston (1990) in the narrative therapy world, Mahoney (2003) in the cognitive-behavioral world, and Stolorow, Brandchaft, and Atwood (1987) in the psychoanalytic world, to name a few, is that we are working with the organization of experience.

Siegel (2009, p. 155) expresses this by saying, "healing is integration, psychotherapy is facilitated integration catalyzed by the relationship between two people. . . . When the degree of differentiation and/or linkage of components in a system such as the brain or our relationships is changed . . . we are changed as a result." Tronick's language (2009, p. 102) is that "therapy is a process of changing individuals' biopsychological state of consciousness, their sense of themselves in relation to the world."

The "what" of what is changed in psychotherapy is the core organizers that govern perception and expression, often a change that organizes something in (support, intimacy, freedom, etc.) previously organized out. This could be a change in one's imagination, core organizing beliefs, schemas, filters, scripts, state of consciousness, meaning-making, or whatever one's preferred term may be. Freud thought it auspicious when one could recognize something new as new. Tronick writes, "successful self or self-and-other creation of new meanings leads to an expansion of the complexity and coherence of the individual's state of consciousness." (Tronick, 2009, p. 87)

Ogden (2009) refers to "'mentalizing,' the process by which we make sense of the contents of our minds and the minds of others," and continues on to say: "Through mindfulness, we become aware of . . . procedural tendencies as these contribute to implicit mentalizing. . . . Mindfulness is . . . useful in changing procedural tendencies so that implicit mentalizing becomes more adaptive and responsive to current life situations instead of the past (Ogden, 2009, p. 222).

Normally, it requires a new experience to counteract an old one, and to begin reinforcing new neural pathways (Cozolino, 2006). In terms of mindfulness, Siegel (2007) has established that mindfully relating to aspects of oneself is an experience that generates such new neural nets, and affects neural plasticity (Doidge, 2007).

## Psychotherapy: Assuming an Impulse to Enlarge One's Organization of Experience

Freud's development of his concept of the repetition compulsion (Johanson, 2002) led him to a pessimistic, or what he might consider realistic, view that "the aim of all life is death" (Freud, 1961, p. 32). Luckily, something occurs in therapy that seems beyond the theories and/or control (or fumbling) of therapists and/or clients. Peck (1978) was so impressed that growth happens at all, in the face of so many obstacles working against it, that he posited some spiritual force called grace to account for it in his best seller *The Road Less Traveled*.

In Hakomi Therapy, Kurtz (1990) often refers to the concept of negentropy as expounded by Bateson (1979), Prigogine & Stengers (1984), and Wilber (1995) -- the notion that there is a force in organic life that moves to build wholes out of parts, as well as the more well-known second law of thermodynamics that posits the opposite. By any name ("transformance" for Fosha, 2000; "the life-forward direction" for Gendlin, 1996, pp. 259-263), there is a natural impulse to heal through moving toward increased wholeness that can be experienced phenomenologically, and which therapists always count on, that has received increasing research support in recent years (Eigen, 1996; Emde, 1988; Fosha, 2006, 2008, 2009a,b; Ghent, 1999, 2002)

When working therapeutically with a client's way of organizing their experience, the possibility simply must be assumed that it is plastic enough to reorganize, and that some aspect of the person wants it to organically unfold. Bateson (1979) expressed support for this by saying living organic systems are self-organizing, self-directing, self-correcting. Siegel (2009, p. 163) argues the human mind embodies an inherent push toward integrative complexity, as does Tronick (2009, p.99) who talks of systems gaining resources for increased complexity and coherence.

Fosha (2009b, p. 175) gives this assumption strong support through saying, "transformation is fundamental to our natures. Deep in our brains, there for the awakening and activation in facilitating environments, lodge wired-in dispositions for self-healing and self-righting (Doidge, 2007; Emde, 1983; Gendlin, 1996; Sander, 2002, Siegel, 2007) and for resuming impeded growth" (Ghent, 1990; Grotstein, 2004, Winnicott, 1965).

A perspective from the sciences of non-linear systems is that transformational changes are fostered when "inherent fluctuations act like continuous perturbations in the form of noise on the collective behavior of the system. Within ranges of the control parameter, the system maintains its preferred behavioral pattern despite the noise" (Thelen & Smith, 2002, p. 63).

However, when the internal and/or external perturbations shake the system's ability to operate out of old order parameters, it can come to a critical point where transformation to new states becomes possible.

So, when one loses a job, a marriage is threatened, drugs are getting out of hand, or kids leave the nest, the old ways of coping no longer function, and a bifurcation point arises that might lead one to therapy. Fosha (2009a), LeShan (1989), and others also argue that concentrating on the positive in the present, the person's best self, and mobilizing to walk into the future with realistic hope can also lure the system forward.

Wilber (1995) adopted the language of holons from Koestler (1967); a holon being shorthand for a whole that is made up of parts and in turn part of a larger whole, a fundamental of systems theory. Wilber studied various holonic systems discovering twenty tenets of evolution that drive or pull a system to develop. Here are a few that support the notion that there is an impulse toward growth one can count on in therapy.

- Holons display capacity for self-transcendence, symmetry breaks creativity (Whitehead) or emergent transformation into new wholes with new forms of agency and communion.
- Holons have directionality toward increasing complexity with a greater overall simplicity.
- Holons have directionality toward increasing differentiation (producing partness, novelty or a new manyness), and integration (producing wholeness, coherence or a new oneness).
- Holons have directionality toward increasing organization/structuralization.
- Holons have directionality toward increasing relative autonomy.
- Holons have directionality toward increasing telos of larger/deeper contexts.

And now, before entering a more specific discussion of how mindfulness can work with emotions in the context of the organization of experience, we return to Tronick's beginning metaphor of messiness.

Messiness is the wellspring of change, and the stuff out of which new meanings emerge. Systems that are fixed, static, and tightly controlled do not change. They remain the same even if they are complicated. For example, spacecrafts have enormously complicated control systems, but they do not develop; nothing new emerges with them. They have a singular purpose, variability is limited, and if variability gets too great, the spacecraft simply fails. By contrast, self and dyadically organized systems generate new meanings. Self-organized private meaning making, such as self-reflection or mentalization (Fonagy & Target, 1998), may lead to a new insight. So might engaging with another person. Either may generate a new state of consciousness (Tronick, 2009, p. 98).

## **Mindfulness Studies the Organization of Experience & Helps Reorganize it through Compassion**

### ***Top Down Processing with Mindfulness***

Mindfulness can function as a tool for studying the complexity of one's emotions in relation to their embeddedness in one's organization of experience (Johanson, 2006a), thus discovering core organizers in implicit memory where they can then become available for explicit reorganization (Kurtz, 1990, 2008). For Germer (2005, p. 6), this is employing mindfulness as "a psychological process (being mindful)," described by Baer (2003, p. 125) as "the nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise." Siegel (2009, p. 151) writes that to "be mindful . . . means that we intentionally seek to notice the categories that shape our preconceived idea of how we structure our perceptions. We avoid premature categorizations, come to an experience with an emergent sense of novelty and freshness." Khong (2007) notes that this approach has similarities to Heidegger's concept of releasement consciousness (*Gelassenheit*), where releasing oneself to the reality of an event is contrasted with automatically imposing one's view in an unconscious way. Sundararajan's (2008b, p. 15) concept of savoring is appropriate here: "Savoring . . . is a receptive mode of information processing, a 'letting be' characterized by awareness and acceptance of one's own emotional states, a capacity generally known as 'affect tolerance' (see Krystal, 1988)." Likewise, Frijda & Sundararajan (2007, p. 15) talk of discovering refined aspects of emotion by approaching them with "experientially engaged detachment." Or, as Fritz Perls was heard to say, "I am the bulls eye the arrow hits every time."

Mindfulness as described here is an expression of non-doing, where one self-consciously suspends agendas, judgments, and normal common understandings (Johanson & Kurtz, 1991; Sorajjakool, 2009). In addition to the passive capacity to simply witness experience as it unfolds, a mindful state of consciousness may also manifest essential qualities such as compassion and acceptance, highlighted by Almas (1986, 1988), Schwartz (1995), Germer (2006) and others; qualities that can be positively brought to bear on what comes into awareness.

For clinical purposes, mindfulness can be considered a distinct state of consciousness distinguished from the ordinary consciousness of everyday living (Johanson & Kurtz, 1991). In general, a mindful state of consciousness is characterized by

awareness turned inward toward present felt experience. It is passive, though alert, and exploratory. It seeks to simply be aware of what is, as opposed to attempting to do or confirm anything.

These characteristics contrast with ordinary consciousness, appropriate for much life in the everyday world, where attention is actively directed outward, normally in the service of some agenda or task, often ruled by habitual response patterns.

Though mindfulness is distinguished from ordinary consciousness, it is not a hypnotic trance state. Awareness is fully present and heightened; those such as Wolinsky (1991) argue mindfulness is actually the way out of the everyday trances we live at the mercy of unconscious, habitual, automatic patterns of conditioning.

This use of mindfulness in relation to emotions functions as a bridge between Eastern and Western perspectives on psychology through its combination of passive distancing aspects of witnessing that can lead to the sense of unity consciousness valued in the East, and active compassionate awareness that can foster affect based healing to internal parts sought in the West.

A fundamental aspect of mindfulness is that it can allow clients to get some distance on the way they are automatically driven or activated by their present organization (Khong, 2004). They can move from *being* their symptoms to *having* symptoms, making, in Kegan's (1982) sense of the evolving self, what was once subject, now object. As Segal, Williams, and Teasdale (2002) discovered in their work researching cognitive-behavioral methods for depression relapse, what is most clinically helpful is that the client's relationship to negative thoughts and feelings is altered (Segal, Williams, and Teasdale, 2002, pp. 38 ff.). It is the distancing or de-centering, mindful aspect of cognitive work, which proves helpful through allowing one to shift perspective and view negativities as passing events rather than abiding realities.

As a state of consciousness, mindfulness can be encouraged in relation to anything present, our emotions as well as breathing or walking, the dishes being washed, or the thoughts in one's mind. Psychotherapists, of course, are especially interested in encouraging clients to be mindful of sensations, emotions, thoughts, feelings, and memories that might be connected to deeper core narratives, transference, schemas, filters, scripts, introjects, beliefs, or other ways of conceptualizing the organization of experience.

The receptive concentration of bare attention on present reality yields experiential knowledge valued by therapists and clients alike.

. . . direct or experiential knowledge bestowed by meditation [is] distinguished from inferential knowledge obtained by study and reflection. . . . Conceptual generalizations interrupt the meditation practice of bare attention, tend to 'shove aside' or dispose of, the respective particular fact, by saying, as it were: 'It is nothing else but . . .' and finds it soon boring after having it classified. Bare attention . . . keeps to the particular (Nyanaponika, 1972, p. 55).

Nyanaponika adds that, "Mindfulness enters deeply into its object . . . [and] therefore 'non-superficiality' will be an appropriate . . . term, and a befitting characterization of mindfulness" (p.43). This concept is attractive to therapists who have found that clients continually rehashing their stories in ordinary consciousness can indeed begin to feel superficial. Thich Nhat Hanh (1976) concurs that, "Meditation [another word for mindfulness] is not evasion; it is a serene encounter with reality" (p. 60). "The term 'mindfulness' refers to keeping one's consciousness alive to the present reality" (p. 11).

When therapists help clients become mindful about what they are experiencing, a number of possibilities are brought into play. Nyanaponika Thera (1972, p. 46) notes that "the detrimental effect of habitual, spontaneous reactions . . . manifest in what is called, in a derogative sense, the 'force of habit'[with] its deadening, stultifying and narrowing influence, productive of [identifying] with one's so-called character or personality" may be studied. To do this "we must step out of the ruts for awhile, regain a direct vision of things and make a fresh appraisal of them in the light of that vision. . . [The insight from mindfulness] is helpful in discovering false conceptions due to misdirected associative thinking or misapplied analogies" (p. 52).

False conceptions are often perpetuated because "on receiving a first signal from his perceptions, man rushes into hasty or habitual reactions which so often commit him to the . . . misapprehensions of reality (Nyanaponika, 1972, p. 33)." To counteract this,

in practicing bare attention, we keep still at the mental and spatial place of observation. . . . There is . . . the capacity of deferring action and applying the brake . . . of suspending judgment while pausing for observation of facts and wise reflection on them. There is also a wholesome slowing down in the impetuosity of thought, speech and action. [This is] the restraining power of mindfulness (Nyanaponika, 1972, p. 25).

Thich Nhat Hanh (1976, pp. 10-11) adds:

Bare attention identifies and pursues the single threads of that closely interwoven tissue of our habits. . . . Bare attention lays open the minute crevices in the seemingly impenetrable structure of unquestioned mental processes. . . . If the inner connections between the single parts of a seemingly compact whole become

intelligible, then it ceases to be inaccessible. . . . If the facts and details of the conditioned nature become known, there is a chance of effecting fundamental changes in it.

Mindful therapy may begin then by taking some aspect of what we have created (sensations, feelings, memories, etc) and mindfully following the thread back to the level of the creator (core organizing beliefs or order parameters). Nyanaponika (1972, p. 61) suggests, “[use] your own state of mind as meditation’s subject. Such meditation reveals and heals. . . . The sadness (or whatever has caused the pain) can be used as a means of liberation from torment and suffering, like using a thorn to remove a thorn.”

In clinical practice, an implication is that mindful attention to present experience goes beyond free association (Kris, 1982) in that it is more focused while still open. Top down processing, termed here *mindfulness of the mind*, assumes the integration mentioned above will yield rich contextual knowledge if there is discipline to stay with one emotion as the cooperation of the unconscious (Kurtz, 1990) works to unleash the impulse to heal.

To trust the wisdom of organic unfolding into increasing levels of wholeness implies that the therapist must proceed in a disciplined way in terms of process, and a non-directive way in terms of taking cues from the client (Weiss, 2008). The best leader follows advises the ancient wisdom of Lao Tzu (Johanson & Kurtz, 1991), echoed in contemporary times by Winnicott (1982) who affirmed that it doesn’t matter how much therapists know, as long as they can keep it to themselves.

The reward for mindfully following the thread from a client’s emotion to the level of their core organizing beliefs is transformation. Siegel (2007, p. 31) reports, “Experience can create structural changes in the brain.” This is the basis for interpersonal neurobiology that demonstrates how the mind shapes the brain (Gallese, 2001; Lewis et al., 2000; Lipton, 2005; Siegel, 1999). Experiences change neural firing that changes neural connections. Siegel (2007, p. 31) then goes on to say, “mindful awareness is a form of experience that seems to promote neural plasticity.”

### **Compassion**

Germer (2006) cautions that there is a danger in that mindfulness within therapeutic applications leaves out the crucial element of compassion. Brach (2003, pp. 27-31) agrees that healing work must include the wings of both clear mindful awareness, and of compassion that allows for wholehearted acceptance. Kurtz (2008) has taught for many years that cultivating loving presence is essential alongside mindfulness. Fosha (2009a) likewise, emphasizes the importance of positive affects while transforming suffering into flourishing. In the Buddhist tradition, the practice of bare attention in Vipassana meditation is often combined with the practice of Metta meditation that serves to cultivate compassion.

A gratifying development in Western psychodynamic work through the influence of attachment, developmental, and psychotherapy efficacy studies is research supporting the use of compassion and positive affects in therapy (Baumeister & Leary, 1995; Beebe & Lachmann, 2002; Bridges, 2006; Davidson & Harrington, 2002; Decety & Jackson, 2004; Fehr, Sprecher, & Underwood, 2009; Fosha, 2000, 2004, 2009c; Fredrickson, 2001; Fredrickson & Losada, 2005; Germer, 2009; Gilbert, 2005, 2010; Greenberg & Paivio, 1997; Greenberg, Riche, & Elliott, 1993; Ji-Woong et al, 2009; Johnson, 2009; Keltner & Haidt, 1999; Laithwaite et al, 2009; Lamagna & Gleiser, 2007; Lewis, Amini, & Lannon, 2000; Panksepp, 2001; Paivio & Laurent, 2001; Prenn, 2009; Schore, 2001; Shiota et al, 2004; Trevarthen, 2001; Tronick, 1998; Tugade & Frederickson, 2004). While Kurtz (1990) and others affirmed this approach over thirty years ago, it was not the mainline model of “professional demeanor” (Kurtz, 2008, p. 15) at the time.

Siegel’s (2007, p. xiv) study of interpersonal attunement in relation to attachment issues leads him to suggest “that mindful awareness is a form of intrapersonal attunement. In other words, being mindful is a way of becoming your own best friend,” an internal act of compassion.

Affect that encourages growth in the context of mindfulness-based therapies stems from the compassion of the patient functioning in Siegel’s sense as a friend to him or herself, and the parallel component of attuned compassion from the therapist. Here mindfulness potentiates top down processing, often in relation to developmental or attachment issues.

### **Self States**

The core aspects of mindfulness, inclusive of passive awareness and active compassion, are essentially present in all clients. These potentials are there, regardless of the client’s object-relations history as it shows up on the ego level of past conditioning. This has led some theorists to refer to these essential qualities as comprising a Self, Core Self, Heart Self, Ontological Self, or a Self-state. The concept of a larger self, new to Western psychology (Schmidt, 1994), has likewise received research support in recent years (Almaas, 1988; Eisman, 2006; Fosha, 2005; Marlock & Weiss 2006; Mones & Schwartz, 2007; Panksepp & Northoff, 2008; Russell & Fosha, 2008; Schwartz, 1995).

Schwartz’s (1995) concept of the Self includes passive awareness alongside a number of essential qualities that can be actively employed in healing. Siegel (2007, pp. 16-17) puts it this way:

With mindful awareness we can propose, the mind enters a state of being in which one’s here-and-now experiences are sensed directly, accepted for what they are, and acknowledged with kindness and respect.

This is the kind of interpersonal attunement that promotes love. And this is, I believe, the intrapersonal attunement that helps us see how mindful awareness can promote love for oneself.

A clinical implication of Self-states is that therapists become conscious of differentiating in their work the larger Self elements of awareness and compassion that client's can utilize on their own behalf.

### ***Bottom Up Processing with Mindfulness***

Mindfulness may be used in top down processing of emotions, as well as bottom up processing of sensations and physical tendencies when trauma is present (Ogden, Minton, & Pain, 2006; (Rothschild, 2000), and ordinary talk therapies risk retraumatization.

Ogden is justly acclaimed for developing ways to use mindfulness in directed ways that promote healing in a safe way that avoids this risk.

"Directed mindfulness" (Ogden, 2007) is an application of mindfulness that directs the patient's awareness toward particular elements of present-moment experience considered important to therapeutic goals. . . . Directing mindfulness toward emotions or toward the body makes it possible to utilize precise interventions targeted at emotional processing--the experience, articulation, expression and integration of emotions--as well as sensorimotor processing--the experience, articulation, expression and integration of sensations and physical actions (Ogden, 2009, pp. 222-223).

Through attending preferentially and exclusively to sensorimotor processing when arousal is at the edge of the window of tolerance, patients learn that the overwhelming arousal can be brought back to the window [of tolerance]. This can be done independent of any particular emotional or cognitive content. Noticing and changing somatic tendencies in the present to the exclusion of emotions and content limits the information to be addressed to a tolerable amount and intensity that can be integrated, facilitates affect regulation and paves the way for future work with strong emotions without causing excessive dysregulation (Ogden, 2009, 2. 226).

In the following quote, Ogden talks of utilizing mindfulness with core organizing beliefs and procedural tendencies, which operate in implicit memory and can easily generate an unwanted trauma vortex.

To discover and change procedural tendencies, the therapist is interested not only in the narrative or "story," but in observing the emergence of procedural tendencies in the here and now of the therapy hour. Through the practice of mindfulness, patients learn to notice rather than enact or "talk about" these tendencies. Therapist and patient together "study what is going on, not as disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded" (Kurtz, 1990, p. 111). Because mindfulness is "motivated by curiosity" (Kurtz, 1990, p. 111), it "allow[s] difficult thoughts and feelings [and body sensations and movements] simply to be there, to bring to them a kindly awareness, to adopt toward them a more 'welcome' than a 'need to solve' stance" (Segal et al, 2002, p. 55). Mindfulness also includes labeling and describing experience using language (Siegel, 2007; Kurtz, 1990; Ogden et al, 2006). Such non-judgmental observation and description of internal experience engages the prefrontal cortex in learning about procedural tendencies rather than enacting them (Davidson et al., 2003). Since emotions and procedural tendencies are the purview of the right hemisphere (Schore, 2003), while language is the purview of the left hemisphere, mindfulness may serve to promote communication between the two hemispheres (Siegel, 2007; Neborsky, 2006). pp. 221-222 Ogden, 2009

### ***Conclusion***

In addition to being friendly to emotions through providing an accepting space where they can be welcomed and learned from, it is also obvious that mindfulness is being friendly to the field by bringing people together who were not sure they had any business being together: Humanists, Psychoanalysts, Cognitive-Behaviorists, Brain Scientists, Traumatologists, Positive Psychologists, as well as Elective General Practitioners and those open to spirituality. One can anticipate a lot of future dialogue and debate on the various ways mindfulness could be used in therapeutic protocols with emotions and a myriad of presenting issues (Johanson, 2009c).

### ***Case Study Verbatims Illustrating the Use of Mindfulness and Compassion***

What follows are case verbatims with commentaries that illustrate actual clinical use of the above discussion of theory. The following are individual sessions with a wife and husband that both participate in a veteran's program offered by a church-

related mental health center with state and county funding. The program offers therapy groups for veterans, support groups for spouse-partners, individual sessions for each, and couples sessions. In this example the vet Ben chooses to work on issues in individual sessions because he feels he would have to contain himself too much in a couples' session with a non-vet. However, he is happy for his wife Trish to get individual support.

### **Wife Trish**

Client: So, I'm really struggling with Ben's wanting to go with me and the kids, alone or separately, wherever we go. It felt like caring and protective when he first got home from the deployment. Now it's starting to feel smothering or something. I can feel some angry part of me getting touched. But, I don't want to push him away and get him activated, and make him feel like we don't want him. And, he is also a bit angry and distant with Ed [four year old son]; kind of ordering him around instead of being warm in his communications.

*(Client telling story with appropriate affect in ordinary consciousness)*

Therapist: Okay. So, I'd probably need to continue to deal with Ben directly about what's up with Ed. On the smothering thing, it sounds reasonable to be feel hemmed in when you are so used to being self-reliant with him away. But, you are saying it feels like something in you is cranking up your reaction beyond what is normal ((?))

*(Sorting out issues in story, and working to collaborate on where the session might focus. The ((?)) symbol implies a certain unattached curiosity in the therapist's voice tone that invites the client to explore her experience more deeply.)*

Client: Yah, it feels like some kind of fire that is ready to react to provocation before there is any.

*(Client taking responsibility for her part in the couple's interaction and expressing a willingness to explore it, knowing Ben is doing the same in his own sessions.)*

Therapist: So, exploring more deeply this part of you that is ready to feed the fire seems good, huh?

*(Proposing an agenda that seems to be where the client's curiosity is. The "huh?" communicates that the therapist is not attached to the agenda and is willing to be corrected or have the proposal be fine tuned.)*

Client: Yah. Let's. I don't want to get into something that ends up being more ugly than it needs to be.

*(Mini-contract confirmed.)*

Therapist: Good. Okay. There are a number of ways to get into this. How about you imagining the last time Ben came along that seemed a bit much, and we can slow down and study what that was like for you?

*(This is an invitation to switch states of consciousness into mindfulness that is fairly brief and straightforward since it is the fourth session and the client has already been exposed to the process.)*

Client: (Client closes eyes, slows down, turns her awareness inward toward her felt present experience. Almost immediately her shoulders shake, and she shows emotion in face and voice). Oh, it was yucky!, but I didn't let myself express it like here.

*(While the client is observing and reporting her experience, it seems she is fairly fused or blended with the yucky part, and doesn't have much distance.)*

Therapist: So just remembering that last time is pretty activating, huh?

*(Looks for non-verbal assent to contact statement).*

Therapist: How about we get a little more distance on the issue by just imagining you will be calling down the hall to let Ben know you are going out, anticipating he will say, "Oh, I'll come too." But before you actually call, stop and be a witness to whatever is evoked in you prior to calling. As you anticipate his response, notice what comes up for you spontaneously, without you efforting anything -- any sensations, muscle tensions, feelings, attitudes, thoughts, memories . . . ((?)).

*(The therapist attempts to modulate the energy level by evoking enough of a signal to guide the process, but not so much that the person becomes the emotion as opposed to being present to it. More specific suggestions are offered to support a mindful state of consciousness. Notice the therapist does not limit the study of experience to affect alone, but broadens the range of possibilities.)*

Client: The anticipation would be more like, "Don' leave! I'll be right there."

*(It is a good sign for a client to fine-tune the words or process. It is an indication she is immersed in and listening closely to her experience.)*

Therapist: Great. Anticipate the "Don't leave!" and study closely what it evokes in you.

*(The word "study" supports mindfulness in that it invites someone to be present to their concrete, felt experience, but also a step back where they can notice and be curious about it, as opposed to simply being swept along by it. It is a middle position between "talking about" their feelings or simply "acting them out.")*

Client: I notice some sense of resentment with my cheeks and arms warmed up, almost hot, but I'm clamped down, and feel tension in my face and arm muscles.

*(Good witnessing by the client who is both present to her experience and able to comment on it from the position of an observer.)*

Therapist: Uh, huh. Maybe if you just hang out with the resentment, befriend it, and be curious about it, you will sense more about it, or it will tell you more about itself ((?)).

*(Now that the client has been invited into a mindful space, the therapist encourages staying in the state longer, and deepening into present experience with trust in the organic impulse to unfold toward greater wholeness or complexity.)*

Client: It seems to be muttering something about "unfair" between clenched teeth, but afraid to really be heard.

*(More threads or context gather magnetically around the original report of anger as the experiential spaciousness of the mindful process allows the unconscious to lead more deeply into unhealed constraints.)*

Therapist: Like really in a bind ((?))

*(A simple contact statement addressed to the present experience facilitates the deepening of the process.)*

Client: (More emotional, with a younger quality to her voice) Yah, like her father loves her, but won't let her go play with the other bigger kids, and she is really mad, but can't say so because he is really strict, and will punish her right there in front of the other kids, and she would really be embarrassed!

*(Process spontaneously deepens into a memory.)*

Therapist: Oh, a memory comes up. How old does she seem to be?

*(Contacting details like age help stabilize the memory, and referring to "she" as opposed to "you" helps maintain the witnessing position. At this point the process has gone from becoming mindful of some aspect of creation--the anger--and descended close to the level of creation, the memory that informs a core belief about not being able to be liberated to explore in freedom and/or express displeasure about not being able.)*

Client: Four, maybe five.

*(. . . more processing, deepening and stabilizing the memory . . .)*

Therapist: As you simply view the four-five year old from your position of compassionate awareness, what do you sense that she most needs that she is not getting in her situation . . . ((?))

*(Therapist invites both witnessing and compassionate aspects of the client's larger self-state.)*

Client: She needs to know that it is unfair for her dad to limit her and over-protect her, and then scare her into not even being able to express her feelings about it. And, . . . she needs to know, to know, uhh . . . it won't be this way forever . . . that

sometimes people in power do try to hold you back, . . . that's true, . . . but . . . that there will be times when she finds the freedom to use all her strengths and energies without being held back.

*(Here the empty, non-agenda space of compassionate awareness releases itself to the situation of the inner child and receives some relevant psychological-emotional information. The slowness and space between realizations is an indicator of a mindful process.)*

Therapist: Yes. So, go ahead and communicate that to her in any verbal and non-verbal ways that seem right, perhaps having her look in your eyes so she really gets your presence, and check whether she is taking it in or not.

*(A therapeutic directive that invites her to take the awareness and loving presence of her self-state and apply it interpersonally to this inner child, thus, as Daniel Siegel puts it, helping her mindfully become a friend to herself. Communicating through the eyes and face are crucial for safety and communication as Porges' research shows.)*

Client: Yes, she is getting it. But, it is a new thought to get used to, kind of like a fragile flower coming up that needs some tender care.

*(Acknowledging both the transformation of organizing in new information previously organized out, as well as the fragility of the process that will need more integration.)*

Therapist: That's really important to follow up and keep integrating to foster this new neural network. In particular, ask her if she is willing to have a conversation with you when you go home, directly or through journaling, about how to have a conversation with Ben that acknowledges both your knowledge of his care and your need for freedom to use your own strengths.

*(A directive to help foster this intra-psychic relationship, so the internalized object of the inner child and her larger self-state can dyadically regulate the affect that gets stirred up in these situations with the husband, as well as other situations.)*

Client: Yes, she wants that, . . . and needs that . . . to keep from going into that suppressed rage, and to know more about what is really possible.

*(Relationship is reinforced)*

Therapist: You can really help her grow into a new future by experimenting with this new possibility of freedom in relation to real situations. And do you feel you will be able to have a little distance on the anger when it arises in situations like with Ben, so that it doesn't completely take over and blend and fuse with you?

*(Reinforcing compassionate intra-psychic relationship, and checking for distancing or decentering aspect of mindfulness.)*

Client: Yes, I think I'm much clearer now about what the anger and fear and holding are about, and if it comes up too hard, too fast, like with Ben, I'll be able to ask for a time-out before we talk more, so I can sit, check with the young one, and get more distance and centeredness before sorting things out with him. I'm not quite clear about what is going on with Ben, but I have a more relaxed sense of compassion for what is going on with me.

*(Starting to complete and move back into ordinary consciousness.)*

Therapist: Awareness and compassion are an ongoing practice we keep learning from. Good luck with this one.

### **Husband Ben**

Therapist: Hey, good to see you.

*(Promoting positive affect and transference, nourishment, secure attachment, and what Fosha--AEDP, refers to as not just seeking a new ending, but also seeking a new beginning.)*

Client: Uh huh. And what is so good about it?

*(Trusts therapist enough to challenge -- a return greeting in ordinary consciousness.)*

Therapist: (Smiling and making eye contact) Oh, you know. No good reason really. Well maybe your engaging smile, your dedication to your family, your persistence, your loyalty. Not your good looks, for sure. Well actually, you are skinnier than me. I wouldn't even be able to deploy.

*(An attempt at integrating humor into the process. If people are at least co-creators of the meaning of their lives, then the creativity they used to organize their experience in one way is still available to help reorganize it in a new way. Humor affirms this capacity, which would not be appropriate with someone who was an absolute "victim" or "sick." Also an example of the use of self-disclosure-- Prenn, (2009).*

Client: (Laughs). Hey you can be skinny too. Want to join me each morning with a ten mile run?

*(Appropriate rejoinder reflecting decent therapeutic alliance, a lot of mutuality, though still asymmetric. It is important that clients know the therapist appreciates them in their strengths as well as their vulnerabilities.)*

Therapist: Pass. Although, I am working out a lot. I can now do three laps around the car without needing an oxygen tank! So, what is going on that it is not so good to see you today?

*(Transition from initial nourishing small talk and contact to issues at hand. Important that positive exchanges never gloss over the truth of present experience.)*

Client. Still having a hard time just relaxing with Ed. End up ordering him round, like I'm trying to whip him into shape or something. Geez! The kid is barely four, and feels like I'm an E9 [Sergeant Major]. But, the most distressing thing is that I was walking around the village when Trish and Ed were in church; fairly relaxed, taking in the green, starting to feel that maybe I was in a relaxing place when a car backfired and I hit the deck! Jumped back up really quick, but really embarrassing and I haven't been back in town since.

*(PTSD symptoms: exaggerated startle response, sense of reliving trauma experience, significant social stress, avoiding activities and places.*

Therapist: Wow! Lower brain just took over. Yah, very disturbing.

*(Contacting present experience in a way that validates the event. 10th session and therapist has been sharing some physiological information with Ben that helps him feel that his reactions are in the ordinary realm in terms of what he has been through, and that it is known, recognizable, and workable.)*

Client: Seriously. How can I function in the world and think about getting an ordinary job?

*(More symptoms of detachment, estrangement from the world, and poor sense of future possibilities.)*

Therapist: So, just remembering the backfire is activating. Let's stand up together and do some resourcing. Stand in that short-stop stance, feel the ground under your feet . . . feel the flexibility in your knees . . . rock right and left a little bit. Notice the transition between the two . . . Notice your strength and readiness to do what needs to be done. . . . Put your hand on your lower stomach and breathe into it on the in breath, and make your hand move out. . . . Can you feel your hand there? What tells you it is there? . . . Just notice whatever other signals you are getting from your body.

*(Because the activation levels are taking the client in a hyperaroused state beyond his window of tolerance, the therapist abandons verbal, top-down processing that could risk setting off a trauma vortex. The client allows him to become very directive, concentrating on the body instead of emotions, since they have done resourcing together before. The therapist does encourage mindfulness of body signals. The instruction to "just notice whatever other signals" is a more general invitation to mindfulness. The therapist is exploring how resourced the client is in relation to being present to experience from the theoretically more safe distancing place of mindfulness.)*

Client: I feel like I'm on lookout.

*(The physically ready stance is resourcing, but evokes the memory of serving as a lookout.)*

Therapist: Yah, looks like your head is rotating a bit, bobbing and weaving slightly, like you are really vigilant.

*(Therapist contacts the experience, but is a bit worried about not wanting to throw the client back into a traumatizing memory that would overwhelm.)*

Client: I can sense my eyes are tightened and squinting. It feels like when I was big into R&S [reconnaissance and surveillance]. I was always good at the Avoid Ambush drills and did a lot of gap work [lining out safe passages through mine fields].

*(Client is on the dynamic edge of being able to mindfully witness his sensations and tensions, and being in danger of getting flooded and fused with traumatic memories. Learning happens on the edge between order and chaos, and the therapist attempts to track the balance.)*

Therapist: Let's just bring your awareness and curiosity just to the eyes, to the tightening, not what it means, but just study it in terms of muscular tension alone, and notice what happens . . . reporting on your experience without coming out of it to tell me about it.

*(Therapist feels things are too volatile and chooses to employ what Ogden calls "directed mindfulness," directing mindfulness to lower brain generated sensations de-coupled from emotion, stories, etc. Reporting without "coming out to tell me about it" is a helpful directive for keeping the client's mindful focus on the unfolding of internal experience, which is interrupted when they feel they have to come back to the normally expected realm of interpersonal discourse to report.)*

Client: As I pay attention to the tightness, it seems to loosen up. . . . Now I'm noticing some kind of fear in my gut.

*(The process unfolds in this mindful state with one thing becoming connected to another that fleshes out this procedural tendency.)*

Therapist: So, let's pay attention to the fear in the gut simply on a sensation level, and follow it wherever it goes.

*(Continued use of directed mindfulness of sensorimotor processing. The "we" language of "let's us pay attention" supports both secure attachment, and the dynamic of there always being an interpersonal parallel process to the intra-psychic exploration mindfulness often encourages.)*

Client: The fear sensation seems to travel up into the throat . . . where it clamps . . . down, . . . or, clumps up . . . kind of like a ball.

*(Good witnessing that serves to self-regulate instant, out-of-control fear and maintain a curious, open stance toward it.)*

Therapist: I'm just guessing, but it seems like the sensation wants to move, and there is some other part of you that wants to block it for some good reason we don't know right now. How about we experiment with you holding this pillow to your face and mouth and allow it to be the part that is clumping up the movement of the sensation. Don't force anything, but just hold it there and notice what arises spontaneously.

*(This is an example of a taking over technique from Kurtz who finds that when a defense is supported in the state in which it naturally arises, it paradoxically allows the process to go forward. The word "experiment" underscores an experimental attitude that underlies mindful work, which lends itself to more curiosity and allowing, as opposed to forcing or engineering. It fosters the attitude that whatever is evoked in the process is fine and natural and becomes ongoing grist for further processing. Likewise, the phrase "I'm just guessing" makes it crystal clear the client needs to go with the truth of his experience and feel free to ignore the therapist's guess if it is not on.)*

Client: Uh, okay . . . (holds pillow close to mouth) . . . oh! (shows signs of increasing agitation) . . . (holds pillow forcefully toward mouth so the sound is quite muffled while screaming into it repeatedly in rhythm with rocking motions of head down and up.)

*(Spontaneous occurrences such as this that are not the result of directives, are usually trustworthy. The pillow muffling the sound has apparently worked in taking over the function of some part of Ben that didn't want him yelling.)*

Therapist: Okay Keep screaming as long as it feels good, feels right.

*(We are not working with a hydraulic-expressive model here, but an information processing one, so the therapist is not encouraging simple catharsis or emptying. But, tracking pleasure in terms of what feels good, right, or satisfying is often a good indicator of completing some action tendency that has been thwarted.)*

Client: (Finishes screaming in a semi-exhaustive, but seemingly good state) Oh man! I got it . . . phwu . . . both parts (more heavy breathing, catching breath) . . . the scream is "Get out! Get out!" I'm so tense being responsible for my men, worrying about their welfare, worrying I'm going to have to call some wife and give her the most shocking f-ing news of

her life, and this is no place to be. They need to get out of there, get out of danger. The pillow is duty, mission [core Army values. Never abandon the mission.]

*(The wonderful result of encouraging a mindful, curious process is that client's end up interpreting themselves, which often allows the therapist to follow more than lead.)*

Therapist: Whoa. Yah. You nailed it. How horrendous being responsible for life and death. No wonder you want to get them out of there.

*(Basic human confirmation.)*

Client: God yes! I think this is why I hesitate to go to church. I don't like this God business.

*(A spontaneous connection arises.)*

Therapist: Okay, so we need to check in more about doing God-duty. Right now, check in on how your body is doing. Notice if there are any other sensations or movement tendencies that are talking to you.

*(Therapist invites a search for other aspects of the mind/body that might be involved in this procedural tendency to be in hypervigilant duty mode.)*

Client: There is energy in my legs for sure.

*(Good witnessing of what is there without slipping into over activation.)*

Therapist: Sense into the energy and notice if it wants to mobilize you into any kind of movement. If so, slowly follow just the beginnings of the movement.

*(Here the therapist has a hunch and is entraining awareness toward movement, when energy can actually lead to other things as well.)*

Client: . . . (slowly, mindfully checks in with energy) . . . yah, it wants to move the legs . . . IT WANTS TO RUN!

Therapist: Yah! So in your imagination now, and also allowing your legs to move up and down as much as you want, yell to the squad to get out and run! No mission here! Nobody left behind! No reason to be here! Run! Run! Run!

*(We know from trauma work and recent research in neurobiology that the imagination can stimulate the same neural networks as in real life, and can be used to complete action tendencies frozen in time. The instruction here takes into consideration the counter message of the clumped throat that prevented the natural expression of screaming and running in the war zone.)*

Client: (Takes a few minutes to really get into the running away scene where he shepherds his men like a sheep dog, with actual legs going up down rapidly while running in place and imagining. Finally collapses on floor in a good way and leans back against the sofa.) Oh, man! Oh, geez. I finally feel relaxed, like I don't have a foot on the gas and brake at the same time.

*(Natural result of an action tendency taking its course, and an implicit procedural tendency coming into cortical consciousness.)*

Therapist: Great. Very nice. So, just sit back for awhile and savor what it is like to be in this state of relaxation. Notice in a curious spacious way what is different in your sensations, tensions, feelings, attitudes, whatever.

*(Important to savor and integrate the new experience. A large part of mindful processing is simply slowing things down.)*

Client: (follows instruction in slow mindful way.) . . . I really like looking around with my eyes in a soft way that takes in more information actually than when they are tense and seriously focused.

Therapist: So, from this relaxed state, I would like you to experiment with inviting the on-duty Sergeant you that is mobilized to be on mission and worried about his men to come into view. Let me know when you have some kind of visual or kinesthetic image that he has come into view.

*(This is an example of the distancing-while-still-being-present aspect of mindfulness. Saying "visual or kinesthetic" makes room for those who don't get visual images easily)*

Client: Okay. He is front and center.

Therapist: Good. So, check if you are in that place of compassionate awareness that can express to him some gratitude and thanksgiving that he can go on this impossible God-duty where he takes on a mission while carrying all this concern for his men that just wants to get them out of there. And, if you are in that space with him, notice if he can take in the appreciation.

*(This type of mindful therapy is never about exorcizing or fighting against parts of one's internal ecology. Honoring or respecting the benevolent intent behind each part, as Richard Schwartz suggests, helps make each part a harmonious and coherent element of one's narrative. The compassion of the client's larger self-state that can express appreciation to the God-duty warrior is not necessarily voting for such a position in our war-torn world. The qualifier "if you are in that space" makes room for parts of the client's inner family, team, squad, committee, or tribe to be present that might have objections to thanking the God-duty guy, which would then need to be dealt with first. Here the therapist suggests an interchange. Another option would be to ask the client to sense into what the God-duty guy needs from him right now in terms of a response, and then offer it.*

Client: Yes he is getting it. He appreciates the acknowledgment.

*(When any member of a team is acknowledged and respected for their concerns or perspective, he or she tends to relax, trust the leader, and be willing to go along with the team's decision, even if it is not exactly what they were advocating.)*

Therapist: Good. He is an important and needful guy to call on, that not everyone has. What I would like us to do next is have you stand up again and slowly, mindfully go back and forth between three positions, really studying the minute differences that go into each position, until you can consciously move between them at will with your mind/body/spirit, which is different than when they just happen to you, with or without your intention. The first is the war zone-God-duty-on mission-worried about his squad guy. There are appropriate times this guy needs to take over things. The second is you at home with your family, safe, behind closed doors, relaxed like you are now, in that place where you can enjoy them and allow them to enjoy you. The third is when you are out with your family in the village, where a little more assessment of danger is called for since you are no longer inside the safety of your home, but normally it is far far from anything like a war zone. Okay?

*(Learning to take on these various positions voluntarily in terms of sensations, tensions, thoughts, feelings, attitudes, etc. does not take away the power of lower brain activation to click in when stimulated by internal or external stimuli. It does have an empowering effect on vets to do this differentiation practice that consciously reinforces realities such as "here I am in the city where cars backfire, vases fall off the ledge and crash, kids light firecrackers, and yes, sometimes people use guns." And, it seems helpful to give both permission and practice to taking on the appropriate modes of mobilization for different situations.*

*(Session continues with spending a good amount of time integrating this ability to assess and mobilize appropriately and consciously)*

## Summary

The initial theory aspect of this essay outlined the complexity or messiness of emotions. It then moved to outline how emotions are an integrated and integrative aspect of the universal need to organize and make meaning of one's experience. It was then argued that psychotherapy could be broadly conceived as working with the organization of one's experience, especially with important emotionally laden aspects of life previously organized out. The assumption was underlined that doing psychotherapy with living organic systems implies an impulse to heal or move toward transformation that allows the therapist to track how a process is unfolding, as opposed to needing to engineer one. Mindfulness, as a specific ability of consciousness to be both passively aware and actively compassionate, in what some theorists have termed a Self-state, was explored as a premier tool for studying the organization of experience. A mindfulness-centered, somatically inclusive process allows implicit core organizers to become explicit, and available for modification. Annotated clinical verbatims were provided that illustrate the use of mindfulness in top down processing of emotions, and in bottom up processing of sensorimotor material when too much traumatic activation is present.

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#### Biography

**Greg Johanson, Ph.D.** is a Founding Trainer of the Hakomi Institute. He has been active with the USABP for a number of years as a Board Member and on the editorial committee of the USABP Journal. He and his wife Hope live in Mill City, OR [greg@gregjohanson.net](mailto:greg@gregjohanson.net).

# The Relational Turn and Body Psychotherapy

## II. Something Old, Something New, Something Borrowed, Something Blue; Individual Selves and Dyadic Selves in Relational Body Psychotherapy

Asaf Rolef Ben-Shahar, Ph.D.

### Abstract

The therapeutic relationship is a matrix of relationships, from the functional relationship of ‘doing something for’ the client, through the attachment-based transference dynamics to the genuine I-thou moments of shared humanity. The relational dynamic is created by the tension among those fields. This paper sets out to explore what is meant by the idea that there is no such thing as a body, only bodies in relationship (Orbach, 2003). Exemplified with case vignettes, theoretical background and clinical examples, this paper attempts to present the exciting discipline of relational body psychotherapy and the new horizons it may offer to the field of body psychotherapy.

### Keywords

Intersubjectivity – Functional – Relational – Mirror-neurons - Transference

This is the second of four papers, together forming *The Relational Turn and Body Psychotherapy*. These papers examine the touching points between body psychotherapy and the exciting and encompassing field of relational psychoanalysis. The first paper *From Ballroom Dance to Five Rhythms* (Rolef Ben-Shahar, 2010), explored some basic concepts in relational psychotherapy. It also pointed to the relevance of relational thinking to the history and practice of body psychotherapy. This paper expands the discussion on intersubjectivity, attachment and dyadic selves, examining the balance between regressive and novel aspects of intersubjectivity. The third paper: *Salsa Lessons and the Emergent Self*, will explore connections between somatic organization, relationality, and the place of the self in relational body psychotherapy. Lastly, the fourth paper: *Gliding on the Strings That Connect Us*, will demonstrate the use of resonance (somatic countertransference) in body psychotherapy within a relational framework.

### Introduction – Relational matrix and wedding vows

Our wedding day still stands as one of my happiest memories, a resource I find myself drawing upon time and again. I remember standing hand in hand with my wife and watching our guests. We were deeply connected and full of love. We stood there as one, yet we were also highly differentiated: a bridegroom and bride, Asaf and Tom, Adam and Eve. The Rabbi spoke of us creating something new, a new family, a new bond of love which has never before existed, a bond like no other bond in the world. “At the same time,” he said, “you stand here together like every couple who has ever gotten married: you repeat the same vows, you share the same sentiments, and you walk the same path. You are symbols, you are man and woman. At the same time: unique and archetypal, old and new.” Somehow, although my mind could not fathom this contradictory position, my body recognized it as true.

According to a centuries-old tradition, still in place in many countries, every bride should have five items on her body during the wedding ceremony. The verse reads like this:

*Something old, something new  
Something borrowed, something blue  
And a silver sixpence in her shoe.*

This Victorian English poem marks the importance of embodied-wedding symbolism. Each one of the five items represents a different aspect of (and a blessing for) the marital union. *Something old* is an item symbolizing continuity and the link to the bride’s past and family. *Something new* represents optimism, hope and new beginnings. *Something borrowed* may stand for leaning against other people’s experience and trusting in the support of family and friends. *Something blue* – a symbol of love, good luck and purity. A sixpence (an old English coin) in the bride’s shoe is, of course, an emblem for wealth and prosperity (Tevis, 2007).

Since the field of relational body psychotherapy is a marriage of sorts (between different professional milieus), this paper will try to stay true to form and bring these items into embodied, professional life.

Gregory Bateson (1979), who forever insisted on seeing both the forest and the trees, boldly wrote: “According to the popular image of science, everything is, in principle predictable and controllable; and if some event or process is not predictable and controllable in the present state of our knowledge, a little more knowledge and, especially, a little more know-

how will enable us to predict and control the wild variables.” (p.37) However, Bateson continues, “This view is wrong, not merely in detail, but in principle.”

We enter therapy with explicit and implicit expectations, with spoken and unspoken vows. We enter therapy with hope, some of it justified, some of it wishful thinking. Since pain is our primary motivation for seeking therapy, we look to the therapist to help us with this pain, we pay our therapist to make our pain go away; and this promise will be broken. It will be broken because the human bodymind is not a machine, even though it may sometimes be useful to pretend it is so. As ‘not-machines,’ we cannot be fixed. We can heal – and we really do heal, but we cannot be fixed. And one of these broken vows concerns our contract – yes we will help you, but not as you think we will: we will help you by relating to you.

Every meaningful relationship, not the least therapeutic ones, is a matrix of dimensions. The interplay between these dimensions creates the rich tapestry of human relatedness, and would provide us, here, with a lens through which to examine relational body psychotherapy.

The first dimension is that of utility or function (something borrowed): Each and every relationship fulfils some purpose; we want something from the other, be it material or emotional. Our engagements with other people include a functional, utilitarian side to them. When we enter therapy, we expect our therapist to offer their service to us – and the contract is based on a functional vow.

The second dimension is transference (something old). It means that into each new relationship we bring the wealth of our previous relationships, particularly attachment relationships, and the way we have internalized these. Any newness in relating is therefore partially colored by our previous relating-models (organizations).

The third dimension is the humanistic one (something blue). In this dimension, notwithstanding the transference and utility relationships, there exists a genuine meeting of people inasmuch as they are people. This meeting takes place beyond the roles and functions, beyond the history and future.

These three levels interact and are not mutually exclusive. Successful therapeutic relationships flexibly dance among all three dimensions. Moreover, the richness of intimate relationships arguably exists in a fourth dimension (something new) which is created by the tension among these three fields, a matrix that includes both symmetrical and asymmetrical aspects, utilitarian and humanistic, transference and I-thou.

In this paper, I wish to suggest a possible way of looking at this complex relationship between preserved and novel aspects of self not only in psychic terms but also in the way they manifest in the body.

Winnicott (1951, 1971) speaks of the transitional space as an in-between space - between reality (interpersonal field) and fantasy (internal, intrapsychic field) - between me and you. Does this intersubjective field have an anatomy? Does it have a body? I believe that this “us-ness” indeed has a body. The placenta is an obvious organ of this shared body – belonging both to mother and baby, to the babymother. But the placenta represents a primary intersubjectivity – one we are born into, this is our primary body. We have a shared body before we develop a differentiated, individuated body. Just like the placenta, mirror neurons too could be thought of as transitional phenomena - they do not belong to us and to our nervous system (or at least not entirely) - instead, mirror neurons might be understood as the nervous system of the relational field, as the part within our body that isn't only our body - this is the body of the relationship (and we only carry half of this body) – this will be expanded on in the last section.

This way, we might understand somatic transference as embodied sensing of the intersubjective field. When we ‘feel into’ the relational body, we do not simply sense our ego-centered, skin-boundaried body. Instead, we sense the shared-body, the potential-space-body: we feel into the intersubjective third. And we do so through the nervous system, the endocrine system, the immune system of our shared body. The bond between self and other and between intrapsychic and interpersonal ceases to exist as a conceptual phenomenon and becomes an affective, embodied dance. We have prepared for this wedding for a long time – so, let's boogie!

### **Something borrowed – the utility (functional) field**

On a very basic level, the utility relationship is the motivation for seeking therapy, and all other relational dimensions are answerable to this one. By the end of therapy, if no shift has taken place for the client, if none of his goals (or orientation toward those goals) has changed, this would not seem like a good relationship. Our clients usually arrive to therapy in a hurting place, and are willing to give us, in return, what we want – be it money, time, energy, relationship. Psychotherapy is not (only) a sacred profession; we do want things from our clients too. On the functional level, these are very clear: they pay us. We receive a socially accepted reward for our worth; we are paid for being willing to put our own functional needs aside and primarily attend to their needs. The payment is therefore a compensation for the inequality of the utility relationship, as well as an acknowledgement of our expert *service*.<sup>1</sup>

On this level, the therapeutic relationship is one of service, interdependence, mutual needs, and utilitarian gains that develop and are woven between therapist and client. Some relationships center around, and are almost limited to, the functional field. Service relationships are a good example. When I pay someone to paint my flat, we contract a functional relationship. Not only is our relationship focused on the function, but I may even limit the development of other relational dimensions lest it

<sup>1</sup> For example, see Muriel Dimen's (1994) extraordinary discussion on money, love and hate in psychoanalysis.

would obstruct the work. For example, I might leave the house and come back only when the work is done. The language of utility relationship is one of contracts.

The therapeutic contract is often seen as a very rigid one. Possibly because so many other dimensions of relationship develop therein, we ensure and protect our needs and functions very early on: our meetings are fixed in time, there is a firm cancellation policy in place, and money is frequently paid without real room for negotiation.

The particular nature of the service we are providing/giving (our function) and the exchange rate (money for help) turns the utility dimension into an asymmetrical, power relationship. Our client's utilities are explicitly placed at the center of the relationship. While both parties contribute to the functional field, they do so unequally. Within the functional relationship, the basic question we pose to the client is "What can I do for you?" and the quality of the relationship is measured by our capacity to dialogue with their answer to this question satisfactorily. Let me illustrate a therapeutic relationship focused on the functional field.

Richard was a lean and anxious 54-year-old insurance broker, who was referred to me by his physician. Richard was reluctant to start therapy; he would have preferred medication. He suffered from debilitating panic attacks for many years, and slept very badly. Recent change of job (an unsolicited promotion) brought with it great distress, and Richard felt pressured by new demands, and bullied by his boss. Inquiring into his history, I discovered that Richard had a physically abusive father, and he described himself as forever struggling with depression. However, Richard made it clear that he did not want long-term psychotherapy.

What was most striking for me when I sat with Richard was his jaw. My own jaw was aching from the moment he sat in the chair with me, and his face looked strung, tense, and effortful. I offered Richard to do some bodywork together, and to my surprise he readily agreed. The immediacy and tangible nature of my offer was possibly more appealing (and less scary) than speaking about his pain. After some warming up of the area, I applied strong pressure to the masseter muscles and waited. Richard's face became crimson red almost immediately, and he got up and started pacing the room up and down. "I'm furious," he said. I gave Richard a racket and big pillow and he started hitting and shouting. One could almost see the cushion changing faces before one's eyes: at first his boss, then other bullies from his life, and in the end – his father. It was as if this small tense muscle held an entire history of subordination.

Richard came to see me three more times, and he reported a great improvement at work and at home. He confronted his boss and workers assertively: "I am no longer everybody's doormat," he told me.

Richard would have undoubtedly benefited from psychotherapy. In many ways his life was very rigid, but he was not ready for, nor was he interested in, such an endeavor. Our brief work together helped open the door to reorganization long enough for something to change, and for that particular context – it was all that was needed. And my place was that of an expert mechanist: I knew where to press.

The functional therapeutic intervention is a journey into habit formation and deconstruction, and has an important place in many therapeutic relationships. Keleman's (1981, 1987) Accordion Exercise (where bodymind organizations are exemplified as posture, amplified and reorganize), for example, offers a skilled application of functional change – and many forms of somatic interventions mainly operate on that level.

This type of focus is not necessarily a bad practice. While therapy cannot and should not always be quantifiable, we do have to facilitate a process of change: even if the change is *just* in the orientation to ourselves and our problems. However, ignoring the transferential and I-thou dimensions, as is historically a common practice in bodywork, does not mean these dimensions are not present within the therapeutic relationship. The insufficiently trained bodyworker is often impacted by these other dimensions without being aware of it, leading to potentially problematic effects on the client, therapist, and the therapeutic relationship.

### Something old – the transferential field

"Personal influence is our most powerful dynamic weapon." Sigmund Freud<sup>2</sup>

Were humans simply machines, the relational complexity could have ended in the utility field. A huge web of utilitarian functions and interests would have created a complex world of needs and contracts, all driven by explicit and implicit agendas of functions. Thankfully, though, we are more than machines. We are first and foremost social creatures. As soon as we enter a relationship, however simple it may be, we (both of us) inevitably position ourselves in the relationship in accordance with our previous relational forms (Boadella, 1992; Pulver, 1963).

Everything we know about relationships is with us from the onset of any new connection. We carry our mothers and fathers, siblings and teachers, heartbreaks and expectations. Harry Stack Sullivan (1954) illustrated: "even though only two people are actually in the room, the number of more or less imaginary people that get themselves involved in this two-group is sometimes really hair-raising" (pp.8-9).

The psychotherapeutic relationship, since it is from the onset an intimate relationship on the one hand (we talk about our deepest pains and yearnings), and a very asymmetrical relationship on the other, is a fertile ground for transferential dynamics. While all relationships carry transferential dimensions, the therapeutic relationship is unique for its willingness to name these influences, work with them and do it without shaming.

<sup>2</sup> (Freud, 1926, p.224).

In classical psychoanalytic theory, transference was seen as a unilateral event, where “the patient-therapist ‘dyad’ becomes a stage on which the patient re-enacts formative experiences and reactions, and so brings directly into the interactions between the patient and the therapist the very processes by which his personality developed” (Karle & Boys, 1987, p.200). It was recognized that the patient transferred past experiences and expectations - frequently attachment relationships (Dozier & Bates, 2004) - to the therapeutic situation and an important goal of therapy was to help the patient disentangle the tainted projections of previous forms (Houston, 1995; Klein, 1960). In this one-person psychology model of transference, the analyst was at most, responding to the projections of the client.

Questions then started to arise regarding the realistic presentation of this unilateral dimension. Jung, for example, perceived the therapist as deeply and emotionally involved in the therapeutic process (Field, 1996, p.84) and Sándor Ferenczi (1930) already recognized that the transference dimension represented a bilateral relational field, where the analyst’s personal biography and experiences (transference history) play out in the therapeutic field as well. Hans Loewald (1986) exemplified the disenchantment regarding the therapist’s neutrality:

The resonance between the patient's and the analyst's unconscious underlies any genuine psychoanalytic understanding and forms the point of departure for eventually arriving at verbal interpretations of the material heard or otherwise perceived. The analyst, during that internal journey, in his effort to stay sane and rational is often apt to repress the very transference-countertransference resonances and responses, induced by the patient, that would give him the deepest but also most unsettling understanding of himself and the patient (p.283).

Loewald therefore recognized that the transference dynamic was a bilateral field. The past histories of both psychotherapist and client affected the current therapeutic relationship (McQueen, Kennedy, Sinason, & Maxted, 2008), and both parties had to collaborate in order to extract genuine connection from this complicated biographical matrix. This entanglement is not merely verbal, though, as it also manifests in the bodily attitudes of both therapist and client towards one another (Orbach, 2004; Schneek, 1966, p.218).

Relational psychoanalysis represents the culmination of what both Ferenczi and Loewald began arguing for. The psychotherapist’s own biography, as it manifests in the therapeutic relationship, is now not only seen as inevitable but is further understood as essential for the therapeutic relationship. Stephen Mitchell (2004) wrote: “there is no way to filter out the analyst’s impact on the process” (p.540). The disentanglement of transference dynamics thus becomes a joint voyage of seeking clarity in the faith of the possibility of, and for the purpose of, real connection (Dozier & Bates, 2004). Christopher Bollas (1987) for example, suggested that the analyst must become *lost* within his countertransference “for long periods of time” (p. 203) before the process of identifying, sharing and disentangling can take place. Bollas encouraged therapists to surrender to disorganization before inviting their clients to do the same. In fact, as Mitchell (2005) emphasized, if the patient doesn’t get “under the analyst’s skin” (pp.5-6), then the therapeutic process is limited in scope. The art of therapy involved entering those old organizational patterns (attachment schemas) and providing corrective conditions to recover what Winnicott called real-self (Bowlby, 1988). Therefore, relational perspectives challenge Freud’s concept of primary narcissism – we seek connections (and are a part of dyads) from our very beginning (Ainsworth, 1969; Bacciagaluppi, 1994).

Like the functional dimension, therapist and client enter the transference dimension asymmetrically. The distress and dependency that clients bring to psychotherapy mean that most therapeutic relationship also activate attachment styles (i.e. parent-child organizations). The transference dimension is informed by and is in tension with the utility dimension. Beginning therapists often get angry that transference phenomena seem to prevent the natural course of treatment, and clients get frustrated that instead of focusing on what they wanted to achieve they seem to be preoccupied with the therapeutic relationship and with the therapist.

Within the transference field, the relationship can take many forms. The therapist is in essence asking “who are we to one another?” We may be father-daughter, mother-child, two lovers, abuser-victim etc. Transference dynamics therefore potentiate a corrective experience. Each dyad is certain to be of deep relevance to both of our lives. When a sound therapeutic alliance is created in the transference dimension, a secure attachment can form between therapist and client. Such a relationship was shown to be a reliable predictor for positive therapeutic outcome (Farber, 2008, p.64; Holmes, 1996).

When we transfer our previous relational organization into a new relationship, we engage in an act that is both degenerative and generative at the same time. The degenerative aspect manifests as repetition-compulsion. At worst, transference prevents us from enjoying and benefiting from the reality of a relationship, because we are in fact relating to our own internalized models, recreating these in the present. At best, transference provides the therapeutic dyad with the very opposite: an opportunity to relate differently; to liberate the ghosts of our fragmented past from their repeated patterns. I believe that in our repetition there is also a wish for things to be different, and when we find a facilitative relationship that can contain our transference and challenge it at the same time, we stand a chance of stopping cyclical and painful patterns.

Transference phenomena in psychotherapy are often expressed as highly rigid forms of relating. A client who is used to being rejected, for instance, may interpret anything the therapist does as a sign of rejection. Character armor could be seen as somatic expression of rigid transference phenomena. The therapeutic relationship aims at moving transference dynamic from a solid organization to a more fluid and adaptable movement.

We are highly invested in our somatic, cognitive and relational organizations. When we experience a threat to our familiar forms we take refuge in relational organizations. Constantine Sedikides and Lowell Gaertner (2001) illustrated this:

“Encountering a threat to the individual self ignited protective strategies; namely, an identity shift to the collective self.” (p.14) The relational position suggests that the self is first and foremost relational, and that the primary (perinatal) intersubjective self is transference: we co-create a dyad that is similar to our primary intersubjectivity (Trevanthen, 1974). We partake in a relationship that is similar to our attachment relationships, yet offers curative aspects to it (Gruenewald, 1971, p.79; Spiegel, 1988).

I believe that transference dynamics are always part of relating. These are inescapable since we carry aspects of our relational organizations with us everywhere. After all, we were created from these wider selves. James McLaughlin (1991) exemplified this claim: “The transference ghosts of the past are never entirely laid to rest. In the intensity of new work with qualities unique and not yet known, they return in fresh shape to revive shades of significance I had long forgotten I knew.” (p.613)

A short case vignette will demonstrate transference work within body psychotherapy.

Lilly is a beautiful 60-year-old woman whom I have seen for individual psychotherapy for nearly six years. Lilly is one of the most creative people I have known, yet when we met she was consumed by fears and anxieties, with a wide avoidance spectrum. While her mother was physically and emotionally abusive, her father engaged in multiple romantic relationships and was mostly absent from home. Lilly’s mother used her to lure her husband back: either to discipline Lilly or to buy her clothes. Her mother forever treated her as a silly, useless, and unlovable child. Throughout our work together, Lilly began to reclaim her life and separate from her tyrannical mother. I would like to offer you a moment from our work together, which changed the course of the psychotherapy.

It was during a period when my baby daughter woke up every 45 minutes, every night. Both my wife and I were exhausted and I was finding it very difficult to function at work. But with Lilly I found it exceptionally tempting to fall asleep. Notwithstanding the erotic aspects of our transference, our relationship was primarily paternal: she frequently called me Daddy Asaf. Our relationship was an opportunity for her to reconnect – as a girl – with the father that she never had, and mourn for the loss of her childhood, for me it was a chance to have a daughter who favored me and sought connection with me (at a time when my daughter was only interested in mom).

One day Lilly asked that I hold her, lying down, in silence. I felt a joyous bond weaving between us and a sweetness that I knew from connection with my daughter, and before I realized I woke myself up with a loud snore. I looked at Lilly apprehensively, and she was gleaming with happiness: “you fell asleep, you fell asleep” she cried with joy. During the sessions that followed there was a marked difference in Lilly’s trust; it was as if she allowed herself to surrender to our relationship more honestly and fully. Over a few sessions, I learned that her father rarely slept at home. His visits to her mother and siblings were always brief and practical, and Lilly yearned for him to stay, so that they could have a *real* family. Lilly had known that I had a baby girl a few months previously, when I took paternity leave, and she was very worried that her own story would be repeated: the father that left for another family and abandoned her. Yet falling asleep in the session made me the father who stayed. Lilly began to trust me to remain loyal to our connection, and to her in the process. Gradually, and alongside our father-daughter relationship (which would always be there), another relationship started to develop – one where we could sometimes meet as subjects.

### Something blue – the I-thou field

“When *Thou* is spoken, the speaker has no *thing*; he has indeed nothing. But he takes his stand in relation.”  
Martin Buber<sup>3</sup>

I take this to be our saving grace: genuine moments of connection occur despite all that was discussed here before. Regardless of our previous history and the involvement of our wounds in choosing our partners, friends, and professional direction; notwithstanding the truth of transference trances and how tainted our connections are, real meetings of souls do take place in the world.

The previous two dimensions presented quite a grim prospect for interpersonal relationships. We are flooded by explicit, and more so unconscious and implicit interests and agendas that shape our communication; we operate out of utilitarian calculations, all the while doing so without properly seeing the person we are with. All we are able to engage with are mirror images of our previous relationships. Should this picture truthfully represent humankind, then all we have left to do is learn and acknowledge our dark, egocentric and forever calculated relatedness, attempting to destroy our naiveté in favor of open-eyed, if hopeless, realism.

But we are more than that. We are more than our uncultivated drives which, at best, could be sublimated, granting us a noble façade and entry passage into society. We are also capable of deep experiential connections to other persons that transcend utility or transference dimensions; we are capable of genuinely meeting as people, uniting in our human similarity. Martin Buber (1958) described the I-thou relationship as a stance. We cannot fully know it or even speak of it without losing this connection. The transcendence is transcendence from utilitarian and transference dynamics, and is primary and self-validating. It might be understood as surrender to a wider self. Within the wider self, it is meaningless to speak of me and you as separate: “If *Thou* is said, the *I* of the combination *I-Thou* is said along with it.” (ibid, p.3)

<sup>3</sup> (Buber, 1958, p.4).

I-thou dynamic is a magical occurrence indeed. As Erich Fromm (1957) realized: “The desire for interpersonal fusion is one of the highest striving in man” (p.14), and the momentary I-thou connections present a more hopeful prospect for humanity. The humanistic movement, which is one of the strongest influences on body psychotherapy, represented a third force in psychology, perhaps because of its recognition of the possibility of meeting. Both Carl Rogers (1961, 1970, 1986) and Abraham Maslow (1968, 1971) repeatedly expressed their belief in the possibility of I-thou connections.

It is easy to see that the I-thou dimension is always reciprocal: this is where we unite as one, regardless of our roles and gender, utility or function, history or age. This is where we meet as two people who share a self. There is something peculiar about I-thou connections in psychotherapy. While the previous two dimensions are asymmetrical and involve power aspects, the I-thou connection is a place of equality and symmetry. Amidst a highly unbalanced relationship, and mostly without intending to do so, a shared human place grows where we are nothing but the same.

I-thou meetings are rare occurrences of intersubjectivity. They are effortless and deeply meaningful, mostly taking place in silence and often difficult to speak about, even later on. It is my belief that, because of the immediacy of touch and similarities in somatic organization (with all our differences, we share very similar anatomies), body psychotherapy in general, and touch in particular, are facilitative for I-thou moments.

Humanistic psychology had put great emphasis on this dimension, believing that those moments of meeting can serve to promote health and humanity. Discussing heart-based ethics, Faith Kaufhold Ray (2001) suggested: “Openheartedness does not mean there is no direction in therapy, but rather that defining and categorizing problems must never precede a kind, uncensored human connection.” (p.27)

Here, in the core of I-thou we declare “I am here with you” and our declaration serves as an invitation to connect, an invitation with which we demonstrate our equal human longing for connection.

The dualistic division (you and I, body and mind) does exist, but outside of this place and through the tension with the transference and utility trances, here we are one. In these humanistic moments there is nothing to be done, no therapeutic skill to be applied or techniques to be executed; in fact, we cease to exist solely as *you* and *I* and become us. Our capacity to remember our separate subjectivity comes from the multilayered truth: we are fully and completely this shared dyadic self, but this is not *all* of who we are. Nathan Field (1996) wrote about those moments “where two people feel a profoundly united sense of one another yet each retains a singularly enriched sense of themselves.” (p.71) These moments emerge from the meeting of the two orders of wider self: the unity of the I-thou and the unity of transference wider self (attachment); they exist in the tension between primary and secondary intersubjectivity.

Joining into an encompassing wider self is an act of creation, as we partake in the creation of newness, and indeed this unity is a creative act. In *The Art of Loving* (1957), Erich Fromm considered creative activity as an important way of attaining union and softening our existential loneliness and isolation. This relates not only to interpersonal union but also to spiritual connection: pathology does not preclude generative, transcendent connection (and vice versa). Spiritual and personal connections are sometimes possible even when not all psychological blockages have even been noted. At the same time, the capacity to deeply relate to another and to spirit does not imply liberation from transference and pathological elements.

The therapeutic value of I-thou moments is huge. Amidst a potentially humiliating and unbalanced relationship, where one party is possibly needy and dependent on the other, where the importance of the relationship to the two people is rarely symmetrical, those moments of equal connection are an invaluable gift. As Ferenczi (1925, 1949) wisely noted, the very entry point (initial positioning) of the psychotherapeutic relationship is potentially wounding and shaming as it repeats a highly unequal transference scenario.

Cultivation of these moments in psychotherapy may provide a balancing, healing place for the inevitable wounding rejection of our children and our clients.

Body psychotherapy (and bodywork) can easily take both therapist and client to a place that Franklyn Sills (2009) called *core states*, where “the emptiness of all forms, their transience and interdependency, becomes clear; it is understood that therapist and client are not separate, that their processes mutually arise.” (p.46) Perhaps these affective moments are close to the shamanic notion of surrendering to the *big love* (Keeney, 2005), where the dualistic nature of our perception is experientially challenged and we unite as parts of a larger, wider mind.

The following vignette may illustrate a therapeutic I-thou moment.

When Daniel, a gifted body psychotherapist (40 years old, married, and father to three) came to therapy, he wamed me that one of the issues he would like to work with concerned his bisexual orientation. Daniel and I ventured on an increasingly analytical exploration and, despite my occasional nudges, there was seemingly no sign of any erotic dynamics. We would normally sit side by side and I have rejoiced in having such an ally, a man with whom exploration could take place without threats of inconvenient enactments. While this position was comfortable for us both, it compromised both regressive aspects of his process and our capacity to work with erotic material. And then, eight months into therapy, his lower back started to ache.

Since we both like working with touch, we have chosen to attend the ache bodily, and in parallel process Daniel’s vulnerability started showing up more regularly in therapy. One session, after doing some pelvic work, I felt a surge of erotic awakening in me. A long conversation started between us about Daniel’s protecting us both from homoerotic charge. Once acknowledged by him, I noticed my own apprehension and appreciation surfacing: here was a man who had boldly processed his sexual orientation – more than my own homophobia ever allowed me to. When I managed to relax into this place, something happened. Daniel looked at me, and for a brief moment we were not therapist or client, but two people. Daniel reached out and touched my arm gently, and smiled. “What is it?” I asked. “You know, Asaf,” he replied, “it seems that you

are asking to relieve your embarrassment of our moment.” He was right. That ‘moment’ that he was referring to, I believe, was not our homoerotic process, but the moment that followed – where we seemed to be symmetrically human - two men as one.

### Something new – the relational tension and the second return to co-consciousness

*Don't surrender your loneliness  
So quickly.  
Let it cut more deep.  
Let it ferment and season you  
As few human  
Or even divine ingredients can.*

*Something missing in my heart tonight  
Has made my eyes so soft,  
My voice  
So tender*

*My need of God  
Absolutely  
Clear.  
Hafiz<sup>4</sup>*

Different therapeutic approaches organize themselves differently along these three described models. In coaching and outcome-oriented psychotherapy, for example, the transference dimension is rarely addressed and if it does emerge, it is at the service of the functional relationship. Similarly, I-thou connections may be seen as facilitative for the overall outcome but are not focused upon. Psychoanalysis and psychodynamic approaches, on the other hand, may begin with the functional dimension but as soon as transference dynamics emerge they become the focus of therapy. The transference relationship is understood as reflecting other areas in the client's life and as the axis for change. Humanistic – as well as some body-centered psychotherapies (Kurtz, 2007) cultivate the I-thou dimensions. This is sometimes done at the expense of acknowledging the complexity of the transference and utility dimensions of the therapeutic relationship.

The fourth dimension is one of embracing paradox and withstanding tension. Each and every human relationship has the potential of existing in all three dimensions: the functional, the transference and the I-thou. The relationships we partake in are both reciprocal and asymmetrical, saturated with transference projections and yet holding a potential for true meeting of souls, full of implicit unspoken agendas yet embedding transcendence of ego-centred utility. The dialectic tension among these three dimensions creates yet another order of connection: one where contradictory tendencies coexist in dynamic and co-created ways – where newness can actually take place. Martin Buber (1958) described the awakening into relational complexity with one of the most beautiful phrases in modern philosophy: “But a moment comes, and it is near, when the shuddering man looks up and sees both pictures in a flash together. And a deeper shudder seizes him.” (p.72)

The therapeutic relational matrix is a field of fields: it is the tension held between the three dimensions of utility, transference and I-thou dynamics. These different dimensions cannot be reduced to one or the other. It is, as Stephen Mitchell (1988) wrote, a “*multifaceted relational matrix* which takes into account self-organization, attachment to others (‘objects’), interpersonal transactions, and the active role of the analysand in the continual re-creation of his subjective world.” (p.8)

In a previous paper (Rolef Ben-Shahar, 2010), we have discussed the phenomenon of intersubjectivity as the special, semi-autonomous field created between two people involved in affective relationship. When we both submit to a relationship, a third entity emerges to create an ‘us’ in which we partake, yet at the same time are shaped by. Colwyn Trevarthen (1974, 2004) argued that we were born into a primary intersubjectivity: i.e. we are first and foremost a baby, and only later we develop as a baby. The primary intersubjectivity could be thought of as preconscious relatedness – it lacks the knowledge of our split. This enmeshed state, where self is decentered and bodies are entwined, does not carry the complexity of a relational event.

When we recognize our separateness, surrendering to a larger self carries much more weight – and involves more fear – than that of a baby. The relational self, as Sullivan (1953) noted, is characterized by tension between intimacy and separation – being a part of, and apart from at the same time. Mature surrender is a second return of consciousness: a holding of the both/and of individuation and belonging, of a self that lives within the bounds of the skin and a self that is dynamically created in relationships.

Relational dynamics involve an impossible task. They involve concurrent working with all relational dimensions: the functional relationship, awareness of transference relationship and use of transference dynamics, and allowing for (and even cultivating) I-thou positioning.

Together, this matrix is a hive of contradictions and possibilities, which we cannot master by trying hard to grasp the different levels, but that instead requires of us to surrender ourselves into the emergent wider mind.

<sup>4</sup>(Hafiz, 1996, p.50).

Psychoanalyst Jessica Benjamin (2006) considered this intersubjective meeting as “a dyadic trance that is mutual and cocreated, though not symmetrical.” (p.378)

The following vignette can illustrate the relational stance, as the holding tension of various relational dimensions:

Melissa and I had been working together for eighteen months when she arrived one day in a physically and emotionally fragile state. A 30 year old pianist (married), Mel brought into therapy a very complicated history of familial incest and boundary violation. Our transference dynamics were similarly complex, with recurrent shifts between paternal, sibling, and authoritarian relationships, all the while dancing to and fro with erotic charge, and learning (by stumbling) to create safety in a non-sterile environment.

In my own countertransference, I was washed into my history of body-shame, dissociation and terror, and it was very difficult at times to discern the two enmeshed stories (which were both supported in supervision and personal therapy).

During that special session, Mel complained about her inability to form stable boundaries. I offered some work with strings and we each created our boundary, using a string, on the floor. After noticing what our physical boundaries felt like, I suggested that we swap places to experience the other person’s boundary and learn about our own boundary in the process. We then returned to our own strings, and I asked that we each made a small change to our own boundary, to reflect a learning that we took from the swap. Mel tightened her boundary and made it slightly more ordered; her breathing slowed down, her face less flushed and her posture calmed.

When I was trying out Mel’s boundary, I suddenly recognized how much rigidity mine had, and then consequently made a very tiny opening in my string. Immediately, I froze, as if all my blood washed away from my body. I couldn’t see Mel at all, I was instead a child in a paddling pool, exposed, shamed, and screaming. Mel took my hand and held it; my breathing relaxed, and I too came back.

And alongside this momentary role-reversal, and while the two stories of shame were concurrently acted upon and woven into one another, there was a glimpse of home, and of newness.

The repetitive story was similar to what it had always been, but it was not the same. Somehow, the shaking of our frame (the therapeutic positioning) brought the tension of our multifaceted relationships to the fore and allowed for something different. The break in the boundary – in my body, and in the relational ‘fixation’ fostered a change. Mel witnessed us both enter the familiar (and familial) transference spirals – yet we together, survived. And this survival can account, in my opinion, for many of the changes that followed in Mel’s life.

### **The wedding march, or Whose nervous system is it anyways?**

#### **[Mirror neurons]**

“We are inherently ‘designed’ to have visceral reactions to each other’s actions, mishaps and feelings.”  
Robin Balbernie<sup>5</sup>

Once more, I am standing with my wife in front of our friends and family. As the Rabbi speaks, I can see a tear running down my father’s face, a novelty. Our hands are connected, our hearts are beating. We turn towards each other in unison and smile. Yes, we are enmeshed, I am not sure where my hand ends and Tom’s begin. But we are at the same time highly differentiated: we are both at once deeply connected and yet deeply separated.

The placenta; what an amazing organ! Has there ever been a more concrete symbol for the fluidity of the self and for the negotiated space between *I* and *Thou*? As the fetus develops it grows in a territory that does not belong solely to the fetus or to the mother. The fetus is regulated by the placenta, which in turn communicates with *the mother system*, and shapes the womb, the endocrine system: the mother. Baby and mother create one another already in the womb.<sup>6</sup> Like Winnicott’s transitional space, the placenta is the epitome of developmental relationality. There, at our very beginning, we share identity with our mother. It is within the placenta that our shared existence is at its clearest: our bloods flow, our separateness and togetherness physically sensed and pulsating to and fro. We are one; we are two – and we share a space that is both. “Even if viewed from a purely *biological* point of view,” wrote Margaret Mahler and John McDevitt, (1982) “the newborn infant is only a partial system: between the distress signal and the relief of need, there must be a mother.” (p.828)

Natural Birthing pioneer Michel Odent (1994), claimed that the huge surge of adrenaline after childbirth, which is followed with parasympathetic activation, contributed to the mother and baby’s alertness immediately after birth, ensuring the possibility for eye contact and bonding. We are biologically geared to connect.

It is for these reasons - not only of the ultimate dependency of the human newborn, but also of its shared existence with its mother - that early relationships have been seen as fundamental for the organization of self (for the first creation of united and separated forms) (Mitchell, 2000; Suttie, 1935). In his tender work *The Origins of Love and Hate*, Ian Suttie (ibid) described how at the early developmental stages, self and other were not differentiated. The early love relationships, before weaning, are therefore the base upon which the child learns not only to form other relationships, but also to form its own identity (ibid).

<sup>5</sup> (Balbernie, 2007, p.309).

<sup>6</sup> Traverthen (1974) described this as *primary intersubjectivity*.

If the placenta is the heart of our shared self, if it is the first intersubjective organ, than mirror neurons are its nervous system. Mirror neurons were discovered during the mid 1990s (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996) when Italian researchers (accidentally) found that motor neurons involved in reaching out were activated (in monkeys) by merely watching others reach out to grab a raisin. This discovery led to an extensive study of this miraculous phenomenon – someone else’s activity influences my nervous system!

Apparently, in order for mirror neurons to be activated, the stimulus needs to have affective meaning for the observer. (Gallese, 2001) Is it not a physiological translation for countertransference? Ann Marie Barry (2009) posited that mirror neurons break down the barrier between ourselves and others, “as the actions or expressions of others resonate within us, we empathize and recognize the other as us.” (p.80)

But I would like to suggest a more radical claim: that the barrier between our self and others never fully existed. That we have two types of bodies. Our first body is a half-body, one that can only come into existence when we connect with another. This body is the body of our dyadic-self, a body that is forever incomplete. On that level, we dynamically move between identities and connections. Our second body is our skin-boundaried one, a body that is centered and can be known by us without connecting to another. Our seeking connection and individuation can also be seen as the tension between those two bodies, between those two nervous systems.

Some changes and healing might therefore only take place within a larger body – and the relational body psychotherapist lends her body to surrender to this shared body, where regulation is no longer self-regulation, but instead dyadic. The client and therapist move from belonging to one another and coming back into their separated selves. If we adopt this view of bodies, we could start to think about different types of pathologies – those that happen within individual bodies, and those belonging to the shared body. Similarly, therapeutic interventions may vary between working with the larger or smaller body.

I am particularly interested in understanding resonance in those terms. It is my deep belief that intersubjectivity is primarily somatic, and therefore – when I resonate (somatic countertransference), it is not my own centered body that I sense – but instead, I am feeling into a co-created, shared self. This view has great therapeutic implications, which will be demonstrated and discussed in the fourth paper of this series. I hope that you can share my excitement at the prospect of not only being a body and having a body, but also of belonging to a body.

Traditionally, a Jewish wedding ceremony ends with the bridegroom breaking a glass (by crushing it with his right foot). In our wedding, there were two glasses wrapped in aluminum foil. Two right feet crushed the glasses, everybody cheered, we cried. Hugs were everywhere, our faces ached from smiling, hearts were wide open. And then came the music and, as we knew we would, we danced, and danced, and danced.

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#### Biography

**Asaf Rolef Ben-Shahar, PhD** is a relational psychotherapist, writer and trainer from Israel. Asaf integrates Body-psychotherapy and trancework within a relational framework. He teaches in a variety of academic and clinical settings in Israel and Europe and is widely published. Asaf is married to Tom and a father to Zohar, he collects tattoos, enjoys country music and loves animals and birds. [asaf@imt.co.il](mailto:asaf@imt.co.il)

# The Experience of Shame in Human Development and Psychotherapy

Yudit Mariah Moser, MA, CPC, SEP

## Abstract

The experience of shame plays an important role in human development and the renegotiation of developmental issues in the therapeutic process. Shame has many negative associations but in the last decade, researchers like Allan Shore and Daniel Siegel have distinguished between the positive role shame can play in the social learning process and the negative effects it can have if not resolved appropriately. This distinction has come to be known as “healthy shame” and “toxic shame.” The lingering effects of toxic shame can be challenging for both those who suffer it and therapists assisting clients to reframe their experience and to move past shame-centered dynamics. This paper first reviews the distinction between healthy shame and toxic shame, then explores how shame can be addressed in the therapeutic setting with attention to both physiological and relational cues.

## Keywords

Shame and self-regulation – Toxic shame – Disguises of shame – Physiology of shame

## The positive socializing function of shame: “We don’t do this”

Cozolino (2006) described shame as a mechanism for child rearing and socialization. Parents concerned with teaching their offspring the rules of their cultural and social environment seek to help the child internalize the norms of their environment and uphold them even during the absence of parental control and guidance. According to Cozolino, shame has a positive role in the development of consciousness and social responsibility and therefore assures the cohesiveness of our social unit. Shame can therefore be seen as a self-conscious emotion, an inhibitory, biologically based response that evaluates our own actions from the viewpoint of the other.

In his groundbreaking work on self-regulation, Allan Shore (1999) pointed out the importance of a healthy shame experience to build neurological and social resiliency. According to Shore, in the stage between 12 to 18 months of age, an infant develops a sense of expectancy for sharing positive affect with the caregiver, which is the foundation for shame development. During the second year of life, with increased motor coordination and exploratory drive, the toddler meets more disapproval and disappointment. The parental role has shifted from a primarily care-taking style to a socializing function and mis-attunement between caregiver and child occur more frequently. In the face of this surprising negative feedback, the child experiences what Shore called a “rapid state transition” (p.241), that inhibits excitement and causes a rapid shift in the autonomic nervous system: very quickly, the energy-mobilizing sympathetic functioning shifts to a withdrawn, energy preserving, parasympathetic response.

Shore (1999) recommends differentiating between shame and guilt. Shore sees shame as a developmental precursor of guilt. While shame is primarily a visceral experience, based on preverbal imprints, guilt on the other hand is language-based, more complex, and therefore less permeating. In essence, guilt is experienced as a rejection of our behavior, whereas shame is experienced as a rejection of our self. The guilt experience signals a rejection of undesirable behavior, which motivates our reparative capacity. Shame is rooted in our hard-wired need for attachment, and rejection is experienced as a more devastating threat to the self. Shore emphasized that deflating experiences of shame need to be followed by relational repair and re-attunement. The parent reaching out to the child as part of the relational dance is crucial for psycho-biological health. The child experiences that it is possible to tolerate deflating shame affects and come back into relationship and equilibrium. The experience of negotiated state transition eases the stress response and the shame experience can be metabolized and regulated. This process of short-lived shame, followed by repair, benefits the social-emotional development of the child and further stimulates the maturation of the orbito-frontal cortex (Shore). Repeated experiences of returning to attunement solidify the trust in positive outcomes of difficult social interactions and therefore supports affect regulation capacities. The experience of repeated immediate repair creates visceral, sensory, motor, and emotional memory imprints (Cozolino, 2006).

## Toxic effects of enduring shame: To make a mistake versus being a mistake

Given that shame is a powerful, preverbal and physiologically re-organizing experience, the question arises: What happens when parents shame the child excessively and fail to support the child’s affect regulation by not welcoming the child back into relationship? Siegel (1999) argued that sustained shame and lack of repair is toxic to our brains. When shame is internalized, it alters our sense of self and becomes part of our self-perceived identity. In our own eyes, we become flawed, not good enough, and not lovable. Our ability to differentiate is compromised; we see ourselves as being a mistake rather than making a mistake. In this sense, the toxic effects of prolonged shame, held in the imprints of our early parent-child interaction, have been shown to have a negative impact on our right hemisphere and limbic system network development (Cozolino, 1996). The shame-prone child becomes hypersensitive to perceived criticism, reinforcing a lack of self-worth and sense of

disconnection from the world. Over time, shame may also be experienced as an inner, critical voice—an internalized script that keeps the cycle of shame alive. Enduring shame might be connected to the deep pain of loss of love and unity. Sylvan Tomkins has captured the experience of shame with these words:

If distress is the affect of suffering, shame is the affect of indignity, transgression and of alienation. Though terror speaks of life and death, and distress makes the world a valve of tears, yet shame strikes deepest into the heart of man...shame is felt as inner torment, a sickness of the soul...the humiliation when one feels himself naked, defeated, alienated, lacking in dignity and worth.

### **Expressions of—and defenses against—shame in therapy**

Early unregulated and pervasive shame is at the core of many psychological problems. Psychotherapy offers an opportunity to renegotiate early shame imprints. The work with developmentally based shame dynamics is sensitive territory that calls the therapist to become familiar with the body language and disguises of shame. Cozolino (2006) described shame as a visceral experience stimulating the same areas in the brain as those activated by physical pain. The primitive, nonverbal nature of the shame experience frequently makes it difficult for clients to articulate the experience and name what is happening. Cozolino (2002) described the body posture of submission— averted gaze, rounded shoulders, hanging head— as a possible indicator for shame (p194). In my observation as a therapist, when shame emerges, clients tend to lose muscle tone and vitality throughout their whole body. Energetically, they step out of contact and appear to shrink or diminish. This experience is frequently described by my clients as feeling heavy or small, wanting to "fold in on myself" and an urge to disappear and hide. As my clients allow shame to move, they may have a visceral experience such as nausea and skin irritations.

By its nature, the shame experience triggers feelings of acute vulnerability and deep discomfort. Consequently, the attuned therapist must watch for possible masking behaviors like nervous laughter and disproportionate anger towards a social situation, as well as the role of shame in transference enactments. Badenoch (2008) examined the close ties between shame presentations and defensive responses. She asserted that clients may not be able to tolerate or witness shame experiences and may instead go directly to the expression of anger or rage. The impact of dysregulated anger in this shame-rage dynamic makes it very difficult to track the origin of the experience. Other clients may avoid the unbearable humiliation of shame by isolating themselves socially. Irrational beliefs often are at the heart of toxic shame presentations. A common dynamic is the child who finds it easier to tolerate a shame identity of being flawed than the unbearable sense of feeling betrayed by the very people who were suppose to love and protect her. Through the lens of the shame-prone client, it is easy to see criticism, rejection, and abandonment in nearly every interaction as he or she struggles to achieve perfection.

### **Reflections on processing the shame response in therapy: Ashamed but connected**

In addition to recognizing the body language and possible masking behaviors of shame, the conscientious therapist is called to remain differentiated when shame enters the relational field. To witness intense shame can, in itself elicit shame. As therapists, we must stay present and track our own responses in the moment, which means we first must have explored our own shame history and become familiar with any of our own unresolved shame-related issues.

In my experience, the completion of the shame response requires surrender into the physiology. Change occurs when we are able to endure and wait with one another for the movement of shame and the desire to engage socially. It appears that the earlier the shame experience, the more the viscera will be involved in its imprint. Shame often elicits the sensation of nausea; a sense of needing to expel what is not inherently ours through coughing and spitting. The repeated process of balancing parasympathetic shame states with positive emotions within a relational context of 'feeling felt' loosens the debilitating grip of toxic shame and frees up more capacity for joy, creative expression, and compassion. Because shame is rooted in preverbal imprints of mis-attunements that have lingered unresolved, it is essential to keep language simple and to stay in contact with a sense of ease, humor and compassion when shame emerges.

### **Conclusion**

Great strides have been made recently in our understanding of the role of shame in society and what clients need in order to move past unresolved shame imprints. While many psychotherapeutic processes elicit shame responses, shame itself can be a silent and unrecognized emotion, often blocking the psychotherapeutic process. To use the emotion of shame for developmental resolution, therapists must understand its dynamics: the regressive and visceral nature of shame, resistance to the shame experience and shame's association with various defense mechanisms, and the simple ways by which lingering shame issues can be transformed by naming it, normalizing it, and helping clients move their shame experience to both physiological and psychological completion.

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### Biography

**Yudit Mariah Moser, MA, CPC, SEP** is a Somatic Psychotherapist and Somatic Experiencing Practitioner. She lives in Vancouver, British Columbia, Canada where she maintains a private practice and facilitates somatic study & play groups and trauma education classes. Mariah can be reached at: [info@openingtoGrace.com](mailto:info@openingtoGrace.com)

# The Continuum Theory of Human Development: A Theory of Life Span Development and its Application to Therapeutic Intervention

Stefan Deutsch

## Abstract

The Continuum Theory of Human Development has proven to be an effective theory of development across the lifespan. It works in an integrated, sequential manner on four fundamental tracks which are all developmental. They are (1) awareness (2) envisioning (3) communicating (4) loving unconditionally. Whether the objective is a life goal or emotional healing for an individual it has also proven to be useful when applied to therapeutic interventions. Two case studies illustrate the applications of the method.

## Keywords

Self-actualization – Unconditional love – Lifespan theory – Adult development - Neuroplasticity

## Introduction

The Continuum Theory of Human Development hypothesizes that a functional unity – the nature of which is probably very similar to the functional unity that the United States Association for Body Psychotherapy (USABP) refers to when discussing Body and Mind<sup>1</sup> – exists between Body, Mind and Self.<sup>2</sup> It posits a theory of lifespan, has a developmental model of Self, hypothesizes about the origins of dysfunctional behavior, and has a variety of diagnostic and therapeutic techniques used within the framework of the therapeutic relationship. (using USABP descriptives)<sup>3</sup> In addition to having an applicable framework for therapeutic interventions, the theory also provides insight and guidance for parenting, aging, personal development, marriage, midlife crisis, etc.

The theory, when applied, has proven that it can provide a fresh lens through which to view human development. This in turn provides a new perspective on the causes of behavior and approaches to psychotherapeutic interventions. The Continuum Theory works in an integrated, sequential manner on four fundamental tracks which are all developmental – they are awareness, envisioning, communicating, and loving (unconditionally) which directly affect the neuroplasticity of the brain (Schwartz and Stapp, 2005), causing substantive and lasting changes in behavior along the life span.

According to Fritz Perls (1951), awareness is 90% of healing. We claim that awareness is 100% of the beginning of healing. Without awareness the process cannot even begin. Tracking a client's body signals - the beating foot, the clenched fist, the redness in the eye, the averted glance, the deep sigh, the misplaced laughter, the cough, and a myriad of signals large and small - and pointing to those signals, bringing clients back to their own body from the story they want to tell, from the mind they want to live in, without fully feeling their feelings - is one of the gifts of the Gestalt therapy approach. As Perls says, "The body never lies..." whereas clients have become adept at manipulating language and with it, the therapist. Working with the body therefore creates a present-centeredness, an ability to be in the moment whereby one can connect to one's thoughts and feelings. As a further expression of bodywork, Gestalt Therapy advocates the affirming touch of a hand, holding of the client's hands, the holding of a client in a fetal position, a hug, laying a client on the floor while gently soothing him or her – all as part of the expressed need for nurturing on the part of the client, and with the expressed permission of the client. These are acts of giving unconditional, loving energy. Many clients are in therapeutic relationships simply for the unconditional acceptance that a therapist can provide. This system of cosmology brings both the client and therapist face to face with unconditional love. Using those terms as a central feature of each session, illustrates that these moments of contact clearly represent the giving of and the getting of loving energy for both. I will go into further detail and give you a functional definition of loving energy - what it is, where it comes from, and why it is so important in healing - later in the paper.

## Therapeutic Tools to Assist in Healing Relationships

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<sup>1</sup> ".....the common underlying assumption being that a functional unity exists between mind and body. The body does not merely mean the "soma," which is separate from the mind, the "psyche." Although many other approaches in psychotherapy touch on this issue, body psychotherapy considers this principle to be fundamental." (USABP website)

<sup>2</sup> I believe that Mind in some cosmologies often includes more than Brain, and other times, refers to Brain alone. Not being certain how USABP defines Mind, I will treat Mind as synonymous with Brain for this paper. In my definition of Self, it is not used synonymously with Mind.

<sup>3</sup> "Body psychotherapy involves a developmental model, theory of personality, hypotheses about the origins of psychological disturbances and alterations, as well as a rich variety of diagnostic and therapeutic techniques used within the framework of the therapeutic relationship." (USABP website)

As fundamental and foundational as awareness is, my belief is that it is only the beginning. Someone becomes aware of their anger, rage, and resentment toward another person in their life. I am referring to anger that was repressed, unexpressed, or expressed but without satisfactory resolution. This is an important first step. Yes, finally acknowledging and expressing it is freeing, and in that sense healing. Often it only serves to end that relationship, which is not the ultimate goal of the individual in therapy. The ultimate goal, for which many do not feel empowered enough and trained enough, is to transform that relationship into a loving, nurturing one. But how does this person get from that rage to transforming the relationship into a close, loving one? Without a vision of having a loving relationship, without knowing how to communicate both the anger and vision in a loving way, and without knowing how to keep the context – that the healing of the relationship is the ultimate goal – people wind up venting, dumping and losing viable relationships. As Harville Hendrix says in his training, “I divorced a perfectly good woman.” That happens over and over – and often as a by-product of therapy.

For clients to simply go back to a parent, spouse, sibling who hurt them and say “you really hurt me”, or “you are hurting me and it is not acceptable,” is not fully healing because it is missing the empowerment piece. It is missing the knowledge and power to transform that, or any relationship, and the tools necessary to give the relationship the best chance possible. It is missing vision, communication and unconditional loving. The confrontational nature of many of these disclosures results in the denial on the part of the other, defensiveness often in the form of attacking back, and the withdrawal of both from the relationship as much as it is feasible. This can include spouses and siblings who stop talking, adult children who don’t call their parents, or friends of 20-30 years who will never see each other again. This is often the result of a communication without vision, without the know-how of communicating lovingly, and without having part of the vision as central to an unconditionally loving relationship, instead of just ‘telling the truth.’

### **Awareness Beyond Gestalt Therapy**

The Continuum Theory continues where Gestalt Therapy leaves off and Cognitive Behavioral Therapy begins. CBT emphasizes goal setting – achieved by making changes in thinking and behavior. In this work we call it “the creating a vision phase.” Although creating a vision can start at the beginning of working with clients, its completion should come after a client has come into full contact with his or her feelings through the awareness work. A clear awareness of what is, without denial, is needed to create a powerful and complete vision. The form and content of the vision will go through changes throughout the process. The next question this client needs to answer for him or herself is, “What kind of relationship do I want to have if I could have it be my ideal relationship? What is my goal here?” Creating a vision where there is a lot of history is a skill that needs to be taught and it takes clients time to learn. In essence, what I ask of my clients is to completely discount their past interactions, let go of their experiences with the person they are trying to heal their relationship with, and just say and write down exactly what they want. We are not discussing whether it is possible or not, only focusing on what he or she wants going forward.

### **To Change Relationships, We Need Vision**

Most clients struggle a bit with this phase because for them, writing a list of things they want seems to be too similar to wishful thinking. “Of course I would like a close, nurturing relationship, but this self-centered person never provided that for me, so how is anything going to change?” “My mother never said she loved me, so I know she doesn’t.” “You can’t change a person and I don’t want to even try.” After we surmount this obstacle and get into writing a vision, and a new goal for the relationship, often the behavior of the client begins to subtly change toward the other. The purpose of the exercise is to bring guidance and direction to one’s own behavior. If you want a loving relationship perhaps you need to initiate certain ways of behaving and respond in certain ways to behavior which are different from the way you used to initiate and respond.

The reason interactions begin to change, if ever so subtly, is because each human being needs to always give love and hopes always to get love in return. You can rely on this like gravity,  $E=Mc^2$ , or like the earth spinning on its axis every 24 hours. Once the vision is written, the truth is out: no more hiding the painful fact that what the client wants is a loving relationship. So why do we act in ways that are unloving when that actually hurts us, as well as the other? And because human beings need to always give love unconditionally and hope always to get love unconditionally, when the other perceives that something is changing - that clients are behaving more unconditionally, giving them the life-sustaining energy that they need so much – it begins to subtly change their actions and reactions as well. Now the relationship begins to slowly spiral upward instead of the downward spiraling it has been stuck in for years, or even decades. We have introduced unconditional loving energy into the equation.

### **Effective Communication Needs Love**

After writing the vision, the client has a goal - part of which, in this case, has to do with improving a relationship. In essence, it includes another person, as opposed to losing weight (which only includes the person wanting to lose it). If a goal involves others, it must be communicated to others. A client needs to own their goal, know it by heart, and wait for the right

time to communicate this goal. As part of the preparation, we begin to work with the fact that the other person needs to love, and needs to get love for their very survival – emotionally speaking. Knowing that people want to love - need to love, helps us accomplish two important things. One is that people do not hurt us, or behave conditionally because they have a goal or plan to do that. It is in spite of their needing loving relationships and closeness. They are actually sabotaging one of their most important needs. What this means is this – they are not acting in ways that hurt us INTENTIONALLY. As a matter of fact, they are missing the very tool set – awareness, vision, communication and the ability to be unconditional - that we are trying to learn and use. What this concept helps to support is our ability to forgive the other. The purpose of this is not for us to accept the acts that hurt, but to see them as unintentional. From this context we can formulate what I have found to be the most powerful statement anyone can say to another. This statement dissolves most- if not all, of a person's defenses as it creates a new context, one that both persons know to be the truth.

“I know you love me and you know that I love you. I know our relationship has been painful at times and we have distanced ourselves from each other, because we just did not know how to forgive and heal. My vision is for us to begin that healing so that we can have a close, nurturing, loving relationship. I hope you know that I am being sincere and that you will consider this a request for us to move our relationship closer. There is no rush on my part, it is a vision I will hold onto and patiently wait for you to join me – hopefully soon.”

What most people don't know about visions when applied to relationships is that they have the same power as when we apply them to wanting to buy a house, wanting to become a teacher or lawyer, wanting to take a trip – in other words, we know that everything starts with a vision and if we hold onto it, we find ourselves moving toward that vision until we have the reality. Visions are incredibly powerful, focused energies – and like a focused light beam – the laser, are able to literally go through obstacles placed in front of them.

The fourth track which I also begin working with right from the first session is unconditional loving energy and behavior. Here is a functional definition for loving unconditionally.

### **Definition of Loving Unconditionally**

*Loving Unconditionally - The giving and receiving of loving energies under any and all circumstances. Whether another's behavior pleases us or displeases us. It is always a conscious choice that must be done on a consistent basis with those you're in relationship with.* To be clear: what it does not mean is accepting any and all behavior from others. As a matter of fact, it demands that you also love yourself unconditionally which means that you only accept unconditional behavior from others, and you let them know lovingly, in no uncertain terms, when their behavior is not acceptable.

### **The Importance of Loving Unconditionally**

There are four life-sustaining energies human beings need: air, food and water being the three that science addresses. The Continuum Theory states that there is a fourth life-sustaining energy that human beings need and that is “loving energy.” This energy is needed as nourishment specifically by the Developmental Self, as opposed to the body or brain per se – although the three are fully integrated. This would explain two very important things. 1) Why conditional behavior feels so painful to all human beings: loving energy is being withheld, and 2) Why the body and brain still can function well when we feel rejected and unloved, but another part of us feels pain. We know that it is not our liver, kidneys, bones, or heart. Therefore logic tells us that it must be something else other than the body. That other part in pain must be the Self. Loving energy has quantum energetic properties, generated by conscious will, that are brought into existence from one moment to the next. Loving energy can be sent (given) to another or withheld from another. **This is the reason we feel loved, even when no one touches us or we feel pain, again, even when no one touches us.**

The Life-sustaining energies of air, food and water are cyclical; they need to enter the body, be utilized and leave the body. An interruption in either direction is painful and life threatening. It seems to be the same with loving energies. It is equally painful to have our love, our ‘exhalation’ of loving energy, rejected as it is to not get love. Finally, whenever we ‘ingest’ life sustaining energies of air, food and water, we feel energized. It is the same with loving energies. When we are deprived of any life sustaining energy, we feel weak and lethargic. Most often this is the case when we are deprived of loving energies. Since loving energies behave much the same as life sustaining energies we can deductively surmise that loving energy is a form of life sustaining energy.

Decisions guiding loving behavior are a form of thought, and are quantum energetic episodes which can be consciously generated by the Self, like staying patient, calm and loving, even when upset. They may also be subconscious and automatic, like jumping out of the way of a moving car or yelling when someone says something we don't like.

Once a client has gotten in touch with the fact that a certain relationship is painful and lacking love, has created a new vision for that relationship, has understood that what has transpired - as painful as it may have been, was not intentionally orchestrated by the other, that this other being needs to love and be loved as much as he or she - and has learned to communicate his or her vision in a loving, inspiring, enrolling manner - he or she is now ready to reach out to this person and

communicate their vision. For some, the safest and most comfortable way of initiating communication and putting their vision out there begins by writing a note or an e-mail.

### **Synonyms for Loving Energies**

Like Eskimos who have many words for snow, we have many words we use which are synonymous with loving energy and transfer a quantum amount of loving energy to another. They are: warmth, kindness, patience, encouragement, acceptance, understanding, appreciation, inspiring, affection, compassion, empathy, a touch, a hug, generosity, giving, just to mention a few. But when I work with clients I have noticed that none of the substitute words have the kind of visceral, energizing effect on human beings as does the word “love.” When people are confronted with their need for love, with the absence of love in their lives, with the fact that they and others in their life **deserve** unconditionally loving behavior without having to earn it, and with the fact that their behavior toward themselves or others has not been unconditional, they often break down and cry – which they definitely do not do when words such as compassion, or empathy or acceptance - or even affection, are used.

### **An Effective Model for Psychotherapy**

When training or healing the physical body/brain we can explain in simple lay terms exactly what an athlete or a client needs to do, and why, for optimal results. The broken foot of my wife needed a cast until the bone healed, after which she needed physical therapy to 1) Strengthen the muscles that atrophied, and 2) bring back flexibility to her joints and muscles that stiffened from the cast during the months she had to keep her leg up and the bone was healing. She understood exactly what was happening because bones and breaks and healing and physical therapy have been defined in lay terms. This helped her buy into the process instead of being skeptical and dismissive.

Whether the objective is a life goal or emotional healing, and whether the client is a parent, an employee, a student, or a couple, having each understand how human beings function enrolls them in their own process and takes the mystery and gamble out of it. This is especially important and apparent in therapeutic interventions where healing is the goal. Having a client know what is being done and why enrolls them into the process because they can understand it.

Again, using this cosmology, I devised a process of educating, training and when necessary, rehabilitating the Self, which results in achieving both life goals, and what we call healing in psychotherapy. But my clients never feel that there is something wrong with them, psychologically or otherwise. There is never a label put on them. What they understand is that their potential for navigating life has not been developed fully and they have never been given the life skills and tools necessary which is the reason they are struggling in certain areas of life.

### **Consider the following Case Studies:**

- #1. A 5 year old wanting a candy bar before dinner.
- #2. A distraught mother of 3 ADD boys, with an ADD husband ready to have a mental break down.

The problem each of these individuals face is caused by the lack of education, training and nourishment of their Self, and the continuing consequences thereof.

In Case Study #1 I will use the concept of the Developmental Self and its four facilities to explain how the theory applies to parenting, at a time when either most of education and training or damage takes place.

In Case Study #2 we will see the results of damage to Self; as our language so aptly conveys, damage to Self-esteem, to Self-respect and to Self-support. We bundle it by saying someone is being Self-destructive. The Continuum Theory simply acknowledges that being Self-destructive is a result of damage to Self – specifically Self’s four facilities.

### **Case Study – #1**

Let’s break down the following scenario to see what is needed in education and training for the highest level of Self’s potential performance to be reached. Also, we can see how generally this potential is unintentionally damaged, causing major problems for intrapersonal and interpersonal relationships.

- A 5 year old becomes insistent before dinner – is he/she hungry and wants a candy bar?

A child will have an innately healthy reaction to being hungry, according to the developmental model of Self:

Child becomes aware of hunger - awareness

Child loves/cares about meeting its needs - loving oneself unconditionally

Child has a vision/goal of meeting its needs - vision

Child asks for a candy bar to meet its needs - communication

Child insists on getting a candy bar - loving oneself unconditionally

Mother knows better, candy bars will ruin the child's appetite: she ignores the request, or says no, or gets angry. How do her responses damage his Self, its four facilities, and reaching Self's full potential?

Child becomes aware of hunger: given any number of the Mother's responses, child concludes that there is no point in becoming aware – in Gestalt we call this 'an introject' - since his awareness is ignored, discouraged. Self's awareness is damaged.

Child loves/cares about meeting its needs: child concludes I am not loved, not worthy. The ability to love oneself and create the vision of having one's needs met is damaged.

Child has a vision/goal of meeting its needs: child concludes that there is no point in having goals - having goals and vision is discouraged. The ability to vision is damaged.

Child asked for a candy bar to meet its needs: child concludes there is no point in communicating – communication is discouraged. Self's ability to communicate gets damaged.

In the future this person will 1) not be aware of his hunger, 2) deny his hunger when asked, 3) not ask or insist upon having his hunger met, or 4) become aggressive and violent, trying to meet his needs.

This simple example is played out in many, many forms again and again in most people's lives with much more negative and significant results than the example of not getting a candy bar. In order to develop Self's four facilities, the mother would first have to have engaged the child in the following way: by patiently saying "I hear you are hungry and you want a candy bar." In validating his awareness, the mother has accomplished 90% of the task of raising a healthy adult. She validated the child's Self by acknowledging the awareness, the goal/vision of having his needs met and the communication of the child, all in one fell swoop. The result is that the child learns the value of being aware, having a goal, and communicating it. He also learns that loving oneself, and feeling worthy of meeting one's needs is a positive, not a negative thing.

The actual result, whether the child gets the candy bar, becomes secondary – because it is when Self is not validated, and its needs are not acknowledged, that all four of its facilities are damaged. The sentence: "I hear you are hungry and you want a candy bar" – can be followed up by giving the child a number of choices, again with the understanding that developing a child's Self is of paramount importance developmentally – even more so than if he eats candy before dinner or not. "So candy bars are delicious and I can understand why you want one. But what is the problem with having a candy bar just before dinner? Yes, they do spoil our appetites and also they are not going to help us grow strong and smart. So here are a couple of options, tell me which one you want: Option #1 or Option #2. Which one would you prefer?"

This validates and then empowers the child, giving him the power to make the best choice for himself and feel that his life is in his hands. When we parent or educate children as if they did not have a 'Real Self' we fail to recognize the importance of responding to their awareness; we fail to understand the need to be unconditional, to develop their ability and courage to communicate their needs, and to love themselves.

We can easily substitute an adult in the place of the child. Not acknowledging someone's needs, their awareness, and not hearing their communications feels unloving, and since we all need love, the individual will feel hurt. Not being aware of our own needs as adults, not having the vision to get it, not knowing how to ask to have those needs met in a loving manner, and not knowing how to love others unconditionally creates the pain people experience in their relationships.

## Case study #2

- A distraught mother, C., of 3 ADD boys with an ADD husband, is ready to have a mental break down. Communication with husband is totally frustrating her, she feels no support from him. The typical upper middle class goals of college and professional careers for her under-achieving boys seem unrealistic, which is also depressing her. She is contemplating divorce, is a perfectionist, and is self-critical.

According to the model of a Developmental Self, C. is aware of being frustrated, feels alone, hopeless, and is physically and emotionally exhausted. Her only release is tears. She is not aware that she screams at her family a lot and that this has consequences. She has no positive vision to inform either her actions or communications.

- C. is angry, not listened to by husband or children, feels unsupported, screams - awareness is damaged
- C. has a context guiding her vision that it is useless to talk, nothing will change, kids won't be successful, she is a failure as a mom and wife - visioning is damaged
- C. can't motivate husband or children and can't communicate without screaming - communication is damaged
- C. criticizes herself endlessly, and does same with husband and children, little patience - does not love others and herself unconditionally

C's story was: nothing will ever change and she is afraid that she doesn't have the strength to go on. She feels sabotaged by a husband who has no patience and says all the wrong things to the kids, and makes her job even harder with them. She doesn't think she can communicate and be heard or that she can behave with her family in an unconditional way. She feels she has failed as a mother and wife.

C. was anxious to make some changes before her family fell apart. We created a detailed vision that included some of the following – “Her husband respects her and is willing to listen; she believes in her children and treats them patiently; she has been and will continue to be a caring, loving mom; she herself is OK; perfection isn't necessary, that her many good qualities are sufficient.”

In a relatively short amount of time she became more aware of her own reactions to situations. Her words and communications were informed by her new vision: her positive goals for the family, children, and husband. Her behavior became more unconditional. Her family began to notice changes – she became more patient, spoke with a calmer voice. They responded. After about 6 months of work, her husband, liking the changes he noticed in her, decided he wanted to learn how to listen better and came to a few sessions where they learned and practiced mirroring – an attentive listening tool. That experience aligned him with C. and he stepped back from criticizing the children, and started interacting with the children by following her lead. She also became more accepting of herself, focusing more on her strengths than weaknesses. She also came to acknowledge the success she had in developing her four facilities and her Self's potential. After one year of relatively sporadic visits (20 at most) C. decided that things were so much better at home and with herself that she no longer needed to continue. The goal with C. was to re-educate and train the four facilities of her: “what if Self was real.” We successfully rewired her brain by working with the four fundamental tracks in an integrated, simultaneous way.

## Conclusion

The recent discoveries of the brain's neuroplasticity explain how working on the four developmental tracks are causing lasting and substantive changes in behavior along the lifespan. By working with one's Developmental Self and training its four facilities, we are able to utilize the brain's ability to reorganize and grow new neural pathways, and optimize the degree of rewiring that occurs in the brain. The Self, given the opportunity to develop and rewire the brain, helps us to be exponentially more powerful and effective in life – to accomplish things we haven't been able to by just using the body or the brain. Just think about the effectiveness of a Gandhi, a Mother Teresa, a Martin Luther King Jr., and many other lesser known but equally Self-actualized individuals. When the Self fully potentializes, our life experience is transformed. A potentialized Self gives us a sense of control and this is when we can begin to truly shape our life and take responsibility for who we have become.

## Afterthoughts

My background is in both philosophy and physics. When I first embarked on a mission to create a lifespan theory it seemed to me that a coherent and cohesive theory about who human beings are, and how we develop, should be able to answer any question that pertains to a stage and development within that stage along the life span. In other words, a theory of development or therapeutic intervention that claims to be useful should be equally applicable to effective parenting, as it is to aging, as it is to explaining mid-life crisis, healing marriage strife or offering enrichment, or be applied to therapeutic intervention. It is my personal belief that ‘theories’ that are not universal and focus on only one area, and are not useful when we try to apply them to another area, are missing something central and therefore make their effectiveness questionable. The Continuum Theory has proven to be efficacious when applied to any and all areas.

Since I am continuing with my mission to create a super-ordinate theory of human development that is grounded, simple to use, and effective across the lifespan, your feedback to the above statement, as well as to the concepts of the Continuum Theory of Human Development are not only appreciated, but invaluable.

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### Biography

**Stefan Deutsch** received his BA in physics and philosophy from Hunter College, and then went to NYU graduate school for Movement Therapy. His love for the logic of philosophy and the theoretical discipline of physics made him realize that it was the theoretical realm of human development throughout the lifespan that he was interested in. So he decided to home school himself. Years of reading and questioning led him to find answers about life span and human development that satisfied his seeking mind, his logical mind and his need for disciplined thinking. Presently he is writing a book about his theories and is a Gestalt Psychotherapist. [stefandeutsch@msn.com](mailto:stefandeutsch@msn.com)

# The Somatic-Energetic Point of View: Towards a Bioenergetic Character Analysis<sup>1</sup>

Philip M. Helfaer, Ph.D.

## Abstract

The somatic-energetic point of view is explicated as the foundation of a bioenergetic character analysis. Personal development is the heart of learning. Functional process, the concept of identity and antithesis, and character are discussed. Sexual identity, as a core of character development, the therapeutic relationship, the stance of the bioenergetic analyst, and the concepts of the mind, the inner world and the flow of life are placed into the somatic-energetic context. A specific form of bioenergetic observation is described. Research possibilities and flexibility of bioenergetic analysis portend future developments.

## Keywords

Somatic-energetic – Bioenergetic character analysis – Sexual identity – Functional – Therapeutic relationship

## THE SOMATIC-ENERGETIC POINT OF VIEW

The somatic-energetic point of view is the key to the theory and practice of bioenergetic analysis. Over the years Alexander Lowen (1970, p.3) stated many times that, "Bioenergetics is a way of understanding personality in terms of the body and its energetic processes."

The somatic-energetic point of view originated with certain of Wilhelm Reich's clinical observations and theoretical work from the time when he was still a psychoanalyst. Clinically, Reich described what was then a new category of observable phenomena in the therapeutic situation, and he developed functional interventions based on those observations. The observable phenomena had to do with the appearance and movements of the body. Theoretically, the energetic point of view emerged in conjunction with Reich's questioning of Freud's tension-reduction theory of pleasure. On the basis of clinical observations of behaviors related to sex and orgasm, Reich pointed out that an energetic factor was needed to explain sexual arousal and orgasm. Sexual experience and behavior did not make sense simply as tension reduction.

These observations pre-date his efforts at scientific investigations into the nature of the energy. It is important to understand that his subsequent scientific studies do not change or affect the description of the clinical phenomena, the observational stance, or the validity of the therapeutic interventions.<sup>2</sup> This means that the energetic point of view does not depend on a specific conception of the nature of the energy.

I use the term *point of view* deliberately. A point of view is a specific way of looking, seeing, and observing – a unique and specific way of looking at a person. In psychotherapy, the point of view – the way of looking, observing, listening – is the most important tool of the therapist. In bioenergetic therapy, the somatic-energetic point of view is the crucial point of view.

While 'point of view' may refer to an individual idiosyncrasy, within a theoretical context, a point of view has objective meanings that can be shared with others. Generally, three things characterize a point of view. It is inherently guided by conceptions, or ideas, that have a basis in observable phenomena. There are paradigmatic, typical, or representative observable phenomena, behaviors, or events which are inherently associated with a point of view. Third, there is the unique way or style of looking; and this can be taught and learned. A dancer, for example, will most often look at someone's movement differently, say, from a psychotherapist.

The point of view finds functional expression in actual clinical observation – the practice of looking, listening, seeing, and understanding. I have found that therapeutic observation is a skill that takes years to develop. Reich was a remarkable, naturalistic, skilled observer. Those who experienced Alexander Lowen in a workshop were usually impressed with his capacity for observing and noticing, for seeing the essential. When I began to practice psychotherapy, the first thing I learned is that the therapist has to learn to listen. Learning this deceptively simple art occupied me very intensely for some years. I found out over time that there is listening and listening, or perhaps you could say, listening and hearing. Even more subtle for various reasons is the art of looking and seeing. In training, I say over and over again, "Look, look, look, and look – until you see."

If we learn to look and see, what typical energetic phenomena might we observe? I have found that I can place the relevant, typical clinical events, behaviors, and phenomena into several categories. I have arrived at these categories through

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<sup>1</sup> An earlier version of this paper was published in *The European Journal for Bioenergetic Analysis and Psychotherapy*. 2004. Vol. 2. (Discontinued). A portion of this paper was presented at the Biennial Conference of the International Institute for Bioenergetic Analysis, May 2001, Belgirate, Italy. The latter presentation and the earlier version of the article were dedicated to Ellen Green Gianmarini. I received help on the earlier version of this paper from Prof. Peter S. Fernald, Dr. Divna Todorovic, and Mrs. Susan Kanor, M.A. More than anything, this paper emerges from a lifetime of living and sharing with my wife, Vellie Helfaer, for whom words of thanks and gratitude hardly suffice.

<sup>2</sup> Further discussion of Reich's specific clinical observations can be found in: Helfaer, (1998/2006; 2010; 2011).

continuous reading in Reich and Lowen and many years of looking. These categories may sound very familiar. In listing them here I want to suggest that you imagine seeing and feeling them as living phenomena in the fresh context of the energetic point of view.

There are phenomena having to do with these ten categories:

- i.) Quantity of energy.
- ii.) Direction of energy: including, in towards the center, out toward the periphery, and pathways of energy in the body.
- iii.) Expansion and contraction: it is basic in energetic work to be cognizant of their alternation, and the events that may occur when working with chronic contraction.
- iv.) Pulsation: includes the vibrations Lowen describes.
- v.) Charge / discharge: the orgasm and other expressions.
- vi.) Flow of energy along the longitudinal axis of the body: orgasm reflex, grounding.
- vii.) Functions of the living bladder: the body seen as a single cell; many of the characteristics of the traditional bioenergetic types pertain to variations of the living bladder.
- viii.) Inflation: relates to ungrounded and psychotic states; overcharged head.
- ix.) Over-excitation contained in the core: agitation; often an aftermath of sexual abuse.
- x.) Shock: significant in illness and posttraumatic stress.

The phenomena in all these categories are to be observed in functional aspects of the person having to do with sexuality, the self, and relationship (Helfaer, 1998). The familiarity of the terms should not obscure the fact that I am referring to observable phenomena, not concepts. As such, they could provide a research focus. I found that learning to become a good clinical observer of these phenomena is a difficult matter.

## A PARALLEL ANALYSIS FROM PSYCHOANALYSIS

To further illustrate the significance of the concept of a point of view, I will draw on a parallel analysis by Fred Pine (1990). Pine talks about the “four psychologies” of psychoanalysis: drive, self, ego, and object relations. Each psychology has its typical phenomena and point of view. Each has also been enriched by the developmental point of view and research. All four are valid. None can be reduced to any of the others, and all are required to do analysis. What is important in these points of view, Pine says, are not the theories, but the observable phenomena, the observational bedrock. Drive theory, for example, deals with the reality of enduring urges and wishes, and the fantasies arising from them. Similarly, there are observable expressions of the self, issues having to do with the ego, and those pertaining to the inner object world. Observations of phenomena in the light of all of these points of view are valid, regardless of the theory in which they may be placed.

## CHARACTER

The concept of character is inherent in the somatic-energetic point of view. I understand character as the modification of the somatic-energetic processes of the body in the course of development. These modifications lie at the organismic interface between the deeper biology of the body and the individual's psychosocial adaptation. Character development and functioning are extraordinarily complex. In therapy, characterological understanding of the individual requires continuous and long-term observation from the somatic-energetic point of view. “Looking, looking, looking, and looking” – must begin with the first session of therapy and continue until the last. Character is thus an emergent process, continuously unfolding and revealing itself, as the broader, long-term repetitive qualities become clearer.

It would seem that *character analysis* should be the basic orientation of the bioenergetic analyst. The exigencies and stresses of actual clinical practice have made this difficult to achieve, and indeed, the whole concept has, to my observation, been lost along the wayside. That Alexander Lowen also did not find an easy route here is suggested in these comments:

As an analyst Reich had emphasized the importance of character analysis. In his treatment of me this aspect of the therapy was somewhat minimized. It was further diminished when character-analytic vegetotherapy became orgone therapy. Though character-analytic work takes much time and patience, it seemed to me that it was indispensable to a solid result. I decided then that no matter how much importance we placed on the work with muscular tensions, the careful analysis of a person's habitual mode of being and behavior merited equal attention (Lowen 1975, 41-42).

Lowen's first book (Lowen 1958/2004) grew out of this decision. In it, he attempted a delineation of character types. This book has an enormous amount of useful information, brilliantly insightful understanding of the energetic processes, and of human behavior. In some hands, through no fault of the book itself, it led to the egregious misconception that character analysis and diagnosing character types are somehow the same thing. The book in fact did not facilitate the development of a

bioenergetic character analysis as a therapeutic method. Without going into an extensive analysis of the situation, I will say simply that the problems were too complex and no one, as I see it, knew enough in those early days of bioenergetic analysis.

Lowen, himself, had a certain ambivalence about the matter. His passion was the work with the body and the energetic process. In a letter, Lowen (2001) wrote,

When I look at a patient, I ignore analysis of what I see. I want to get a clear feeling of a patient's energy. I get this from my feeling of the patient's aliveness and that aliveness is a reflection of how much energy a person has and my focus is how well the patient breathes. My aim is to help the patient breathe deeper and fuller. To get the patient to breathe deeper I do not need any analysis. After looking at the patient I go directly to some exercises which will help the patient breathe deeper and fuller.

Most of the many people who saw and experienced this kind of work with Lowen felt its depth and effectiveness. In doing such work, Lowen was present as a person with the patient in a simple, real, and contactful way. I myself am the beneficiary of such work with Lowen which took place over the course of ten years, and I am very grateful for it. It gave me the strength and energy to go forward in my life.

Ironically, in 1990, when my therapy with Lowen ended, I found myself in precisely the same state he said he was in when his therapy with Reich ended. He said that at the end of his therapy, as far as it had taken him, he still had serious problems in his life - that is, character problems - and he held very deep tensions in his body. Faced with the same kind of reality, I took a similar route to his. First and foremost that meant working bioenergetically every day with my body; I also looked for other ways, as I felt a need or saw a way, to increase pleasurable body feeling. Second, for me, it meant an ongoing confrontation with my character issues as they revealed themselves in my relations with patients and especially with my wife. My conclusion now is identical with Lowen's in 1975, when he published *Bioenergetics*. In effective therapy, both work "with muscular tensions" and "the careful analysis of a person's habitual mode of being" are essential ingredients.

## CHARACTER ANALYSIS AND MIND

There was another aspect to Lowen's ambivalence about character analysis. He considered anything that smacks of analysis - psychoanalysis or character analysis - as limited to the mind. Mind, for Lowen, signified the antithesis of feeling, passion, bodily experience. The mind is a computer. The body is the vessel of life. Like many of us, Lowen expressed the feeling that he had been too much "in his head" and that he needed to "get into his body," especially his legs and feet.

These expressions can represent realities about a person and his or her energetic condition. However, the mind, even if it stands in an antithetical polarity with the body, is not inherently inimical to the body. An intellectual defense is often an aspect of character, but that does not make the mind inherently a force negating the individual's life energy. The mind is one expression, and an ongoing expression, of the life of the organism. Losing one's mind is a dreadful thing, never finding one's mind is a great loss, and being mindful of the body is not only a pleasure, it is grounding. In the same vein, the understanding of oneself and another is significant in both therapy and life, and this is a function of perception and the mind.

Analysis, in itself, does not mean not feeling. The feelingful use of the mind and perception, and joyfully losing of one's head are not the same as forfeiting one's mind, nor do they require denigrating the role of the mind in life, including the life of the body. Thinking, also, should not negate feeling. It is another mode of expression and being, as is perception; both can be feelingful and contactful. In our society it is true that the cranium is almost inevitably overcharged. This propensity derives from the culture, but it may also be an inevitable tendency arising from the evolution of the large human brain. The brain is an organ and can be armored or motile.

Energetically, it is important to work consistently with the eyes, the ocular segment, and the cranium. As I have done so, with myself, I have regained the motile, unforced and non-compulsive use of my mind, softened the shock of early trauma, and freed the upper points of the pendular energy swing. I most often go without glasses and find pleasure as my mind grapples with the endless complexities of my work.

There is another observation to be made here. What actually is the analysis in the context of psychoanalysis? This may involve a number of verbally mediated processes, and it can certainly turn into an intellectual one. When it does, Lowen's position is largely supported. However, functioning as it should, analysis should enhance the individual's contact with him or herself, on an emotional level. Character analysis, also, is a process oriented to facilitating the emergence of the person as a whole - energetically, emotionally, and psychologically.

## PERSONAL DEVELOPMENT AND CHARACTER ANALYSIS

Throughout the years, character analysis and an understanding of the energetic functions of the body provided the best tools I had for guidance, support, and help in living my life. The centrality of sexuality, the mechanisms of character, and the energetic functions of the body gave me a much needed framework for facilitating my necessary development as a person.

Using these tools in my own life helped me learn how they could be applied in therapy. The development of my self and my development of bioenergetic analysis go hand in hand. This is my path and my practice.

Development of bioenergetic analysis is ongoing for all of our practitioners. The development of this practice is inherently – I would say, functionally – a part of personal development. I believe that the training and education in bioenergetics should be based on just such personal development. Bioenergetics is not a rigidified "technique" established some years ago by Alexander Lowen, nevermore to change, develop, or manifest individual variations.

When bioenergetics is viewed in this way, as it occasionally still is, there are disconcerting results. When therapists learn something new about the self, therapy, or development – as they inevitably will – the validity of the new knowledge is taken to demonstrate the shortcomings of "bioenergetics." It is not taken to establish the growth and development of bioenergetics. If the psychoanalysts functioned in this mode, psychoanalysis would long since have died. As it is, psychoanalysis has been an ever-evolving, deepening, expanding approach to treatment and the study of mind and behavior, with continuously new applications and variations.

In any case, there have been, and still are, serious difficulties in the way of the development of a bioenergetic character analysis. I wish to mention here some of my own difficulties in this regard, which I believe have a general applicability.

## DESPAIR, CHANGE, AND THE THERAPIST'S SOCIAL WORLD

I found learning and developing as a bioenergetic analyst a difficult path (Helfaer 2008). Like every conscientious therapist, I have studied and exposed myself to a variety of developments in the field of psychotherapy, including psychoanalysis, gestalt, family, and group therapy. I studied various developmental theories, some of the new psychoneurology, and also undertook to learn what I could about the complex and difficult personality disorders. In and through this journey, I did my best to keep my head above water. I relied a lot on my intuitive gifts, maintained my bioenergetic focus, and remained skeptical in the face of colleagues' and others' various enthusiasms of the moment. I saw and heard more than a few in my and related fields claiming to know the true path and calling on others to follow. To my mind, they were usually whitewashing their own fences, using some pat clichés and in fact, not saying much either new, or of substance. However, this sort of fashion in the therapy world indicates something important about the difficulties of the therapist's social world.

In my efforts, in fact, I repeatedly ran into all kinds of doubts and uncertainties. The development of my work as a therapist, as I said, relied a lot on my work on myself and my development as a person. I always believed that only to the degree I developed, could I help another. Needless to say, this is not always a smoothly flowing stream. From time to time, I fell into despair and faced serious internal crisis. I would despair of the capacity to solve my problems or find happiness with my wife, and I would feel utterly inept as a therapist. Suffering, pain, and feelings of blackness, rage, being alone, and dying overcame me.

At such times, I might say to myself, "Maybe I should go into psychoanalysis." If the bioenergetic work was inadequate to solve my problems I'd have to face it. That would be tough to face, but worth it, and I'd have to go on from there – if I survived. The thing is, I was a bioenergetic therapist, at least to this point, and I felt the world of analysis was quite different and not what I wanted.

About the time I was able to face my despair and aloneness, I would begin to emerge from the depths, the darkness, and the contraction. I'd rediscover my feelings for Velma and my own life, and a little more maturation had taken place. These turmoils often occurred in close connection with new learning in one or another theoretical arena. The connection was there, because I could see that my suffering had to do with critical issues surfacing at the moment – narcissism, self, repetition, envy, shame, and so on. The fact of the matter is, they were everyone else's issues too, of course. As the people in the field of psychoanalysis matured, a few courageous ones were able to face their problems and bring a deeper understanding to the work, just as Velma and I were doing in our work. In the meantime, as a result of this process, I was able to bring along with me viewpoints of psychoanalysis, or another field, in an integration with my own experience, and these integrations found a place in my functional understanding of the somatic-energetic point of view.

We therapists, I'm inclined to believe, are peculiarly vulnerable to the influence of the social milieu of which we are professional members. First of all, therapists live – or should live – with an intense awareness of their own emotional reality, history, conflicts, despair, and a sense of their own emotional and sexual health. At the same time, therapists, rightly or wrongly, tend to assume a serious responsibility for others' well-being. So while feeling responsibility for others, we also have pressing needs to resolve our own tensions, misery, and unhappiness, and to do our best to find fulfillment. Our professional practice – and knowledge – are intimately tied in with our own intimate lives.

Developments, ideas, and approaches in the therapy field are often represented as "new," and are convincingly presented by influential, possibly charismatic, individuals who wish to reveal the shortcomings of the old ways and convey a better, truer way to healing. Vying for prestige and recognition are just as much a part of the therapeutic world as any other. For us therapists, it seems to be very easy to fall under these influences. We are vulnerable in this way because of our own seeking and needing. Following these "leaders" can even inculcate a kind of despair and feeling of inadequacy – feelings that would be healed if treated by the new approach! The very development upon which becoming a therapist depends – that is,

becoming a person – is thus undermined. Such proclivities were occasionally awakened in me, at least temporarily, during the course of my development as a bioenergetic analyst.

## FUNCTIONAL PROCESSES

I have used the term *functional* in a few different contexts. Wilhelm Reich's (1942/1973) graphic symbol of organomic functionalism is well known. It shows two prongs branching out from one root and then arcing around and down towards each other. The graphic represents one of Reich's most basic and fundamental conceptions. Of the two branches, one can represent mind and the other the body, psyche and soma. The single, main root represents the life energy process of the individual person or organism. Somatic and psychic phenomena emerge from the common organismic energetic root. The graphic is one way of depicting the fundamental unity of mind and body. Their *functional* identity is an expression, first, of the fact that the two branches emerge from the same root energy process. Second, their functional identity signifies that any relevant mental function, for example, has its functionally identical somatic function.

The two branches turned towards each other graphically depict an antithesis. The graphic represents the idea of a basic biological identity and antithesis between relevant pairs of different functions of the organism. However, the point of splitting, and the formation of two branches swinging out into their own orbits and then arcing in towards each other is more profoundly a graphic representation of human maturation, vulnerability, and complexity. The splitting of energetic function may originate as the result of a trauma. The adaptation to the trauma may result in a blocking of energy, especially of sexual energy. In this case, the antithesis represents trauma and conflict, and necessitates the development of adaptive and defensive functions. In a healthier maturation, the splitting represents differentiation of functions and positive social and personal adaptation, as for example, in the development of the capacities for love and for productive work.

Reich described pleasure and anxiety as the paradigmatic example of biological processes that stand in the relationship of identity and antithesis. Energy moving from core to periphery tends to be experienced as pleasure; the movement from periphery to core tends to be experienced as anxiety. The root energy is the same; the direction of movement differs. On a deeper level, this functional relationship is the same as that between expansion and contraction. This relationship in turn can be taken to the level of the relationship between the parasympathetic and sympathetic autonomic nervous systems.

This concept is a powerful tool in bioenergetic analysis, offering a profound way of observing the person, and a guide for staying on a functionally effective focus. The therapist holds and relates to the patient on both the level of the psyche and the body. Otherwise, the therapeutic process will not engage and hold the person, who will inevitably, fatefully, use the oversight to escape change, turning the therapy into another repetition.

To refer to a process as functional implies that it is a part of, or arises directly out of, the biological energetic process. This also implies that the function in question is alive and present now. The categories of energetic phenomena, listed earlier, are relevant to the process or experience. In addition, when a process is referred to as functional, this implies the kind of complexity, differentiation, and interrelationships suggested in the discussion of the concept of identity and antithesis.

When a therapist develops his or her work on the foundation of personal development and experience, his or her work will be more likely to have a functional basis. It develops directly out of personal, emotional, energetic, and interpersonal experience.

In bioenergetic analysis, there are a small number of basic, functional processes which are the vehicles of the somatic-energetic processes of the therapy. Every bioenergetic therapist knows what these are: respiration, movement, contact, expression of feeling and voice, and the use of stress. These functional processes are not "techniques." When the therapist works functionally, the process will stay alive and relate to the here and now functioning of the client. Mechanically, or contactlessly, approaching the work with breathing, or anything else, as a technique, will lead into a characterological repetition. The situation can be retrieved from such an event when the therapist is able to come back into contact with his or her own aliveness and relate again to the client from there.

The application of functional processes can be seen clearly in the remarks of Lowen quoted earlier. He indicates that he first makes contact with the patient on an energetic level. "I want to get a clear feeling of a patient's energy ... from my feeling of the patient's aliveness." (Lowen, 2001). This is a functional use of contact. The contact is functional because it is a feeling, a feeling in his body as he resonates with the aliveness of the other. This can support or hold the aliveness of the patient. It is not a contact mediated by either touch or words, but it is nonetheless a very deep way of contacting another person.

Subsequent work to facilitate deeper respiration is also a functional process. It is intrinsically, biologically, an expression of and facilitator for the aliveness of the individual. Aliveness, quantity of energy, and breathing are all functionally inter-related. Energetic contact with the patient and the patient's contact with him or herself must be maintained for the work with breathing to remain functional and develop.

The same considerations apply to the use of movement or stress which may follow or go along with the work with respiration. The exercises or stress, (for example, use of the breathing stool), are biologically functional, relating to emotion, character, and energy. Any exercises also require attention to contact between patient and therapist, the patient's contact with him or herself, and, of course, this process requires the therapist to be in contact with him or herself.

What I have been describing are the conditions necessary for somatic-energetic work to remain functional. Therapy is functional to the extent that it is feelingful and contactful, arising out of the therapist's own energetic process and that of the patient's.

As therapists, we frequently speak and write about the 'holding environment' of therapy. In describing the conditions necessary for somatic-energetic therapy to be *functional*, I am, in fact, describing the holding environment created in a bioenergetic therapy. The point here is that when the therapist works functionally, that – in and of itself – is the most important ingredient making up the holding environment. The "holding" is not another different, separate action of the therapist altogether, nor is the "relationship." It is maintaining contact at all times with both his or her own life process and that of the patient, and facilitating the patient's contact with his or her own life process. That is the holding.

## A FUNCTIONAL VIEW OF THE INNER WORLD

Fred Pine provides a description of the development of the intrapsychic world (Pine, 1990, pp. 63-64, 65, 66-68) from a perspective which relies on all four psychoanalytic psychologies. The inner world, as described by Pine is, to my mind, a given. It is a reality. How does the bioenergetic analyst relate to the inner world? Do we prevent it from being a part of therapy if we limit talking? Do we get to know something about someone's inner world if we do not listen and talk with them? Yet, if we only talk, we move away from effective somatic-energetic work.

The energetic point of view has an important contribution here. As the inner world develops, along with it, underlying it, and as a part of it, there are developments and modifications of the somatic-energetic processes of the individual. For each actual phenomenon that might be seen from one of the psychological points of view, there are somatic-energetic phenomena. If the bioenergetic therapist is seeing and relating to the underlying somatic-energetic process, the functional process is held, and the therapy continues to move in an energetic process. In this case, the patient is likely to spontaneously bring forth aspects of his inner world, sometimes feelings or memories to which he would not otherwise have access. The movement from and between spoken revelations of the inner world and somatic-energetic process can be seamless. At other times, various defensive functions, adaptations, and inner states are usefully addressed and sorted out through talking, allowing the client to move more freely into a somatic-energetic process.

I believe that one source of confusion in understanding the inner world from the somatic-energetic point of view is that psychoanalytic theory is thought of as depicting a model of the mind, and the conception of mind in these theories is not functional. Even when the self is considered as a body-self, as in the very scholarly writings of Meissner (1997), the material dealt with is verbal and has to do with the mind. The mind is indeed reified as a kind of entity or set of processes, distinct from biological ones. Research on the brain is supposed to reveal the real nature of the mind, in this point of view, but the relationship is mechanical and actually unknown. This creates an artificial problem as to how the mind and body are related.

The mind must be considered functionally. The phenomena that are considered to arise from the mind – say a report of a dream, or the description of an experience – must be seen as functional expressions of the organism just as much as the vibrations induced by bioenergetic exercises.

There is a significant developmental issue as well. As the inner world develops, differentiates, and unfolds, there is an identical development, differentiation, and unfolding of the somatic-energetic processes of the organism. The somatic-energetic process underlies the psychological development, and the latter depends on the former. However, as growth continues, the inner world of the child, adolescent, and then young adult becomes highly complex and an energized system in its own right. The somatic-energetic system is not separate and distinct from the psychological inner world, nor vice versa. It is necessary to seek access and to influence each one through and with the other.

## WILHELM REICH AND THE BODY-MIND PROBLEM

Wilhelm Reich's analysis of functional relationships and the identity and antithesis of biological functions does not solve traditional philosophical problems conceptualized as having to do with the relationship between the body and the mind. There is no "Cartesian error" addressed, and there is no overcoming of "Cartesian duality." The traditional philosophical questions are utterly irrelevant. From an epistemological point of view, what Reich did is perfectly clear and, in fact, empirical. He introduced into the psychotherapeutic arena a whole new and different category of observable phenomena. He beautifully demonstrated – empirically again in the clinical situation, and also theoretically – the relevance of these phenomena to human functioning. His description of this realm of human functioning also addressed a series of (functional) relationships amongst various sets of the phenomena he described. This adds enormously to the power and usefulness of his formulations. Finally, he courageously developed a systematic approach to therapeutic intervention based on knowledge and understanding of these phenomena and their relationships.

In the course of these developments he also developed a vocabulary for communicating and discussing the relevant issues. It does not take away from these remarkable achievements to acknowledge that most of his colleagues at the time, and almost universally to this day, were, at best dismissive and more generally out-and-out abusively contemptuous. Much of the abusive rejection had more to do with the vocabulary of his theory than the substance of his clinical contributions. In fact, even

Reich's worst enemies confirmed some of his most important observations. Prime examples are Chasseguet-Smirgel and Bela Grunberger (1986, p.178). Peculiarly enough, I find little reference to Reich's work in the writings of my bioenergetic colleagues. We need not look very far for possible motivations of this avoidance.

In this context, we should be perfectly aware that the events, behaviors, and "phenomena" that Reich observed and made central in his therapeutic approach are not strange or unusual phenomena. He did not make them up, and they are readily observed by anyone. Unusual forms of energy are not involved, such as energies claimed to be manipulated by "healers" even to this day. In fact, the phenomena that Reich observed are still observed today in psychoanalysis. Meissner (1998) describes many of them. He points out that, while these events or behaviors are interesting and expressive of the self, they are not part of the "observational base" of psychoanalysis, and therefore "take a back seat" to verbal communications. In other words, a whole world of expressions of the individual are not considered as part of the therapeutic field. Between the two positions – Reich's or the conventional psychoanalytic – which is stranger?

## CHARACTER AND ENERGY

When Wilhelm Reich (1933/1972) wrote *Character Analysis*, he was writing from the viewpoint of drive theory as understood at that time. His formulation of character culminates in the statement:

At the core of the armor's *definitive* formation, we regularly find ... the conflict between genital incest desires and the actual frustration of their gratification. (Reich, 1933/1972, p. 156)

This is a classical drive theory formulation: the core oedipal conflict between drive and defense is the crucial nucleus for character development. At the same time, Reich's formulation makes two revolutionary shifts. It changes the locus of the oedipal conflict from a family drama to one within the person, and in the references to desire and actual frustration, it places the conflict, not in the mind, but into the body (Cf. Helfaer, 1998, pp. 100-101). This, in itself, is a movement beyond drive theory and away from the "psychological" altogether.

This formulation illuminates what we discussed above: the interrelationship between the development of a complex, differentiated inner world and the modifications of the somatic-energetic processes that underlie and are intertwined with it. Here is a basic example of functional identity and antithesis (inner world/core somatic-energetic conflict), and this, generally, is what character is about. Further, as we make use of the "psychologies" of psychoanalysis in this context, they are transformed. They are no longer part of a model of the mind, but an expression of the somatic-energetic processes themselves. Our approach in bioenergetics represents a big shift from the approach in psychoanalysis. We are not merely investigating the psychological; we are contacting the energetic.

Character is complex and multifaceted. Understanding and working with it requires the viewpoints of the four psychologies as they are transformed in the somatic-energetic context. The modifications of the somatic-energetic processes forming the intrinsic core of character are themselves multifaceted, requiring for their description all the various categories of energetic process mentioned earlier. The phenomena of character are nonetheless real, and can be identified in a clear, functional way in therapeutic work with the individual. There is potential for a lot of exciting development here.

## SEXUAL IDENTITY

The conflict between genital incest desires and their actual frustration found, as Reich said (above), at the core of the formation of the armor, can also be said to be generally at the core of the formation of character. This conflict can also be said to be at the core of the formation of sexual identity, one aspect of sexual development and of the individual's sexuality. Sexual identity, at the core of who the person is, has implications for the inner world of the individual and represents a shaping of energetic processes and sexual energy and expression. I want to describe three phases of its development which I believe have not been identified in this way. Each phase has implications for sexual identity specifically as well as for the individual's overall development.

### *i.) Of the species.*

The first phase begins with the earliest days and months of life. The idea here is that the early contact with the mother, nursing, eye contact, and holding establish in the person the sense that might be expressed with the words, "I am the same kind as you." This sense gives the person the feeling of *being of the same species*, belonging by virtue of *being the same-as*. This sense is not usually in conscious awareness. There are times for some people when they lose that sense and are in fact aware of feeling that they no longer belong to the species (Cf. Helfaer, 1998, the case of "Henry," pp. 126-27).

### *ii.) Identification with the genital.*

The next phase, traditionally named the Oedipus phase, is more appropriately called the phase of the *identification with the genital*, (discussed extensively in Helfaer, 1998). In this phase occurs the conflict as defined by Reich which we have been discussing. The nature and outcome of such conflicts determine the security or insecurity with which the identification with the genital is established.

### *iii.) Adolescent phase: maturation and choosing and being chosen.*

The maturing body of the adolescent brings the individual into an evolving understanding of him or herself as an adult sexual being. It also faces both sexes with an evolutionary imperative: choosing and being chosen. This almost inevitably creates intense excitements, conflicts, and preoccupations tending even to turmoil. Underlying all the turmoil, tumult, and conflict lies a basic developmental conflict or task, the *polarity between a feeling of sexual ruination and sexual desirability*.

These three developmental phases, I want to point out, are congruent with the natural, ordinary way of perceiving another person and reflect how we are perceived by them. When we look at another person, the first thing we register is that we are of the same kind, the same species. I am one like her, she is one like me. That this is the case, is indicated by the instances when this is not our feeling. Such is the case, for example, if I feel less than human in another person's presence. Such is the case when the other is seen as less than human, a process that occurs in genocides. Our odd feeling when observing chimpanzees or gorillas who are almost human also hints at this phenomenon.

The second thing we register when we look at another is whether they are male or female. Again, anomalous experiences may prove the rule. Finally, inevitably, when we look at another, just how desirable they are as a man or woman enters into our perception.

The core of identity is sexual identity. And the core of sexual identity are the somatic experiences that occur in these developmental phases: maturation and choosing and being chosen with its conflict between sexual ruination and sexual desirability, identification with the genital and the conflict between the genital incest desires and their actual frustration, and the sense of being of the species or the sense of falling out of that category.

## THE FLOW OF LIFE

Lowen has discussed the concept of flow as "a movement within the organism;" for example, that of charged fluids like blood, but also the movement of excitation through the fluid medium of the body (Lowen, 1975, pp. 51-53). Some years ago I discovered another dimension to the flow of life and found that, without having been conscious of it, that dimension had been serving as an important tool in my understanding. It has to do with our flow of life through time, and the flow of life through us over time.

Once, I was asked for a title for the final workshop of a particular training group. Without hesitation, I wrote what had spontaneously come to mind: "In the flow of life, how do we say good-bye? How do we move on? What do we want?" The sense of being in the flow of life stayed with me from that time on.

There is a constant flow through our bodies – as energetic flow, emotion, and sexuality – and there is an energetic interaction with our environment. As whole organisms and beings, we are immersed in this energetic flow of life, as life is lived through us. We are, as well, immersed in another aspect of that flow, and that is the flow of time. Our body and beings metamorphose through time, in the flow of life in which we participate.

Sometimes, we address issues of "adult development." However this phrase, to my mind, does not capture the functional implications of the flow of life. To know another, I must find out where he or she is in the flow of life and what has been his or her fate at various stages in the flow of life. I need not address this in more specific terms at this point, except to say that, as I see it, this is an aspect of the basic perception of the individual from the energetic point of view.

## THE THERAPY RELATIONSHIP AND THE THREE DOMAINS

In bioenergetics, the picture of the energetic presence of two embodied people interacting and affecting each other, "vibrating like two tuning forks," (Lowen, 2001), conveys the reality of a dyadic milieu quite different from that of the psychoanalytic session, as ordinarily conceived. Conceptually and experientially, there are two quite different worlds here. The energetic and emotional milieu of bioenergetic therapy reflects the focus on somatic-energetic states.

Following and amplifying on some remarks of Pine (1990), we can say that there are three great domains within which the action of therapy occurs: the intrapsychic (inner life), interpersonal relations, and the somatic-energetic processes. The relationship between therapist and client thus falls directly into two major domains within which therapeutic action can occur, the somatic-energetic and the interpersonal. Indirectly, it falls into the inner world domain. For therapeutic action to occur, the therapist has to rely on the essential biological capacity of the patient to relate, that is to bond, form an attachment, or in terms I prefer, to make use of a vital connection (Cf. Helfaer, 1998, Chapter 10).

Beyond this, I want to describe a particular process upon which the action of bioenergetic character analysis depends. Its action depends on the capacity of the therapist to experience, "metabolize," and allow into awareness his experience of the patient from the level of his own feeling and bodily experience. I believe every therapist knows what I have in mind when I refer to *metabolizing* his or her experience with a patient. Metabolizing one's experience refers not only to what I may feel at the time, but what I have to go through, what I have to possibly suffer through, what I have to ruminate about (as if digesting), what I have on many occasions awakened in the middle of the night preoccupied with. It is necessary to sit with each such "metabolic" experience over time until it delivers itself of the messages the patient is really conveying as to who he or she is and how he or she really feels, or does not feel. Often what will emerge into the awareness of both therapist and patient is the hitherto unacknowledged but powerful reality of the patient's character.

The major part of my work with a patient does not by any means always occur during the therapeutic hour. It occurs within me, as my experience of the patient develops its own inner space within me and evolves, metabolizes. This is a functional process, occurring over time, in the flow of life as it is shared by me and by the patient. It is a rich, complex, multifaceted process. It occurs in all three domains for both therapist and patient. Some features of this experience have traditionally been discussed under the terms transference and countertransference. These terms are appropriate, but they may hide as much as they reveal as to the actual, functional process. In any case, the development of every therapy, if it is to be useful, depends on this process.

In this context, I want to comment on love and its place in the therapeutic process. I, as the therapist, need to keep in mind that I am metabolizing my own experience, not that of the client. The experience of the client titrates through my own inner world, my own body, and my own energetic state. It is the therapist's task to metabolize this in such a way that the aspect brought to the therapeutic interaction is in the service of the patient's growth.

It is for this very reason that any preconception that the therapist's love is a curative agent in treatment is a misleading and potentially destructive misconception. When love arises, I do not claim my love as a healing agent. My love is one of my feelings or states, like many others. If I claim a power for it, such as to heal, to reach another, and so on, it is, in fact, no longer love; making the claim changes the very nature and quality of the feeling and state. Further, it changes the interpersonal meaning of the love by introducing the attitudinal coloring that it is an agent. In this case, it becomes associated with power. My love needs to remain my love and my experience, just as with other feelings, including interest and boredom, pleasurable engagement and annoyance, empathy and impatience, and whatever.

My patients usually know, and sometimes indicate they know, when I care for them, or even love them. They also know that is not the goal of our work, nor does it change what they want and need to do for themselves. They still have to face themselves. Knowing someone cares may be soothing. That should not preclude our awareness that a superficially loving attitude may disguise indifference or dislike, create a kind of unreality, and, in fact, provide an impediment to the therapy. In the face of dislike, dread, or other negative emotions, the therapist should expect of him or herself to maintain a commitment and dedication to the patient's well-being and therapeutic progress, even while not suppressing negative emotion.

There are other meaningful difficulties in dealing with love and the conception that the therapist's love is an agent for change. Not the least of these is the question of just what is meant by love in this context. Whose feeling and whose idea of love? Love takes varied forms, as everyone knows, and it is not easily separated from expectations of the loved one. How free can the patient be to face him or herself in the presence of a therapist who in one way or another, consciously or unconsciously, conceives of him or herself as healing through love or even of being a "loving person"? The idea that the therapist's love is a healing agent puts a pressure on both therapist and patient. For the former, it limits authenticity, and for the latter, it creates an unreal expectation and pressure. One no more wants to fail the therapist who supposedly loves than the parent who supposedly loved.

More to the point, as I see it, sooner or later, in a therapy of any duration, I, as the therapist, have to come to terms with myself as to who I am with any particular patient; and sooner or later the patient will have to come to terms with me too. Sooner or later I have to come to terms with who the patient is, in and of him or herself, apart from who I think he or she could or should be and regardless of all my good intentions; and sooner or later the patient, too – it is to be desired – will come to terms with him or her self. All of this means, of course, that patient and therapist must come to terms – in themselves and between each other – with their full range of emotional experience. Such a coming to terms, in the final analysis, really defines the nature of the therapeutic process and the therapeutic relationship, and, given the nature of the process, it is possible, but not at all inevitable, that love will find a place in the final accounting.

## THE STANCE OF THE BIOENERGETIC ANALYST

The relationship between therapist and patient is complex, rich, and multileveled, as is any serious relationship between two people. Here I want to discuss only one other aspect, usually referred to as the stance of the therapist, the therapist's way of working. For example, Pine (1990) says,

My own way of working involves quiet listening, relative anonymity, neutrality, nongratification of drive aims, and interpretation (or question asking). (p. 8)

This is a simple, unpretentious expression of the classical analytic stance. There are several reasons this stance does not apply to bioenergetic analysis. The bioenergetic analyst, for example, quickly loses a large measure of anonymity as soon as he gets up out of his chair and approaches the client, either in suggesting an exercise or to make a more direct contact, for example, to stand beside the patient. This raises a serious question. Can the bioenergetic analyst have a stance as disciplined and consistent as that of the analyst? I believe the answer is yes, if the bioenergetic analyst is willing and able to take upon him or herself the self-development necessary to acquire it.

Before attempting a description of such a stance, I need to clarify a related point that has created a degree of confusion in bioenergetic papers and discussions. This has to do with the idea of "technique." Again, Pine (1990) will be helpful:

Psychoanalytic technique proper came into being when Freud gave up forced association techniques and hypnosis and substituted open-ended listening, listening with evenly suspended attention to the content of the patient's associations. (pp. 42-43)

In other words, the issue of "technique" pertains to the stance of the therapist. In relation to bioenergetic character analysis, that means it is incorrect to refer to a use of the breathing stool, for example, or any other "exercise," as a "technique." Breathing is a functional process, not a technique. The issue here is the breathing, not the stool. The whole process is functional, which means that the bioenergetic therapist needs to be in feeling contact with the patient and his or her breathing as well as his or her own.

The stool, again as an example, is a tool. Its use provides a way of working with breathing. Its use is inherently functional, because, for example, it helps with tensions associated with respiration. It is conceivable that the stool might be employed by a contactless therapist, in a mechanical, non-contactful way, but this is another matter. It is also conceivable that listening to free associations could be performed contactlessly. In either case, of course, the therapy does not develop.

What might be said about the stance of the bioenergetic analyst that could be the basis for a disciplined, consistent, helpful way of working? As I examine my own work, I arrive at four categories that I felt could characterize a disciplined, consistent stance: *observation, being with, getting it, and therapeutic movement*.

*i.) Observation.*

I believe the ability to observe the other is fundamental. Observation must be understood as a functional process. As a capacity, it is based in the total development of the person of the therapist. It requires that the therapist be able to approach the patient openly – open minded, and open emotionally, and energetically – again and again. It requires the capacity to wait, look, listen, feel, and not let therapeutic zeal or anxiety move one too quickly to intervention, or too quickly to a formulation. It requires that the therapist allow the work to unfold from the person of the patient without preconception on the part of the therapist. Observation is informed by the therapist's development as a person, his or her own therapy, readings, teachers, and theoretical conceptions, and at the same time, the therapist needs to be open enough to allow for the unfolding of what is new, what does not fit any preconceptions.

*ii.) Being-with.*

The kind of observation I just described has been called *participant observation*.<sup>3</sup> Indeed, the therapist is participant at the same time as observer. I consider one of the most important qualities, maybe the most important quality, of the therapist's participation is the *capacity to be with* the other. I believe most people will have an intuitive sense of what this means as a feeling, an experience, and a way of being. It is a capacity of the therapist that conveys to the other that the therapist is with the patient in his or her feeling, in his or her journey, sorrows, and joys. Empathy and compassion may be aspects of this quality, but I do not believe they make up all of this capacity. I believe it is unwise if I assume too quickly that my "empathy" necessarily creates in the other the feeling I am with him or her. In fact, it is not always so easy to be with another, and I cannot be with another any more than I have been able to be with myself, say, in my own despair, or, for that matter, in facing the anxiety of overcoming my fears of excitement, joy, and life in a real way.

When I use the phrase, 'being-with,' I have in mind the loneliness I and most of my patients experienced as children. When the child is left alone with his or her own experiences, his or her own fantasy elaborations and terror, when there is no holding relationship for discharge, the experiences become traumatic, etched in the body and limbic memory. *Being-with* thus requires that the therapist has faced the fear and reality of his or her own sense of being alone with overwhelming experience.

Sometimes being-with also means to me, being with an awareness of the character attitudes of the patient. In this case, it is often allowing myself to be with the traits and behaviors of the patient that keep him or her isolated, traits that no one else has been willing to take on and he or she has not yet taken on for him or herself.

*iii.) Getting it.*

This phrase catches the quality of a functional process (Cf. Boris, 1994, "Getting the Idea," p. 31). "Oh, I get it." This happens, after a while, if I can be attentive and open in my energetic observation. I feel what is happening in me, then in my patient, energetically and in terms of what my patient is talking about to me. I get the message. It can't be forced. If I get it, maybe I will have something useful to offer. Often what I get has to do with the unspoken, "ego syntonic" elements of character and their pervasive presence and influence.

*iv.) Therapeutic movement.*

I chose this term to cover whatever it is I might do in the service of "offering something useful." It covers a variety of actions. Some of these actions I see as falling into such categories as:

- a.) Use of myself in an engagement with the patient; soothing; offering contact.
- b.) Eliciting, as in eliciting a developing feeling, perception.
- c.) Holding, specifically, not just the holding environment, but holding for the patient something they have not been able to hold for themselves, such as an early loss in childhood, a failure, a shame, a trauma, an anxiety, an excitement.
- d.) Confronting, bringing back into the foreground a theme which tends to slip away, such as an unwelcome reality, such as the childishness of a behavior, an unreality, a hidden hostility, a "forgotten" trauma.
- e.) Interpreting, offering a new meaning for a pattern, a dream.
- f.) Guiding movement and the energetic process, as in working with breathing, kicking, screaming, grounding.

I see myself doing all of these various things, and at the same time, I am observing, being with, waiting to get it. I find myself in all of these actions, so I cannot make the kind of neat differentiations regarding therapeutic action that, for example, Stark (1999) makes, as in a one, one and one-half, and two person model.

<sup>3</sup> Cf. Helfaer (2007). I believe this term was first used by Harry Stack Sullivan.

As with observing, being with, and getting it, therapeutic movement, if it is to be helpful, requires certain capacities on the part of the therapist. It is the time when the therapist makes his or her own commitment to the joint enterprise that is underway. The therapist, as soon as he or she makes a move, relinquishes neutrality, distance, disengagement. In any move the therapist makes, he or she is there, in it, body and soul. This requires a kind of courageous commitment, a self-respecting and other-respecting commitment to the patient's longing for a better life. Tact, timing, patience, compassion, and empathy are all necessary for useful therapeutic movement. At the same time, the moment of action, of therapeutic engagement, brings in another element: a willingness perhaps to tread where heretofore angels have feared to tread. Without this risk the therapy will remain tepid, and the patient will not confront him or herself on a deep level.

Unfortunately, on the other hand, there are many subtle and not so subtle ways that the therapist's movement can become an expression of his or her own inner drama and takes over the patient's stage. The term 'countertransference' does adequately cover these all too common occurrences. In these moments, the relationship has become, for the therapist, another instance of his or her own early traumatic experiences, and the patient is used in the service of his or her particular drama. This may take on all kinds of coloring, from the therapist's "compassion," or "interactivity," to outright psychotic anxiety.

## CONCLUDING REMARKS

I have described several processes and conceptions that I believe establish the foundations for a bioenergetic character analysis. Basic aspects of the therapeutic relationship of a bioenergetic character analysis are amongst these descriptions. I have delineated these conceptions in such a way as to emphasize that bioenergetic character analysis is a flexible tool that is learned in relation to the therapist's own personal development. It is an open-ended conception in the sense that it is not a fixed regimen of any kind and allows for the learning and development of its practitioners and the possibility of expanding applications.

I have not attempted a clinical description of bioenergetic character analysis, and I have not attempted a thorough development of the concept of character. I have, however, attempted to put the concept in a fresh light. Character is understood as the modification of somatic-energetic processes in the course of development, and it is interrelated with the development of the inner world which develops out of interpersonal experience. This puts the conception of character into a much broader context than the drive theory and psychosexual development theory in which Reich originally developed the concept, and allows for the perception of the whole person.

An implication of the conceptions I have described is that change in bioenergetic therapy must be based in changes in the individual's somatic-energetic functioning, including, but, not limited to, increased aliveness in the tissues and a freer experience in the flow of life. From this picture, it is also clear that the therapist, immersed in such processes, must be changing along with his or her clients. The whole process is an aspect of the flow of life for both therapist and patient, and out of that flow emerge new possibilities for both.

I have not specifically discussed "resistance" or how change occurs, although I have given several indications of the conditions under which change might occur, including conditions which relate to the nature of functional process in therapy and the bioenergetic analyst's stance.

I want to briefly mention a few other key implications. First of all, this analysis puts the energetic point of view on precisely the same conceptual grounds as the points of view of psychoanalysis. It does so by establishing the observational bedrock, the essential conceptual framework, and the existence of paradigmatic observations.

Then, if we therapists look and observe, as I have recommended, it is self-evident that we will see first of all a male or female person, that is, in the case of an adult, a sexually mature person. My own deepest knowledge tells me that for the adult person, his or her fulfillment in life rests profoundly on the fulfillment of sexual love, and his or her whole way of being in the world is grounded in his or her sexuality as a man or as a woman. This realization, as well as the exploration and understanding of sexual identity, will be one main constant guiding thread of any therapy.

Another feature I wish to emphasize is recognition of a specifically bioenergetic form of observation. We have become familiar with infant and child research based on careful and caring observation, the creative crafting of ingenious questions and observational techniques, and guided by significant conceptualizations. When a man or woman patient walks into our office, we have the option to observe him or her with the same care and caring in the service of gaining a deeper understanding of this organism and this individual. It is we therapists who will craft the proper questions, implicitly or explicitly, to elicit the essential knowledge and awareness in the patient and in ourselves. We can derive and create the significant conceptualizations for a somatic-energetic understanding of each unique individual. Our patients deserve just the same kind of careful and caring observation as the infants. Just as each patient is unique, so each patient is a field of research unto him or herself. The somatic-energetic point of view and the understanding of the functional aspects of character provide the conceptual tools to guide this observation. This field of clinical observation from the somatic-energetic point of view is wide open, and there is a great deal to be explored and learned.

In conclusion, I should mention a simple, practical matter. In gaining a working understanding of the somatic-energetic point of view, I find that the single most important necessity is working energetically with my own body, daily, year in and year out.

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## Biography

**Philip M Helfaer, Ph.D.**, has been involved in the development, practice, and teaching of bioenergetic analysis for forty years. He is a faculty member of the International Institute for Bioenergetic Analysis. He lives in Israel with his wife, Vellie. He is author of Sex and Self-Respect: The Quest for Personal Fulfillment and numerous articles. Communications may be directed to : [pmhelfaer@hotmail.com](mailto:pmhelfaer@hotmail.com)

# A Body-Mind Integrative View of the Development of Characteristic Emotional Regulatory Patterns

Daniel Hoffman

## Abstract

Many theorists have explored the development of characteristic patterns of emotional regulation. Recently, research in the neurobiology of attachment has shed light onto the mechanisms underlying these strategies, and suggests connections to earlier somatic theories of emotional regulation such as those proposed by Lowen. Exploring the connections between these theories can lead to a more comprehensive mind-body understanding of how the human organism learns to interact with its environment. This article explores these connections and suggests possible directions for future research.

## Keywords

Attachment – Character – Emotional regulation

Since the beginnings of contemporary Western psychology, there have been currents of support for a view that integrates the mind and body. Reich, a student of Freud, created techniques of mobilizing the body through breathing and other methods and found that emotional processes were associated with this increased mobilization of the bodies of his patients. Lowen (1975), who was a student of Reich, starts from the premise in Bioenergetics that a person *is* his or her body. A similar view of the human being is proposed by Damasio (1998) who speaks of the “deeply interwoven mesh of body and brain that defines a complex living organism” (p. 84). Contemporary research in the field of attachment speaks of the way in which body-mind organismic systems interact with their (especially social) environments to meet the complex needs of those systems (Schore, 2001; Siegel, 1999). It is time we embrace this systemic view of ourselves in order to gain a fuller understanding of the functioning of the human organism. The development of emotional regulation is one area in which we can explore how body and mind integrate into the functional unity of the human being.

Emotion is more than just a feeling. Many thinkers and researchers have defined emotion as a process that occurs on the level of our entire organism. Lowen (1975), starting from his premise that we *are* our bodies, defines emotions as physical experiences within the body that are inseparably linked with impulses for movement (p. 55). He speaks of how the mind functions as part of the body in the consciousness of this process. Siegel (1999) and Damasio (1998) include the body’s role in emotion, and further clarify other levels that are also actively involved. Siegel (1999) sifts through many theories on emotion and arrives at some commonalities. Many theories of emotion, he states, include the idea that emotion is a multi-level process involving physiological and neurological elements, cognitively experienced aspects, and active expressions and behaviors. Emotion, he says, is the dynamic process regulating a human system in relationship with its environment, including social and interpersonal aspects of that environment. Damasio (1998), in his discussion of emotion, talks about the importance of viewing it as an organismic process, and considering the human system as comprised of an integrated body, mind, and brain, which cooperate in the process of emotion to maintain bioregulation.

Emotional experience is at the core of human experience. Damasio (1998) describes emotion as “the highest order direct expression of bioregulation in complex organisms,” which speaks to the fundamental importance of emotionality in our lives (p. 84). He goes on to explain some of the functions of emotion in our lives, including its foundational role in organismic regulation within the context of a social environment. Lowen (1975) considers emotions to be a direct expression of the life of the organism, the means through which the organism expresses itself and relates to the surrounding world. This all contributes to the notion of emotion as regulation that Damasio proposes, since expression and relating are the mechanisms through which the organism can achieve the fulfillment of its needs in such a social environment. In addition to serving the purpose of relating to the outside world to further the survival of the organism, Siegel (1999) notes that not only are emotions *regulatory*, they are also *regulated*. The organism starts with a range of emotional expressive capabilities, and then stanches those which it learns are not effective in its environment.

From the viewpoint of Bioenergetics proposed by Lowen (1975), emotions naturally arise from the developing infant organism. Depending on early childhood experiences, the child either learns that certain emotions are acceptable, with their accompanying impulses, or that they are not. This occurs, he says, through the parents’ responses to the actions of their children. If the parents are not tolerant of certain modes of expression, the movements associated with those emotions are inhibited.

Lowen noticed that inhibition occurs within the level of the musculature. For example, a child who is made to feel ashamed when she reaches for her parents as part of a longing for care will cease this action by inhibiting the muscles involved in reaching. This is the process of what is known as “armoring” the consistent tension that occurs as a result of the inhibitory process (p. 144). Initially, Lowen believes, this inhibition is fleeting, but with repetition, it becomes ingrained in the system.

The summation of all the armoring in the body becomes what Bioenergetics calls “character” – a person’s habitual way of being (p. 41). Character is the way a person has learned to emotionally interact with his or her environment as a result

of his or her early experience of the world. From Lowen's viewpoint, psychological health relates to the capacity for free self-expression. He states, "a person expresses himself in his actions and movements, and when his self-expression is free and appropriate to the reality of the situation, he experiences a sense of satisfaction and pleasure" (p. 49). Attachment theorists (Schoore, 2001; Siegel, 1999) share this view that the process of building an emotional life occurs through early caregiver relationships. They, however, have focused more intently on the effects of these experiences specifically in relation to the developing brain.

Current attachment theory research focuses on how the brain's development is conditional upon characteristics of the relationship between caregiver and infant. Schoore (2001) and Siegel (1999) explain that a child's ability to regulate his or her emotional state is not innate, but develops out of that relationship. Schoore explains that the capacity to regulate emotions, to increase and decrease arousal and activation as appropriate to the situation, is a property of the limbic system and right brain. He relates this ability to regulate emotions with socio-emotional events that occur during the period from the third trimester in utero until the age of 18 to 24 months and the way in which they interact with the genetically programmed formations of brain structures and the connections between them. This occurs when an initial genetically produced overabundance of neural connections is pruned through the process of competition to select those which are most congruent with environmental experience. This creates an emotional landscape in the child that is sort of a best-fit to the environment in which he or she grows up. This is the healthiest emotional situation for the child because it optimizes the fulfillment of his or her needs under those conditions.

Emotional health can be defined as the ability to respond to a situation in such a way that the organism's needs can be efficiently met in relation with its environment (Schoore, 2001). This requires flexibility because the environment is in a state of flux, and so different responses will be appropriate under different circumstances. In order for the organism to effectively accomplish this, the limbic system must be functioning optimally because it is the system responsible for the adapting to novel situations through regulation of the stress response (Schoore, 2001). Because the limbic system's development is dependent on the attuned relationship between caregiver and infant, this capability is the result of the infant's experience of having their emotional expressions effectively met and regulated by those caregivers (Schoore, 2001; Siegel, 1999). Schoore elaborates that this process is primarily non-verbal, involving the synchronization of the mother's vocal tone, posture, facial expressions and movements with those of the infant, which he states creates the groundwork for sensitive social interaction and facilitates the kind of maturation of the infant's limbic system which mediates the ability to respond flexibly to a changing environment.

These exchanges create patterns of socioemotional interaction between infant and caregiver, which are created as the infant learns to selectively send social cues to which the caregiver is sensitive (Schoore, 2001). If the caregiver is able to respond to a wide variety of social and emotional expression on the part of the infant the ability to send that range of expressions continues to be available to that infant. Unfortunately, if the caregiver is unresponsive to certain expressions on the part of the infant these modes of communication are eliminated as part of the pruning process that is at work finding the best fit between the infant and its environment. In terms of Lowen's (1975) view of this process, physical emotional impulses that are thwarted become armored against, which effectively accomplishes the same end. Under either framework, the infant's capacity for flexible emotional expression becomes limited, compromising the above-defined standard of emotional health.

What happens to these pathways of emotional expression which are "lost"? Siegel (1999) speaks of the shame states that result from the lack of attunement between infant and caregiver surrounding an emotional event. He explains that when a caregiver is not able to respond sensitively to an emotional expression, by responding in a fear-inducing manner (which may be a dissociation on the part of the caregiver that compromises the resonant connection, or a violent response to the infant's expression) a state of shame results from the simultaneous activation of the sympathetic arousal system and the parasympathetic inhibitory system, resulting in the release of stress hormones. Shame states are normal in the child, as certain emotional states may have to be met with an external "no" in the case where the infant's expression may put him or her in danger, as in the case of excitedly running into the street to retrieve a ball. Normally, this misattunement, or lack in congruence between the emotions of the child and caregiver, is immediately repaired, and it is only when the misattunement is left unresolved that shame states persist as what Siegel terms humiliation, which compromises the integration of that particular emotional expression. Lowen (1975) believes the mechanism behind this lack of integration is physical in nature.

Lowen (1975) believes armoring is the way in which these impulses are kept from emerging from the organism. Recall his definition that an emotion exists along with an accompanying impulse for action (p. 55). In order to neutralize the experience of an emotion, as must occur in the case where expression of that emotion is seen as dangerous (continuously met with a shame-inducing fear-provoking response from the caregiver) the infant must neutralize that action. This occurs through physical inhibition, which Lowen believes takes the form of an opposite muscular response to that of the original impulse. Again, when this occurs repeatedly, this pattern of inhibition becomes the normal pattern of the organism, and that emotional expression is blocked from the repertoire of that human being. The summation of all of these armors an organism may develop, and thus its general pattern of relationship, is referred to as character and is manifest through the overall posture of that individual. Lowen developed his ideas on character armoring through his own experiences under the tutelage of Reich and his personal and clinical explorations as a therapist. Now that research on the attachment-dependent development of the infant brain has shown clear pathways for the development of the capacity for emotional regulation from a neurobiological standpoint, the questions remain: are the contributions on emotional regulation through the body made by Lowen in line with these theories, and can they contribute to our understanding of human emotional patterns? Research on the relationship of muscular armoring to compromised mental health has not been forthcoming. However, there are many suggestions in the

literature (Schoore, 2001; Siegel, 1999) on the attachment-dependent development of emotional regulatory systems of the brain that point to the body's involvement in the process. This indicates that further research along the lines of Lowen's theories may prove beneficial to our wider understanding of these phenomena. The remainder of our exploration will expound on these possible areas of connection and suggest potential areas of inquiry.

One connection comes from Schoore's (2001) assertion that during the first two months postnatally, the primary connections being made with the amygdala are from the somatosensory cortex, which suggests the importance of this area in early emotional attunement relationships. Schoore elaborates that relating along this pathway occurs through touch, and it is the sensitive emotional touch of the caregiver that facilitates the development of this pathway. Lowen (1975) also suggests touching is a "*primary form of contact*" (p. 27). He states deprivation of caring touch in infancy creates an inhibitory pattern in the organism towards reaching out for physical contact later in life, depriving the individual of the ability to engage in this primary form of socio-emotional contact later in life. Both theorists speak of how important touch is, and say in their own ways how deprivation of this touch creates conditions which inhibit the later capability of the organism for engaging with the socio-emotional environment.

Another area of exploration involves the effects of the caregiver's response to spontaneous gestures originating from the infant. Winnicott (1962) states that these gestures represent an unfolding of that infant's "true self" (p. 145), to which an attuned caregiver response serves to reflect that infant's self-state back onto itself and allows an internal representation of that self-originating state to form. Schoore (2001) suggests that this creates entrainment of the right brain systems of infant and caregiver, generating a resonant state that serves as the context for brain organization. This organization manifests as increased connectivity between right cortical and subcortical systems, allowing a self-regulating functional unity to form, which allows for a higher level of complexity to develop. This higher level of complexity contributes to mental health as it facilitates the capacity to flexibly and appropriately respond to a changing environment to achieve bioregulation.

The idea of the "true self" proposed by Winnicott (1962) corresponds well with Lowen's (1975) idea of those impulses originating from what he calls the "core" or "heart" level of the human being. Lowen divides human personality's functioning into four layers: the ego layer, the muscular layer, the emotional layer, and the core. Rigidities in the top three layers (ego, muscular, and emotional) serve a defensive function, and are hypothesized by Lowen to develop out of the infant's caregiver experience. Operating from the core position without rigidity in the top three layers would be characterized by coordinated and appropriate emotionally based responses to external situations, which is notably an almost identical definition of mental health to Siegel's (2001). The interesting area of potential research here is examining to what degrees the ego, muscular, and emotional defenses proposed by Lowen correspond to compromised brain system development that results from chronic misattunements, as well as the role the caregiver's response to spontaneous gestures on the part of the infant contributes to the formation of these defenses.

Perhaps it is also possible to examine whether Lowen's (1975) emotional layer defenses which he calls "suppressed feelings" may be emotions which, in terms of Siegel's (1999) theory, have been dissociated from awareness as a result of engrained shame states resulting from chronic misattunement. Lowen's muscular layer, which consists of the muscular rigidities which prevent the expression of emotional impulses, may also be related to the phenomenon of the influence of somatic state representational systems on the limbic system's functioning. Schoore (2001) explains that certain parts of the limbic system (the orbitofrontal cortex, amygdala, and anterior cingulate) are connected to the spinal cord and vagal nerve and thus receive real time information concerning the somatic state of the body. This information feeds into the limbic system, which integrates it with information concerning the external environment to create an emotional process. If areas of musculature are inhibited by chronic tension, it may be reasonable to assume that this information concerning this muscular inhibition of a possible emotional response pathway would be fed back to the limbic system in such a way as to reflectively inhibit the neurological aspects of that emotional expression as well. An example of research that suggests this correlation comes from Strack, Martin, and Stepper (1988) whose study demonstrates that activating the muscles involved in smiling increased the perceived humor response in subjects shown cartoons over those in the control group. What remains to be studied is the effect *chronic* (as opposed to induced) muscular activation patterns have on the subjective experience of emotion.

We have mentioned previously Lowen's (1975) idea of "character," the idea of a person's general way of being in the world that develops as a response to his or her early environment and is manifested through postural and physical patterns. This, too, is echoed in the attachment literature. Schoore (2001) states, "In the developing brain, states organize neural systems resulting in enduring traits" (p. 212). He explains that traumatic states (including his idea of relational trauma as defined by chronic misattunement in the attachment relationship), when they occur during the sensitive period of the structural organization of regulatory functions in the limbic system, create characteristic styles of emotional response that limit the organisms ability to relate to shifting external conditions and integrate novel experience. A specific area of the limbic system known as the insula creates internal somatic state representations that serve a key role in emotional experience (Craig, 2002). According to Schoore, this is one area that can be negatively impacted as a result of early relational trauma. If enduring patterns of activation in this area are indeed created as he suggests, this would have an interesting correlation with the lack of the awareness of certain bodily emotional processes. Because Lowen believes that a lack of the awareness of certain physical pathways of emotional expression is part of what perpetuates a person's character, this presents an area of correspondence between these two branches of theory which could potentially be explored further. Throughout this examination, we have made correlations between current Attachment theory and Bioenergetics theory, suggesting commonalities as well as ways in which both theories can combine to form a richer understanding of the human emotional life. Emotional processes occur on the

organismic level, meaning that the ways in which they serve to regulate the organism as well as the ways they are, in turn, regulated, occur on the level of physical structural adaptations, both in terms of the structure of the brain and the structure of the rest of the body. These structural adaptations serve to attune the emotional patterns of the organism to the environment in which it develops, creating a regulatory strategy. If the experience is one in which sensitivity to the natural expressiveness of the infant by his or her caregiver predominates, the ability to engage in this emotional interaction flexibly develops, and person maintains the capability to express a wide and complex array of emotional responses as appropriate later into life. In non-optimal situations, this capability is limited as certain emotional pathways are pruned out of the structure of the limbic system and/or armored against in the musculature to curtail those expressions. By integrating the understanding of both brain-based and muscular-based methods of emotional regulation, it is possible that a more complete picture of the functioning of the human organism can be allowed to form.

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#### Biography

**Dan Hoffman** received his BA in psychology from the University of Michigan. He is currently working towards a Ph.D. in clinical somatic psychology at the Santa Barbara Graduate Institute. His research interests center on understanding how individuals develop their characteristic ways of being in the world. He hopes to be able to help others live more authentically and develop their full ranges of expressiveness. EMAIL: [discoverfreedom@gmail.com](mailto:discoverfreedom@gmail.com)

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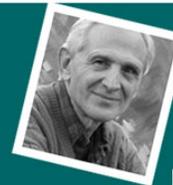
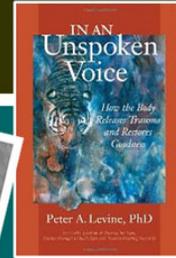
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How does material in this manuscript inform the field and add to the body of knowledge? If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto? If it is a case study, is there a balance among the elements, i.e., back ground information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge? If this is a reflective piece, does it tie together elements in the field to create a new perspective? Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

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## **CORRESPONDANCE ADDRESS**

Jacqueline A. Carleton, Ph.D.

Editor

USA Body Psychotherapy Journal

115 East 92<sup>nd</sup>. Street #2A

New York, NY 10128

212.987.4969

[jacarletonphd@gmail.com](mailto:jacarletonphd@gmail.com)