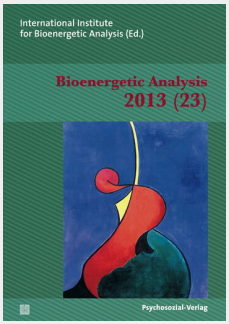
Garry Cockburn

«Seeing what is so simply present”



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"Seeing what is so simply present"

Learning To Be A Bioenergetic Therapist

Garry Cockburn

Abstracts

English

Lowen's ability to see the body was preternatural. His ability "to see what is so simply present" and to explain the whole personality in terms of the body has been an inspiration for all. Like Lowen, gifted first generation Bioenergetic therapists have generously passed on their knowledge to us. As time passes, so does the opportunity to learn from those who were personally influenced by Lowen. This raises issues of how new students of Bioenergetics can learn and keep the tradition alive. This article discusses these issues and provides a structured way of helping students learn some of the basic skills in becoming a Bioenergetic therapist. This approach draws on the training and therapeutic experiences of the author who was privileged to be trained by many of the first generation Bioenergetic therapists. A Workbook is attached to the article, which operationalizes some of the basic skills involved in becoming a Bioenergetic therapist and helps students "to see what is so simply present".

Key Words: "1st and 2nd Simplicity", "Nothing is Hidden", Basic Skills, Workbook

German

Lowens Fähigkeit, den Körper zu sehen, war schon beinahe übernatürlich. Seine Fähigkeit, "einfach zu sehen, was da ist" und die Gesamtpersönlichkeit auf der Grundlage des Körpers zu verstehen, hat uns alle inspiriert. Ebenso wie Lowen haben be-

gabte BioenergetikerInnen der ersten Generation ihr Wissen und Können an uns weiter gegeben. Während die Zeit vergeht, werden die Gelegenheiten, von denen zu lernen, die noch von Lowen persönlich beeinflusst wurden, spärlicher. Das wirft die Frage auf, wie junge StudentInnen der Bioenergetik lernen und die Tradition am Leben erhalten können. Dieser Beitrag diskutiert diese Themen und schlägt ein strukturiertes Vorgehen vor, StudentInnen darin zu unterstützen, während ihres Werdegangs zu Bioenergetischen TherapeutInnen einige der grundlegenden Fertigkeiten zu erlernen. Dieser Ansatz basiert auf den Ausbildungs- und therapeutischen Erfahrungen des Autors, der das Privileg hatte, bei vielen Bioenergetischen TherapeutInnen der ersten Generation lernen zu dürfen. Dem Artikel ist ein Anhang beigefügt, in dem einige der grundlegenden Fertigkeiten operationalisiert wurden, die notwendig sind, um ein Bioenergetischer Therapeut/eine Bioenergetische Therapeutin zu werden und die den StudentInnen helfen, "einfach zu sehen, was da ist".

French

La faculté de Lowen à voir le corps était extraordinaire. Sa capacité "à voir ce qui est si simplement là" et à expliquer la personnalité entière en termes du corps a été une inspiration pour tous. Comme Lowen, la première génération des thérapeutes bioénergéticiens doués nous ont généreusement transmis leur savoir. Le temps passe, de la même façon l'opportunité d'apprendre de ceux qui furent influencés personnellement par Lowen. Ceci soulève la question de comment les nouveaux étudiants en ABE peuvent apprendre et maintenir la tradition vivante. Cet article traite ces questions et donne une manière structurée pour aider les étudiants à apprendre les techniques de base afin de devenir thérapeute bioénergéticien. Cette approche décrit la formation et les expériences thérapeutiques de l'auteur qui a eu le privilège d'être formé par beaucoup de thérapeutes bioénergéticiens de la première génération. Un manuel est joint à l'article, il décrit quelques unes des techniques de base pour devenir un thérapeute Bioénergéticien et aide les étudiants "à voir tout ce qui est simplement là".

Spanish

La capacidad de Lowen de ver el cuerpo era sobrenatural. Su capacidad "de ver lo que simplemente está presente" y de explicar la personalidad en términos del cuerpo ha sido inspiradora para todos. Como Lowen, la primera generación de capacitados terapeutas Bioenergéticos nos ha transmitido generosamente sus conocimientos. A

medida que el tiempo transcurre, también se limita la posibilidad de aprender de los que fueron personalmente influidos por Lowen. Se abre el tema de como los nuevos estudiantes de Bioenergética pueden aprender y mantener viva la tradición. Este artículo reflexiona acerca de estos temas y ofrece un modo estructurado para ayudar a los estudiantes a aprender más acerca de las capacidades básicas para devenir terapeuta Bioenergético. Este enfoque muestra la formación y las experiencias terapéuticas del autor, que tuvo el privilegio de ser formado por la primera generación de terapeutas Bioenergéticos. Se incluye un Cuaderno de trabajo, que operacionaliza algunas de las capacidades básicas necesarias para devenir un terapeuta Bioenergético y ayuda a los estudiantes a ver "lo que simplemente está presente".

Italian

La capacità di Lowen di vedere il corpo era straordinaria. La sua abilità "nel vedere ciò che è così semplicemente presente" e di spiegare l'intera personalità in termini corporei è stata di ispirazione per tutti. Così come Lowen, anche la talentuosa prima generazione di terapeuti bioenergetici ha generosamente trasmesso a noi la sua conoscenza. Con il passare del tempo diminuisce l'opportunità di imparare da quanti sono stati influenzati direttamente da Lowen. Questo ci fa interrogare su come i nuovi allievi di bioenergetica possano imparare e mantenere viva la tradizione. Questo articolo affronta queste tematiche e fornisce una modalità strutturata per aiutare gli studenti ad imparare le capacità di base per diventare terapeuti bioenergetici. Questo approccio si basa sul training e sulle esperienze dell'autore che ha avuto il privilegio di essere formato da molti terapeuti bioenergetici della prima generazione. All'articolo è allegato un libro di esercizi che illustra alcune delle capacità di base necessarie a diventare un terapeuta bioenergetico ed aiuta gli studenti "a vedere ciò che è semplicemente presente".

Portuguese

A capacidade de Lowen para observar o corpo era natural. Sua capacidade "para ver simplesmente o que estava presente" e explicar a personalidade inteira em termos corporais têm sido uma inspiração para todos. Assim como Lowen, há uma talentosa primeira geração de terapeutas bioenergéticos que têm, generosamente, passado para nós seu conhecimento. Com o passar do tempo, no entanto, vão passando também as oportunidades para aprender com aqueles que foram pessoalmente influenciados

por Lowen. Isso levanta a questão sobre como novos estudantes de Bioenergética podem aprender e, ao mesmo tempo manter viva a tradição. Este artigo discute essas questões e oferece uma forma estruturada de ajudar os estudantes a desenvolver algumas das habilidades básicas para tornar-se um terapeuta bioenergético. Esta abordagem se baseia nas experiências do autor como professor e terapeuta, tendo tido, ele próprio, o privilégio de ter sido formado por muitos dos professores dessa primeira geração. Um manual de trabalho prático é anexado ao artigo, operacionalizando algumas das habilidades básicas envolvidas em ser um terapeuta bioenergético, ajudando os estudantes a "ver o que simplesmente presente".

Introduction

The opportunity for students to be personally taught by Dr. Alexander Lowen is past. A personal encounter with Dr. Lowen enabled his students to experience his ability "to see what is so simply present" in a patient's body. It also enabled Dr. Lowen's students to incorporate his energy and therapeutic style into their own therapeutic self-identity. As well, the opportunity to be taught by our gifted first generation Bioenergetic therapists, who helped Dr. Lowen create Bioenergetic Analysis as it is today, is becoming more rare with the passage of time.

And so, today's new students may have to rely on a range of experiences other than direct encounters with our "ancestors". This article addresses some of the issues that arise when thinking about teaching today's students to be Bioenergetic therapists. This is followed by personal reflections on "how I do Bioenergetic therapy" and the impact of first generation Bioenergetic therapists on my practice.

At the end of the article, the contents of a Workbook are appended. This was used to teach students in the first Clinical Year of the New Zealand Society for Bioenergetic Analysis (NZSBA) training program how to begin becoming Bioenergetic therapists. The Workbook operationalizes, through a series of exercises, the learnings that were handed down to me by my first generation teachers and therapists. In these exercises, the role of the student therapist is mostly to be silent so that, like Lowen, they might begin "to see what is so simply present" in the body and psyche of their patients.

Background Issue One: Simple But Not Easy

The daunting thing about watching one of the masters of Bioenergetic Analysis work with a student-patient is that they make it look easy. In the magic of what is happen-

ing, we are somehow able to bracket off "ordinary reality" and enter into a therapeutic space with the therapist and the student-patient where we are able to intuit and to perceive what is happening and to know what is going to happen in the next few moments and what the resolution of the issue might be. And because we "understand" what is happening in that therapeutic space, we might even begin to secretly tell ourselves that perhaps we could work like that. And yet we know that while it looks simple, it is not easy.

Paul Ricoeur's[1] (1967, p. 351) notion of *"1st and 2nd naïveté"* – or "1st and 2nd simplicity" may be useful in understanding the phenomenon of how a neophyte can understand the wisdom of a master practitioner. An image may also help. In New Zealand there is a beautiful conical-shaped volcano, not dissimilar to Japan's Mt Fujiyama, called Mt Taranaki, which is surrounded by a flat circular ring plain. From afar, one can easily see the whole mountain and its surrounding environment – the viewpoint of "1st simplicity". To earn the viewpoint of "2nd simplicity" – the view of the mountain and its environment from the top – one has to climb the mountain, scaling ice-cliffs, being lost in fog and snow blizzards, going along wrong tracks and dead ends, wading through freezing streams, and all the time knowing that, while you have temporarily lost the view of the whole mountain, you are heading in the right direction to achieve "2nd simplicity" and mastery – the view from the top. The process of becoming a Bioenergetic therapist is not unlike that. It takes many years of personal commitment and continuous learning from trainers, patients and supervisors to achieve a simplicity that is not easy. As T.S. Eliot says in "Little Gidding" it is "*a condition of complete simplicity, (costing not less than everything) ...*" (1977, p. 198).

Background Issue Two: How Do I Begin to See What Is So Simply Present or Obvious?

The double perspective of "1st and 2nd simplicity" allows us to better understand the advice of Wittgenstein and Bion, masters of philosophy and psychoanalysis respectively, each of whom spent a lifetime achieving "2nd simplicity" in their discipline. Wittgenstein said, *"Nothing is hidden, just look"*. For the philosopher Wittgenstein, we are unable to see what is right in front of us because it is so simply present (Orange 2010, p. 35). Bion, a psychoanalyst, has a similar idea with his advice to the therapist to enter a psychoanalytic session *"without memory or desire"*. When asked why he suppressed his memory and desire, he explained, that it helped him to experience a

1 One of the giants of 20th century French philosophy.

"flash of the obvious" (Bion 1990, p. 67). And Alexander Lowen had this same uncanny ability to see the whole person in his or her body. His aphorism, "you are your body" sums up his unique gift of "seeing what is so simply present". In comparison, most of us stumble around the foot of the mountain, occasionally getting a glimpse of the peak. Bennett Shapiro, in a personal communication, said that in his own explorations of energy and the body, he felt like an explorer of the Himalayas, and when he thought he had discovered a new peak, he always found a cairn of stones showing that Al Lowen had been there before him.

Personal Reflections on Being a Bioenergetic Therapist

In talking with my partner, Pye Bowden, on how we could teach students in the Clinical Years to better read[2] the somatic and psychic reality of their patients, she asked me, "Well, how do you do Bioenergetics?" As I started to talk, she took notes of what I was saying, and I was later able to elaborate on these notes and turn them into a workshop that was presented at the Professional Development Workshop[3] at Mount Madonna, California, in October 2010. What emerged from this process was later turned into a Workbook that we used to teach students in our training program some of the basic beginning skills in Bioenergetics.

My partner's question got me thinking. How do I see patients? In what ways can I begin to see the things that are "so simply present" and "obvious" to the masters of our profession? It occurred to me to represent this graphically as a series of lens through which I see the patient. In diagram one[4] there are seven lenses, including the lens in eye.

The seven[5] lenses represent seven viewpoints from which to view the patient, especially in the first few sessions of the therapeutic process. From the left they are: (1) the eye of the "I", (2) listening, (3) looking, (4) sensing, (5) family and social landmarks, (6) intuiting an image or metaphor, and (7) the patient's ability to use a somatic framework to understand their psychological problems.

The following paragraphs will describe these seven viewpoints. At the end of the article, there is a Workbook that operationalizes the basic skills implicit in looking

2 Alexander Lowen's ability to read the body had a preternatural quality of clarity and insight. Eleanor Greenlee, of San Francisco, has this same ability.

3 My thanks to Diana Guest, CBT, IIBA Faculty, for encouraging me to turn the workshop into an article.

4 The diagram uses Ralph Steadman's (1979) drawing of Freud.

5 There is nothing special about this number and other important categories could be added.

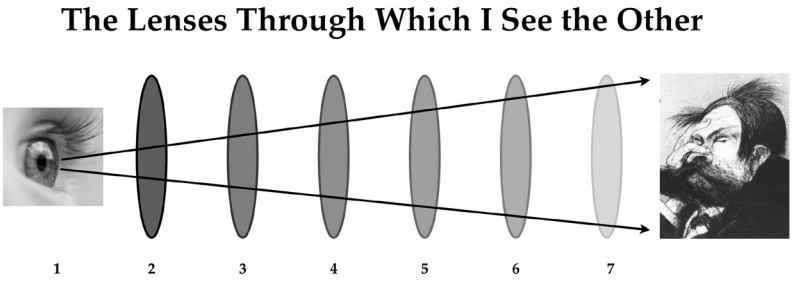

Diagram 1

through each of these lenses. The Workbook was used to help students learn some basic Bioenergetic skills in a way that showed them that being silent and trusting themselves to "do nothing" could be a powerful learning experience.

The Workbook exercises are focused on basic skills for the beginning stages of the therapeutic process. These exercises are not designed to teach students to work with trauma or the more advanced skills of "working through" transferences, resistances, counter-transferences and projective identifications that are needed for the therapeutic process proper[6]. Nor do these exercises presume an in-depth knowledge of character structures, psychodynamic theories and defense mechanisms, or of attachment theory, all of which are necessary for understanding the therapeutic process. Nevertheless, many of these exercises, such as sensing or intuiting, lay a good foundation for a student's initial learning about countertransferential phenomena, and give an experiential basis for understanding advanced theory.

Lens One: The Eye of the "I"

The first lens, of course, which you can't see, is right inside our own eye. This lens represents for me the values I try to hold onto when working with a new patient. When working with patients, I find it useful at times to remind myself of the following points.

I am a *"perpetual beginner"* (Husserl, in Orange 2010, p. 4), as the patient is a "singularity" – there has been no person exactly like her or him in the 3 billion years life has been on earth – so I am on an exciting journey of discovery about the patient

6 For a detailed study of these factors, read the author's paper "An Object Relations Perspective on Bioenergetics and Pre-Oedipal Transferences" (2012).

and myself. I have travelled down many rivers, but I don't quite know what is around the next bend with this patient.

There is a *radical asymmetry* between the patient and myself. Because of this asymmetry, the patient is owed an infinite duty of care (Levinas 1996) to the best of my ability as a suffering human being. So I approach with humility, and yet with confidence that I might have something to offer.

An inherently *ethical stance* comes from being embodied in the world (Levinas 1996). Our three greatest experiences of meaning are: my experience of my own body as being in the world; my intersubjective existence with other bodies; my ethical relationship to other bodies (Ricoeur 1992, p. 317). In this way I am also realistic about the presence of evil and human weakness in the world, and that I have my own *"self-doubt, anxiety, dread, shame, guilt, boredom, blind spots, lust, envy, hate and terror"* (Ogden & Gabbard 2009, p. 90) that are with me for life.

I try to remain *"radically open"* with my mind and body and be available for transference and counter-transferential processes. I endeavor to maintain with my mind and body an "evenly hovering attention" (Freud 1912, p. 111), or "without memory or desire" (Bion 1970, p. 41), and try to allow room for the emergence of whatever is next to appear, moment by moment rather than let performance anxiety shut down my openness to what is "so simply present". This is one of the benefits of bodywork, as this process is a somatic/sensory/affective one as well as a cognitive one. The more I can feel the patient's somatic reality in my body, the more available and empathic I can be for them.

My commitment to weekly supervision is an important element in keeping myself open to new things. That involves speaking about my mistakes, my fears, my countertransferences and my confusions in a supportive and trusting relationship. I am also aware there is a "supervisor" in the patient, witnessing everything I do, which is much more observant than my external supervisor or I can ever be.

Lens Two: Listening

Words are much more than the external expression of thoughts that impart information. Key words convey much about a person's embodied and psychic existence. They can contain and express the full range of a person's conscious and unconscious reality; they contain a person's past and also the promise of their future. They can point to all that is "not yet said" in the infinite resources of a person's life (Gadamer 1975).

So I *listen intently to key words and phrases* patients use to describe the problem/issues that brings them to therapy, as well as how they express their goals – key words

or phrases, such as "I'm a doctor and I'm a *hypochondriac*", "I'm deeply anxious about asking my partner of 35 years *to marry* me", "you have *warm* hands, mine are always *cold*", "even though I'm an extrovert, I *hold back*", "I've been *unfaithful* and I want to discover my *true self*". These key words may be tips of icebergs of meaning. Writers call these: "hot cognitions" (Schore); "the selected fact" (Bion); "moment of common reference" (Shotter); "knowing how to go on" (Hoffman). I am also listening to how they tell me: are they defensive and shamed, confused, too wordy, intellectual, distancing, or perhaps struggling to put a sentence together?

I try to store these key words about problems/goals from the first session in the back of my mind and hold them as compass-bearings for later in the therapy process.

Lens Three: Looking

I look at how *they tell me* – head down, head predominantly to the left or right side; eyes that make contact, eyes that show trauma breaks, eyes that avoid; a mouth that seems immobile with dread or grief, a mouth with a narcissistic smile at the edges of the lips, a mouth with a perpetual smile; a split between the top and the bottom of the face, a split between the left and right side of the face or body; are they breathing, how much and where? (chest/stomach); is there movement or stillness in the limbs and torso?; how are they sitting? (upright, bent over with head resting on hands and elbows on knees, legs tightly crossed as a protective barrier). I am also noticing whether they have predominantly rigid, flaccid or mixed musculature[7], and whether there are any major splits in the different segments of the body. I don't stare, but let these somatic clues float into my awareness, and while noticing them, I hold the awareness of them lightly and hypothetically.

Lens Four: Sensing

I try to sense in my own body what feelings, if any, the patient is expressing or not expressing? Are they over-contained or flooded with feeling? Also, what am I feeling inside, e.g. sadness, numbness, can't think, sleepy, shortness of breath, flooded and confused, finding myself talking too much, excitedly in tune with them? I am also noting if there is a profound dissonance that I am experiencing, something like an

7 I am indebted to Bennett Shapiro for his elaboration on working with these muscular holding patterns.

"the elephant in the room", something that I can't seem to understand or put words to, but can only vaguely sense in my body, or feel in the short-circuiting of some neurons in my brain. I am also sometimes aware that their "devils" (Shapiro 2007), their deep defensive structures, are scanning my own defenses to check out whether I can survive the fearful destructiveness of their omnipotent love and hate (Ogden 1996, p. 185).

In summary, I try to allow myself to gain a first impression (1st simplicity!) of their somatic, mental and languaged stuckness and the strength of their impulse to change.

Lens Five: Family and Social Landmarks

I usually ask patients to *tell me briefly about their family of origin*, number of siblings, where they come in the family and their current social situation (family, partners, flat-mates, occupation). After that I allow the patient's narrative about their family of origin to unfold in its own time in the context of current material as it arises in the therapy. There are exceptions. "I want you to take an extended family history now!" one patient demanded. And he was right. Nancy McWilliams (2011, p. 8) however, strongly recommends taking a full history in the 2nd session, as once the relationship develops into deeper trust, "it may become harder, not easier for him or her to bring up certain aspects of personal history or behavior."

I sometimes ask "is there anything else you think it important that I know?". This may throw up significant material, for instance, "my best friend committed suicide a few months ago", or "I haven't had sex with my partner for the last 10 years".

I am *listening and looking for landmarks that indicate family dysfunctions and traumas*, but I hold these intuitive insights lightly, as each pattern has features unique to this patient. Basically I am looking for patterns of relational deprivation, conflict or invasion. It helps to have studied family systems theory to understand the complexities of family patterns and to know that each family system is unique, with its own lexicon of meanings and associations, its own history of feuds, splits, coalitions, secrets and ways of doing things (Hoffman 1981 and 2002).

My radar is also *seeking signs of dysfunctional roles*, e. g. if their parents were stuck in rigid complementary or competitive roles; if the patient was stuck in a perverse triangle with parents, e. g. the pre-oedipal and oedipal dynamics of a withdrawn mother and an elevated or authoritarian father (clergymen, doctors) – and *I make room for cultural differences*, e. g. in some Indian families, the mother/son relationship can be the main relational axis, rather than husband/wife, as in Western families. In New Zealand, the wider extended family and tribal links are the main relational axes for many Maori patients, and the concept of "the individual self" may be foreign and anti-social.

My radar sometimes picks up an *intergenerational trauma history in a family*, intergenerational impacts of WWII, migrations from another country, a dead sibling within a few years of patient's birth, family break-ups, domestic violence, drug use, mental illness of a parent and grandparents. It may be useful to think that there may be three generations in the room, as some issues do have strong intergenerational dynamics.

I gently allow my attention to *notice obvious somatic splits and character structures* that might be associated with the family history, e.g. rigid or flaccid musculature; oral chest and masochistic lower body; schizoid body with huge angry coat-hanger shoulders; one foot turned at a marked angle compared to the other; the left (feminine?) side of the body markedly different from the right (masculine?) side, but again I hold these somatic guesses lightly and wait.

Lens Six: Intuiting an Image or Metaphor

Most importantly, I try to *intuit an image or metaphor* that captures two things: the person's "struggle to be" and the "ineffable Self" of the other. This is more than empathy (Orange 2009, p. 88); it is seeking to find the common humanity we share as fellow-human beings; it is recognizing their struggle to maintain their deep integrity; it is being open to what Bob Lewis (2008) calls the "inner resonance of inchoate secrets", that Reich called "the indefinable residue beyond reach", and Spinoza (Damasio 2003, p. 36) and Levinas called the "conatus essendi" – the struggle of existing or being.

Sometimes this deeply sourced movement comes as an image, picture, symbol or metaphor. These primitive images can come from the "not-yet-said" somatic and sensory experience of the patient and/or from myself. This "body to body" immediate imagery can be quite powerful, perhaps tapping into the collective unconscious or the deeply personal unconscious and our capacity to dream, e.g. a black spider crawling up/down inside someone's spine; a raven holding a baby in its reptilian claw and pecking at her innards; not being able to be found in a Saharan sandstorm; an insect bursting its cocoon and starting to spread its wings; the struggle not to be annihilated in a psychic black hole, etc.

Lens Seven: The Patients Ability To Use A Somatic Framework To Understand Their Psychological Problems

As the person starts to unfold their story over the first few sessions, *I introduce the possibility of using Bioenergetic techniques* to help them understand themselves from

a somatic point of view as well as from a psychological one. Of course some patients may not be able to understand themselves from a psychological perspective, let alone a somatic perspective, and I have found that introducing some Bioenergetic experiences, such as simple grounding, can give them an awareness about their psychological experience of not being fully present to themselves or others as well as teaching them about somatic awareness.

Firstly, I *teach the person to ground*, using a variety of methods, e.g. tennis ball, knee bends, aligned stance, grounding in a chair, or Lowen's "feeling the earth" rocking. I get them to place their feet in the aligned position and to note how that feels; I ask them to experience their energy rise up into their head when they take an in-breath and lock their knees, and then to notice what happens when they soften their knees on the out-breath. I note which foot they first put the ball under, usually the right foot, but sometimes the left. I listen to what they notice after their foot goes back on the floor, e.g. often they notice their leg is lighter, foot is flatter, and sometimes this awareness is quite dramatic and other times hardly anything is noticed. I always ask them for their experience of the exercise, leaving a lot of space for after-thoughts.

I frequently ask them *what they are experiencing in their upper chest, diaphragm and tummy* or other parts of their body. There is often one area that is repeatedly identified, e.g. pain in the sternum, swirling stomach, strain around the eye sockets, buzzy 3rd eye area and tight across brow, tight soft palette in throat, electric energy in feet that can't be discharged, or a pain in the widow's hump (C7).

I teach the patient *to be aware of and value their embodied experiences*, e.g. by the use of towel to externalize contractions in shoulders, throat, diaphragm and to allow themselves to express spontaneous words. Often there is suppressed grief, which then takes time to understand and process. Sometimes there is an "aha!" experience which helps them on their journey of "identifying with their contractions" (Hilton 1989, p. 60), e.g. "I feel very angry when I hold my head on the left hand side, but relational when I turn it round to the right".

Often patients identify themselves as feeling "anxious". I sometimes teach them that anxiety may be a suppressed feeling, and that the four "primary colors" of emotions are sadness, anger, fear and joy. I then say, "if you had to guess which of these feelings was just under the surface of the anxiety, which one/s would it be, sadness, anger, fear or joy?" I am continually surprised by patient's ability to identify which feeling it is, and which feeling is layered underneath the first feeling, e.g. "I feel angry, but there is a huge sadness underneath that." I teach them that "shame" is not a feeling but a state, and I reframe shame as a biological reaction to the "loss of connection with the good" (Maley 2006) and may show them the "Shame Compass" (Nathanson 1992, p. 312). People can usually identify their withdrawal, their negative self-criticism and

their over-doing it (-aholic) behaviors of the "Shame Compass" and find it helpful that there is a systematic way to describe their confusing experiences.

At times I ask the patient if they would be *willing to explore a Bioenergetic position as a diagnostic tool*[8], e. g. to see what happens if they lay over the physio ball and squeeze it when they get an impulse arising from their stomach. This can allow the person to release their grief or their anger and to find the words that express the emotion more deeply without the shame of eye-to-eye contact. I ask permission to put a supportive hand on their back, if this seems right, or I may be down on the floor my head close to theirs in support.

I am sometimes quite *interactive and spontaneous in creating techniques*, e. g. changing physical distance between us, using objects, such as a towel, to engage in a tug-of-war to help explore relational patterns they are stuck in. This sometimes leads to being quite playful with the patient and having a good laugh. I believe it is often useful to help a person contact their aggression before their grief, and I will use leg gravity drops, followed by heel kicks to help them evoke spontaneous words. These words are often psychic puns, e. g. "effort" becomes "F#@* it", "wait – weight", "avoid – a void", "hole – whole", "I want to get ahead – a head", "infinite – infant", etc.

Vincentia Schroeter and Barbara Thomson's new book, "Bend Into Shape" (2011) is packed with techniques that can be used to help patients access their psyche/somatic realities. John Conger's "The Body in Recovery" (1994) is another great resource for techniques that are well integrated into a rich theoretical bedrock of Reichian, Bioenergetic and Jungian approaches.

Personal Acknowledgement

Whatever skills I might have developed, I owe much to the senior members of the IIBA who have trained me or have been my therapists. Bennett Shapiro, ever the student of Lowen's energetic concepts, has spent years meditating on Lowen's first and major book, *The Physical Dynamics of Character Structure,* later re-published as *The Language of the Body.* Over the past 10 years Bennett has been kind enough to share with me his explorations and the myriad techniques he has creatively developed, allowing me to "road test" these techniques with my patients. From Bennett I have learned many techniques for working with rigid and flaccid structures, and for energizing the somatic resistances (the demonic forces) that defend the inner sanc-

8 My thanks to Eleanor Greenlee, who showed us how to encourage experimentation in Bioenergetic therapy.

tum of the natural child. From Eleanor Greenlee, I have learned to get the patient out of the chair and to begin with grounding, to read and follow the energy of the body in a courageous way, to suggest experimentation using the language of invitation and encouragement, but mostly to respect the holding patterns that the patient has developed to preserve their integrity. From Bob Lewis I have learned the power of allowing the alchemy of the defenses to work even when they are terrifyingly demonic, and to risk the wise-foolishness of following the patient into the labyrinth of their "inchoate secrets". And from Bob Hilton I have learned the need for the exquisite following of wherever the patient needs to go and the therapeutic wisdom of respecting the patient's insights into my own therapeutic narcissism – and also the final paradox of remaining totally available when at the very end I have absolutely nothing to give.

Workbook for Students

As a result of this voyage of discovery, my partner and I organized the above material into a Workbook that clinical-level students used to develop their skills at the beginning level of becoming Bioenergetic practitioners. For reasons of space and layout, the Workbook itself cannot be reproduced in this article, although the content will be included.

Diagram 2 is a reproduction of the Workbook page for Lens 2: "LISTENING TO KEY WORDS". Each page of the Workbook was formatted into sections as follows: *Title:* the particular lens; *Tasks:* the tasks for the therapist to follow; *Notes:* a space for the therapist's observations; *Background Ideas:* bullet-point information on the subject matter; and *Notes:* a second space for notes following the exercise and discussion with the patient.

The Workbook was used by thirteen students over four days of training. For the first one and a half days, the students worked in pairs, one student being the "therapist" and the other the "patient". The "therapist" worked through each page of the workbook with the "patient", completing the tasks as described. On the afternoon of the second day three pairs of students formed a group with one local trainer, and the other three pairs grouped with the second local trainer. Then the "therapist" from each pair of students did a piece of therapy with their "patient" in front of their group members and local trainer, using the information from the notes they had made while looking through the different lenses.

The act of "Putting it all Together" helped integrate the skills the "therapist" had been practicing in the separate exercises. After they had completed a piece of therapy lasting

1. LISTENING TO KEY WORDS

FIND THREE KEY WORDS OR PHRASES

TASK:

- **The therapist reads the 'Background Ideas' below.**
- **The therapist asks the client what brought her to therapy and her goals. (10 minutes)**
- **The therapist does not say a word, but just attentively listens and attunes to what is said.**
- **After the client has finished speaking, the therapist reflects on what has been said and writes down <u>three key words or phrases</u> that seem to be central to the client's story and goals. (2/3 minutes)**
- **The therapist shares these words with the client, and they discuss the accuracy of the words. (5 minutes)**

Notes: The three key words or phrases:

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Background Ideas:

- *Words convey a person's embodied personal, social and cultural experience, past, present and future.*
- *Silence may also express 'the not-yet-said' experiences for which there are no words.*
- *Listen to 'key words and phrases' the person uses to describe their problem and their goal*
- *Listen for 'hot cognitions' (ideas that strike you as significant, and full of conscious or unconscious meanings).*
- *Listen to 'how' they tell you (defensive, shamed, wordy) and the speech rhythms or 'prosody' (Schore), e.g. crescendos/decrescendos, pauses, rushed, flowing, loud, soft, etc.*

Notes: (space for any other notes I wish to make)

Diagram 2

about 20 to 30 minutes, they received constructive feedback from their peers and trainer. The students then reversed roles for days three and four, following the same format.

The feedback from the students was positive. They were struck by how powerful silence could be. They were also impressed at how a maximum amount of information could be obtained from a minimal number of key words or behaviors. They felt empowered by a roadmap that was not overly prescriptive and yet gave them enough structure to practice being a therapist without undue anxiety about "what do I do now?" In subsequent workshops over the next six months, each student worked therapeutically in front of the whole training group in the presence of an International Faculty member, and the gain in confidence and skill was obvious. The basic framework of 'how to be a Bioenergetic therapist' was in place, and each student was able to adapt this to his or her own level of development. It was gratifying to witness students start on their journey of becoming Bioenergetic therapists and to start to take heed of Bion's advice that *"you must learn your techniques and theories so thoroughly that you can forget them."*

The Workbook Contents

Lens One: The Eye of the "I".

There is no exercise included here to help students elaborate their own values, although it would not be difficult to facilitate a group discussion to achieve this. It was not done at the training workshop as the emphasis was on skill development, rather than on having a broader-based discussion on values.

Lens Two: Listening to Key Words

Task: Find three key words or phrases

- The therapist reads the "Background Ideas" below.
- The therapist asks the patient what brought her to therapy and her goals. (10 minutes).
- The therapist does not say a word, but just attentively listens and attunes to what is said.
- After the patient has finished speaking, the therapist reflects on what has been said and writes down three key words or phrases that seem to be central to the patient's story and goals. (2–3 minutes).

➢ The therapist shares these words with the patient, and they discuss the accuracy of the words. (5 minutes).

Background Ideas:

➢ Words convey a person's embodied personal, social and cultural experience, past, present and future.
➢ Silence may also express "the not-yet-said" experiences for which there are no words.
➢ Listen to "key words and phrases" the person uses to describe their problem and their goal.
➢ Listen for "hot cognitions" (ideas that strike you as significant, and full of conscious or unconscious meaning).
➢ Listen to "how" they tell you (defensive, shamed, wordy) and the speech rhythms or "prosody" (Schore), e.g. crescendos/decrescendos, pauses, rushed, flowing, loud, soft.

Notes:

➢ Write down any personal learning from doing the exercise and discussion with patient.

Lens Three: Looking at Body Language

Task: Identify Three Key Somatic Communications

➢ The therapist reads the "Background Ideas" below.
➢ The therapist asks the patient about a recent difficult experience that is related to the problem and therapeutic goals above. (10 minutes).
➢ The therapist does not say a word, but just empathetically looks at the patient, and without trying too hard, lets herself notice the body language.
➢ After the patient has finished speaking, the therapist reflects on the experience and notes three key somatic communications, e.g. the use of hands, the way she holds her body or head, that seem to be central to the patient's story. (2–3 minutes).
➢ The therapist shares these with the patient, and they discuss the relevance of the observations. (5 minutes).

Background Ideas:

➢ What is the patient's body language telling you? What message do you get?

- Is the head held at particular angles when talking about emotive issues, e.g. level, down, stops at a particular place, e.g. looking to the left or right, during intense communication?
- How are they in their eyes and forehead? Present, distant, fixed, somewhat dissociated? Are the edges of their eyes smiling, sad, angry, joyous, fearful, narcissistic, shamed, mixed?
- How are they in their mouth and jaw? Tight, sad, angry, fearful, joyful, bitter, disgusted?
- What's happening with their breathing? Breathing or not? In chest or tummy? Favouring in-breath or out-breath? Perhaps they find it hard to "take-in" reality, or are they needing to "expel" pain and anxiety.
- What is their musculature like? Rigid, flaccid, toned, or mixed?
- What is happening with their hands, arms and legs in relation to the rest of the body- e.g. still, restless, expressive?

Notes:

- Write down any personal learning from doing the exercise and discussion with patient.

Lens Four: Sensing

Task: Identify non-verbal communication by listening to your own somatic reality

- The therapist reads the "Background Ideas" below.
- The therapist asks the patient to talk about their overall therapeutic journey in dealing with their issues. (10 minutes).
- The therapist does not say a word, but is "sensing" what is happening for the patient by listening to his or her own somatic and energetic reality, and to what feelings are evoked.
- After the patient has finished speaking, the therapist notes three key sensory/feeling experiences that she herself has experienced while the patient was talking. (2–3 minutes).
- The therapist shares these with the patient, and they discuss the relevance of the observations. (5 minutes).

Background Ideas:

- What feeling is the patient expressing or not (sadness, anger, fear, joy, shame.)?
- Are they over-contained or flooded with feeling?

- Do they have high, medium or low energy in their communication?
- What do I think/feel/sense is happening in various parts of their body?
- What am I experiencing inside myself (sadness, numbness, can't think or breath, flooded or confused, find myself wanting to talk, irritable, tight in chest or throat)?
- Is there an "elephant in the room" – a sense of something inexpressible, intangible and hard to experience?
- Do I feel "in-tune" on energetic, sensory, emotional, feeling and cognitive levels?

Notes:

- Write down any personal learning from doing the exercise and discussion with patient.

Lens Five: Family and Social Landmarks

Task: Identify key family/social landmarks

- The therapist reads the "Background Ideas" below.
- The therapist asks the patient to talk about their family of origin and any childhood or adolescent issues that might be relevant to their therapeutic journey. (15 minutes).
- The therapist just listens without talking, and notes to herself some key family patterns that might be relevant to the patient's current characterological and somatic issues.
- The therapist writes down three key patterns. (2–3 minutes).
- The therapist shares these with the patient and discusses their relevancy. (10 minutes).

Background Ideas:

- Family of origin, number of siblings, patient's age, patient's birth order, where grew up, parent's current status, e.g. together, separated, deceased.
- Usually allow detailed family history to evolve in the course of therapy – but not always.
- Current social situation: family, partners, children, flat-mates, and occupation.
- Is there anything else important to share, e.g. friend committed suicide.
- Family patterns: dysfunctional roles and traumas; symptoms indicate "child" was triangulated into parental system; ongoing parental issues and relationship; attachment issues; oedipal issues; cultural considerations, e.g. what are the key family values in this person's culture, e.g. place of women in Arab cultures, mother/son relationship in Indian culture.

- Sexual history: family attitude to sexuality, 1st sexual experiences, sexual preferences and orientation, history of intimate relationships, traumatic sexual experiences.
- Trauma history: personal to patient; intergenerational traumas, e.g. WWII, migrations; death of siblings; family breakdowns; domestic violence and abuse; substance abuse; mental health issues.
- Are the patient's somatic, characterological holding patterns reflective of the family history- e.g. hollow chest, swollen musculature, splits in body?

Notes:

- Write down any personal learning from doing the exercise and discussion with patient.

Lens Six: Intuiting an Image or Metaphor

Task: To intuit and image or metaphor that captures both the patient's characterological stance and their effort to express their "true self"

- The therapist reads the "Background Ideas" below.
- The therapist asks the patient to breathe quietly and to share in a relaxed way some thoughts about what they would really like to achieve from their therapeutic journey and what its been like living with their difficulties. (10 minutes).
- The therapist does not speak, but just breathes in time with the patient, staying present to the patient, and without trying too hard, the therapist lets herself notice any images, symbols or metaphors that arise in her own imagination (fantasy), or from her unconscious (phantasy).
- After the patient has finished, the therapist notes down any image, metaphor or story that has come to mind. This may be quite a fleeting thing, so breathe and allow it gently to emerge. (2–3 minutes).
- The therapist shares this with the patient, and the patient may wish to share any of her own images, and they then discuss what emerged. (5 minutes).
- Therapist then checks, how has this process been for the patient, e.g. whether there are any feelings arising from the overall process that still need to be talked about.

Background Ideas:

- "Character structure" both restricts our capacity to be fully present in the world, and yet provides a way for us to express ourselves creatively.
- What do you intuit about the other's struggle to be, or their character?

- What sense do you have of the "ineffable Self" of the other, i.e. their full potential?
- We can intuit these by finding a deep common humanity and having a deep concern for the other. We may be able to find an "inner resonance of inchoate secrets" (Bob Lewis); "the indefinable residue beyond reach" (Reich).
- Sometimes the patient's struggle and their unreachable, inchoate Self can be communicated to us through images, pictures, symbols or metaphors.

Notes:

- Write down any personal learning from doing the exercise and discussion with patient.

Lens Seven: Body Reading

Task: To identify differences in the natural and stressed positions

- The therapist reads the "Background Ideas" below.
- The therapist asks the patient to stand in a natural position. As therapist, what do you notice about the patient? (e.g. width of feet apart, angle of feet, knees locked or bent); any obvious splits (top/bottom, L/R)? what are you feeling in your own body as you observe the patient's body?
- The therapist helps the patient to ground and move into the aligned position (feet parallel, knees slightly bent) and gets patient to report any differences from their natural stance.
- The therapist asks patient to charge/stress the body by "bow & bend-over", then return to aligned stance. What do you as the therapist observe? What parts are tight, hot/cold, energised? Does the person have more ease/difficulty breathing-in or breathing-out? (e.g. a short in-breath and a big out-breath).
- Have the patient sit in a relaxed way, while therapist writes notes on observations. (2 to 3 minutes).
- The therapist then asks the patient about her experiences, and then shares her observations in a sensitive manner. Discuss. (10 minutes).

Background Ideas:

- Somatic defences are revealed through areas of tension, pain, temperature and misalignment in the body.
- Psychic defences are evident in the various defence mechanisms, e.g. denial, projection, intellectualization, splitting, somatisation, etc.

- Character structure is comprised of the overall defence structures in the psyche and body.
- Stress energy and anxiety travels inwards to the core/gut, and goes upwards into the head, locking the diaphragm and reducing the capacity to breathe. Getting energy to go down into the legs (leg drops/kicks) and increased breathing reduces the subjective feelings of anxiety.
- The "externalization" of somatic tension, e.g. in chest, through the use of twisted towel and increased breathing with sound or words such as "tight", can help the patient get in touch with suppressed sadness, anger or fear.

Notes:

- Write down any personal learning from doing the exercise and discussion with patient.

Putting it All Together

Task: Putting it all together

The therapist reads the "Background Ideas" below.

- The therapist does a piece of work with the patient in a group situation, which incorporates the learning from the previous exercises. (NOTE: Don't try to consciously remember – trust your implicit memory (unconscious competence) and the energy of the encounter to guide you – and breathe!!).
- The suggested shape of the work is as follows:
    a. Warm-up: the therapist and patient do a brief review of their work, check out "what issue or bodily sensation feels real or on-top right now", and decide on the focus or goal of the work.
    b. The therapist helps the patient to ground.
    c. Energize either the whole body, or the contraction, or the part that feels most alive.
    d. Work with what emerges, joining the "language of the body" and the narrative. It is helpful to keep in mind whether patient has rigid or soft structures (musculature), or a mixture. In other words, are you working with resistance and surrender (rigid structures), or with the need for boundaries and contained/grounded self expression (flaccid structures), or both?
    e. Help the patient with closure –e.g. finding a crystallized statement they can share with the therapist. It is important to give quiet space and time

for a strong experience to be integrated, as freed-up somatic and psychic energy keeps subtly resonating even though the words have stopped. Check they are ok to end.

Background Ideas[9]*:*

- A good piece of therapy will have the Reichian "wave" shape: 1) tension; 2) charge; 3) release of the charge; 4) coming to rest.
- There are two types of "self-consciousness" when working: 1) "My god, I don't know what is happening or what to do next!!"; 2) "I'm not sure what is happening, just relax and wait for the energy of what is happening to show me what comes next".
- Grounding: lots of techniques to choose from – simple alignment, rocking onto heels/ball of feet, tennis ball, bend one knee at a time.
- Energizing: – again lots to choose from: 1) Total body: bow/bend, jump up/down, over stool, over ball, kicking on mattress, hitting with racket; 2) Contracted part (e.g. throat, sternum, diaphragm, between shoulders): a) "externalize" the tension with twisted towel, breathe and express the physical experience, e.g. "tight!" b) exaggerate the contraction and its opposite, e.g. stick jaw right out and retract it in; 3) "Most alive" part: get patient to amplify this aliveness by moving from that place and following their aliveness with bigger movements.
- "Rigid structures"- energize the resistance, e.g. twist towel, saying "NO, Neveeerr!" and then surrender to what is underneath (usually sadness, fear, anger, or shame); "Soft and early structures" – build boundaries and support the right to be, e.g. a) holding cushion in front of body; or b) breathing-in as push hands out; and/or c) phrase: "I caaaannn have myself!!"
- Four types of supportive language: 1) Empathetic ("that must have been awful for you"); 2) Enquiring ("what are you feeling?" to someone lost in thoughts; "what are you thinking?" to someone lost in feelings; "what's happening now?" if person is silent and you don't know what is happening); 3) Encouraging ("Can you say that a little louder?"); 4) Explanatory ("I'd like to put my hand on your back to offer support. Is that ok?").
- It is important to develop your own style. This takes a long time, so be kind to yourself.

9 Bennett Shapiro, David Boadella, or Eleanor Greenlee created many of the therapeutic techniques in this section.

Note:
These exercises are designed to teach some of the basic skills required in the beginning stages of the therapeutic process. They can help lay a foundation for the more advanced skills and knowledge required to work through the resistances and transferences which both Freud and Lowen have identified as essential to the psychotherapeutic process (Lowen 1971, p. 6f.).

Copies of the Workbook can be requested from the author by email.

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