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Letter from the Editor

In this Issue

Dear Colleagues,
Welcome to the 19th volume of the journal for the International Institute for Bioenergetic Analysis.

The first two papers in this volume provide a scholarly examination of an issue. The first is a thorough review of what is meant by the term "body" from different points of view both inside and outside Bioenergetics, particularly psychoanalysis. Angela Klopstech clarifies complex concepts and by so doing helps open communication and enrich the dialog between various schools of thought. The second paper revisits the controversial diagnosis of Borderline Personality Disorder outside and particularly inside Bioenergetics, with new ideas posed for consideration. It ends with techniques to work with Borderline issues within a Bioenergetic clinical practice.

This makes a bridge into the next two papers, which are more clinical in nature and are concerned with techniques for different populations. Ben Shapiro's paper finds new uses for some of his containing and expressing techniques and provides original work in "rekindling pleasure" with a partner. Dennis McCarthy, who had been in supervision with Alexander Lowen, provides a paper full of cases focusing on his work with anger in children.

The next three papers move us into the area of academia, with a paper on supervising students and then two papers by students. The role of supervi-

sion within Bioenergetics is explored by Alex Munroe. He examines issues valuable for clinical supervisors within and beyond training and provides useful cautions and techniques.

The final two papers represent a new area in the IIBA journal related to academia. I thought it might be of interest to the broader community to see what level of work is being done within the IIBA approved certification programs. Both of these papers, which were assigned in training, were chosen for their open examination of the writers' countertransference issues with a difficult case. These papers illustrate a commitment to exploring countertransference issues in training, in therapy, and in supervision. This in turn points to the integrity within the training programs when it comes to demanding an advanced level of self-actualization before allowing a student to graduate and become a Certified Bioenergetic Therapist.

I hope you enjoy these varied papers. For next year, 2010, I would like to invite Bioenergetic therapists certified in the first wave of the beginning of Bioenergetics from the years 1957 to 1979 to provide papers for the journal. A suggested format is the following: What I have gotten from Bioenergetics (including an optional, "story about me and Al Lowen"); What I have given to Bioenergetics (including an optional, "one of my favorite Bioenergetic techniques and how I use it"). I think these papers from some of the early leaders in our movement will enrich the rest of us, provide generativity, and give us a glimpse into our heritage, which seems all the more poignant at this time when we have recently buried our esteemed founder.

I want to thank my editorial staff, Margit Koemeda and Maê Nascimento as well as Helen Resneck-Sannes, Ulrich Sollman and Scott Baum for reviewing these articles. Thank you for your close attention to these papers as well as your useful comments. Finally, I thank the authors for their contribution to our field and with them I wish you an enjoyable time reading these articles.

Sincerely,

Vincentia Schroeter, PhD, CBT, MFT
Carlsbad, California, USA
November 30, 2008

Memorial Note

On the passing away of Alexander Lowen

November 9, 2008

I am writing this a week after hearing that our founder, Alexander Lowen, died on Tuesday, October 28, 2008. The first thing on my mind is to offer condolences to his son Fred and the Lowen family for their personal loss. Next is to join with you in acknowledging the incredible gifts that he gave to all of us. Where were you when you heard of Al's passing and what passed through your mind? I had this image of a road that took a dramatic turn as a result of bioenergetics, permanently changing the trajectory of my life. Where do you think you would be had you never heard of him?

How did his ideas, his philosophy of health being grounded in the energized alive body affect your life and those you came to counsel? Whether you were part of the first wave of bioenergetic therapists in the 1950' and 1960's when Lowen was carving his own unique stone from the inspiring influence of Wilhelm Reich, or are part of a current twenty-first century IIBA affiliated certification program in the many bioenergetic training programs around the world, you have inherited his legacy. He understood the psychology of the body with a depth no other body psychotherapist ever has. He taught us how to understand and read character in chronic tension patterns and the polarities we struggle with and gave us practical exercises and techniques to loosen the bonds of our suffering. No matter how the winds blew making bioenergetics wax and wane in popularity over fifty years, his adamant belief in the ultimate truth in returning to the life of

the body never faltered. Although some of us may have become enamored of other theories or used new developments in, for example, neuroscience, trauma, and attachment theory to enrich our work with clients, we hold the secrets to Lowen's adamant belief and we know their power and beauty.

Thank you, Dr. Lowen, for the gift of your passion, you unwavering belief in the power of the body, putting your heart and soul into creating bioenergetics, and sharing it all with us. As we let you go with sadness and gratitude, know that we will carry your love and passion for bioenergetics inside us personally and will continue to share it outside us to the benefit of future generations.

Vincentia Schroeter, PhD
Chief Editor,
IIBA journal,
November 9, 2008

So Which Body Is It?

The Concepts of the Body in Psychotherapy

Angela Klopstech

Summary

This paper addresses the issue of how the body is conceptualized in modern psychotherapy and, in consequence, how the conceptualizations inform treatment. The paper also addresses the question to which extent a coherent conceptualization of the body and its place in treatment is necessary (or counterproductive), and possible (or even desirable). The author argues for a multiple body perspective where required centering is provided by a selection process. A clinical illustration is also provided.

Keywords: body concepts, relationality, multiple body perspective, body metaphor,

Mainstream psychotherapy, after decades of bypassing at best and shunning at worst, is discovering the body. It is beginning to consider bodily experience and bodily communication as essential aspects of the therapeutic process. At the same time, what is perceived to be "the body" varies considerably among different schools of psychotherapy; and, in addition, body oriented psychotherapies, by their very nature, have a different perspective from verbally oriented psychotherapies when they address the body. And as the perceptions and concepts vary, so do the treatment approaches. My paper addresses the question of how is the body conceptualized in modern psychotherapy and, in consequence, how the conceptualization informs

treatment. This paper also wrestles with the question to which extent a coherent conceptualization of the body and its place in treatment is necessary (or counterproductive), and possible (or even desirable).[1], [2]

Emergence and Convergence, Part 1: The Discovery of the Body in Mainstream Psychotherapy

This is a time of convergence in psychotherapy: different disciplines have softened their ideological boundaries, have started borrowing key concepts from each other, and are in the process of integrating and absorbing concepts formerly ego-alien to them. The body, how it is viewed and conceptualized, plays a crucial role in this crossover process and the body's place in psychotherapy is being reconsidered. Obviously, it has always been at the heart of body-oriented psychotherapies, e.g. the 'energetic body' and the 'character structured body' (Reich 1983 (first English publication in 1945), 1967; Lowen 1958, 1975; Kelley 1972; Pierrakos, 1987), the 'formative body' (Keleman 1975, 1979), the 'energy flow body' (Boadella 1987), and the 'gestural body' in gestalt therapy. Now, the body emerges more and more in verbal psychotherapy, in varying contexts and with different meaning constructions, perhaps most familiarly through the concepts of somatic countertransference and bodily-based communication.

There are also other convergences taking place. After decades of separation between psychotherapy and neuroscience "the best of modern science [e.g. neuroscience] converges with the healing art of psychotherapy" (Siegel, 2003 preamble). From the convergences of the various fields of neuroscience and psychotherapy, a complex and holistic (brain-mind-emotion-body) view of the human being and of human interaction is emerging. As a by-product, various sub-fields of psychotherapy are discovering the body, but there is an absence of any nuanced conceptualization of the role and place of it in treatment.

1 Revised version of a keynote speech delivered at the inaugural conference of the Northern College for Body Psychotherapy, Lancaster, England, July 2008.

2 This paper is part of a series in which I deal with the broader topic of exploring and defining the place of bioenergetic analysis in the contemporary psychotherapy world (Klopstech 2000a, 2000b, 2004a, 2005a, 2005b, 2008).

While it is clear that the patient's body, or the bodies of both patient and therapist, have entered into awareness and gained a right of existence, how does this existence manifest itself? Non-body-oriented psychotherapies have become aware of the importance of bodily phenomena, mainly immediate bodily experience in the form of body sensations within the patient, within the therapist, and between patient and therapist. There is a growing sense of its role in communication, (tone of voice, facial expression, gestural expression, somatic countertransference etc.), but a place for the actual (whole) body has not been established. Body sensation and communicative process obviously constitute only a part, not a full array of body process. Moreover, even with the awareness of body aspects, there still is the lingering, at times uneasy, often dismissed question of what to do, if anything, with the actual bodies other than being aware of them and talking about them (Cornell 2007). There is an understandable lack of know-how about what to do with the body, and there is also judgment as well as discomfort with the tangible, emerging body itself. Discomfort paired with simultaneous interest creates conflict, which looks for resolution. The discomfort channels interest in bodily phenomena in predictable, limited ways, and into the narrow channel of the body via its symbolization, meaning construction and localized sensation. It forecloses wide-scanning curiosity in the actual flesh and tissue; in gestures in their broadest sense, including the functionality of gestures (e.g. pushing away as a means of creating distance and separateness); in the body in movement (so that sitting is the only way to be): in the body below the face in it's energetic and vital manifestations; in the body in interpersonal connection, or non-connection, with another (via negotiation of distance and space etc.). In contemporary psychotherapy, there is no expanded therapeutic frame to express, act, interact except through the narrow channel of symbolization and localized sensation. And there is still some tendency to view doing, like in acting and inter-acting, as "acting out", and broad gestural expression other than facial is still, often enough, deemed primitive and regressive (Shapiro 1996; Dimen 1998).

So which concept of the body do we, each of us, have in mind when we talk about – or pay attention to – the body in psychotherapy, and therefore, which body is it that we are we **dealing** with (talking to, talking about, fantasizing about, seeing, smelling, reacting inwardly to, reaching out for or moving away from, breathing with, touching, etc) in our consulting rooms? Is it the **actual**

body and if so, what is that exactly: the body of drives, of energy, the breathing body, the moving body, the scientific body, the medical (psychosomatic) body, the sexual body, the impassioned body? And then, is it the moment-to-moment experiencing body (i.e. the body as vehicle for reception and expression of emotion, as carrier of communication), and/or the body as place of and container for personal history; or is it the metaphorical body, the body symbolized in language? And what about the relational body, the intersubjective and interactional body? Does the body just have a face or also a torso, limbs, a skin? Do bodies touch each other, shape each other, move together?

To summarize, what correspondences, overlaps, incompatibilities, matches and mismatches are there between the different perspectives and treatment approaches? Which body is it that we are dealing with? How does the conceptualization of the body inform the treatment approach? In order to answer these questions, I first will need to provide a contextual sense of the by reviewing in broad and selective brushstrokes how the place of the body in psychotherapy evolved and changed over time. A more comprehensive overview, though not with the same focus, can be found in Downing (1996), Goodrich-Dunn & Green (2002, 2204) and Cornell (2003, 2007).

The Place of the Body in Therapy: Brief Historical Overview

1. The Common Ground: Freud

At its origin, psychotherapy was the single theory of psychoanalysis, created by Freud's genius. In constructing and reconstructing his theory, Freud seemed to struggle with the problem of how to conceptualize the body, or the connection of body and mind. His ideas changed over time, from an emphasis on psychic energy, originating from the biological drives of sexuality and aggression, to a structural theory of the unconscious. In conjunction, his treatment approaches changed, from a more body based emphasis on hypnosis and catharsis in early years, to free association and the interpretation of dreams in later years. There is a defined shift in importance from body to language, from matter to mind. All along though, the body seemed

to have held some central, if changing place. It is the body that drives the mind, making a "demand … upon the mind for work in consequence of its connection with the body" Freud (1915, p. 122). Drives are conceptualized as bodily phenomena, constituting "the frontier between the mental and the somatic" (Freud 1915, p. 122). I consider his well-known later statement that the "ego is first and foremost a body ego … derived from bodily sensations" (Freud 1923, p. 23) as a conceptual extension, linking body and bodily processes to the construction of ego and self.

It is also important to realize that Freud initially was interested in a neuroscientific foundation of psychic phenomena. In his (posthumously published) article 'Project for a Scientific Psychology' (Freud 1950, written 1895) he attempts to anchor his understanding of the 'psychic apparatus' in the just recently discovered theory of neurons, foreshadowing the contemporary struggle to bridge psychology/psychotherapy with what was to become neuroscience. He gave up on the project, but indicated in later writing that he considered this failure as merely temporary (Freud 1915, p. 174, 175).

2. Diversification and Divergence

During the decades immediately after Freud, psychoanalysis is further established as a discipline and, even more important, is the development of the broader discipline of psychotherapy with its different schools. Most of these schools are rooted in some aspect of Freudian thought, retaining various theoretical and clinical pieces while neglecting or rejecting others. Originating in the common ground of Freud's ideas, the field of psychoanalysis and psychotherapy widens and diversifies over time with increasingly diverging theories and treatment approaches. For the sake of brevity and comprehension, from this point on, I will mainly focus on the development of psychoanalysis as the example for mainstream psychotherapy, and on the development of bioenergetic analysis, as the example for body psychotherapy. This procedure carries the risk of oversimplification but it has the advantage of limiting an otherwise dizzying array of theories and 'bodies' to a manageable quantity for the scope of this paper.

Freud's theories of drives and the unconscious keep dominating **classical psychoanalysis**, while, simultaneously, the privilege of language over body,

insight over direct experience, mind over matter becomes firmly cemented. The therapeutic frame allows only for the 'languaged', i. e. the metaphorical or symbolized body. The actual physical body, the 'unlanguaged body' representing subsymbolic process (Bucci 1997), is viewed as primitive, to be removed from the consulting room.[3] Consequently, bodily experience and expressions are considered as 'acting out' and regression.

Also, Freud's neuroscience efforts fall into oblivion because neuroscience data and theories are considered as too biological, too focused on the cognitive and irrelevant for treatment issues. **Neuroscience** follows its own path and develops into an altogether medical discipline, in turn considering psychoanalysis as irrelevant and unscientific.

Classical body psychotherapy, as created by Reich (1983, first published in English in 1945), has its roots in Freud's ideas, but in contrast to psychoanalysis, in his early, more body oriented theories. Reich expands Freud's drive theory significantly. He introduces the crucial concept of bodily defenses, the energetic counterpart to psychic defenses, thus developing an understanding of, and a model for, the connection and interaction of body and mind. Subsequently, he went on to formulate not only new body-oriented methods for treatment, but a holistic model of human behavior, based on the concept of energy. Reich's theories get further developed and diversified into different schools of body psychotherapy by his followers, e. g. into bioenergetic analysis (Lowen 1958, 1975, 1988), radix (Kelley 1972), formative psychology (Keleman 1975, 1986) and biosynthesis (Boadella 1987). While they differ significantly in detail, they share the common view that the body and not language, is at the heart of theory and treatment. Their theory and clinical practice centers on the 'energy body' of cells, muscles, flesh and movement, the observable body, the 'touch body', the body as experiencing and feeling agent in the present and the body as repository of history. In this therapeutic frame, the body represents freedom and impulse, not primitivism, and what psychoanalysis labels as 'acting out' is labeled here as aliveness or vitality.

3 I will use the term 'unlanguaged body' for the body of movement, gestures, holding patterns, facial and vocal expressions, in short for the body whose experiences and expressions have not (yet) been transferred into language. More familiar in this context might be Bucci's term 'subsymbolic (Bucci 1997). By 'languaged body' I will be referring to the experiences and expressions of the body that have been put into words. Traditionally this may be referred to as the symbolic or linguistic or verbalized body.

Most schools of psychotherapy, which developed in the decades after Freud, trace their roots back to psychoanalysis, and most of them give little room to the body in their theories or clinical practice. The humanistic psychotherapies are an exception. Particularly gestalt therapy and transactional analysis try to straddle the divide between the languaged and the unlanguaged body, e.g. making room for the body as experiencing and communicating agent. Over time, the term 'verbal psychotherapies' is coined. They are considered mainstream psychotherapy while body oriented psychotherapies remain marginalized. This only begins to change with the emergence of new paradigms in the therapeutic arena.

3. New Paradigms: Relationality and Affective Neuroscience

In the later part of the twentieth century, the psychoanalytic field shifts. By bringing together the British object relations school and the American interpersonal tradition, a new paradigm, **relationality**, emerges that emphasizes the importance of the relationship between therapist and patient. Relationality (Greenberg and Mitchell 1983) is a dyadic theory of mind. It has a profound impact on how therapy process and the therapeutic encounter are conceptualized. Key concepts are subjectivity and intersubjectivity, i.e. the recognition of subjective mental states within oneself as well as in the other; mutuality, i.e. the mutual influence within the therapeutic dyad; co-creation of experience and meaning; two-person psychology which emphasizes therapist and patient as co-creating individuals; enactment, i.e. the intermingling of unconscious experience.

The other paradigm, **affective or interpersonal neuroscience** (Damasio 1994, 1999; Siegel 1999; Schore 2003a), emerges from a renewed interest in and re-evaluation of the role of emotion and affect in human development. It is grounded in a wealth of data originating from new imaging techniques in neuroscience. Emotion and emotional relationships become the core issue in the study of consciousness and the unconscious. Theory building revolves around "body and emotion in the making of consciousness" (Damasio 1999, cover). In this context, the body resurfaces as processor and expresser of emotion.

Emergence and Convergence, Part 2: The Interweave

As old and new paradigms interweave, links between psychotherapy and neuroscience, as well as between brain, body and therapeutic process unfold. Differing therapeutic modalities are beginning to have key concepts in common. As part of this interweave, the body, with its physicality as well as with its various linguistic and cultural meanings, is occupying a prominent place.

The Impact of the Relational and the Neuroscience Paradigms on Bioenergetic Analysis

The relational paradigm changed the clinical practice and the view of the body within bioenergetic analysis in major ways (Campbell 1995, Finlay 1999, Heinrich 1999; Hilton 2007, Carle 2002, Klopstech 2000b, Resneck-Sannes 2002, Schindler 2002, Sieck 2007). All along there had been some unease with the exclusively energetic and characterological body and the potentially mechanistic and overly objective view of the body. The relational perspective made room for subjective and intersubjective experience of patient and therapist, questioning the hegemony of assumed objectivity in bioenergetic theory.[4] In my view, the integration of relational ideas allowed

4 The coexistence of the objectively assessed (by the therapist) and the subjectively experienced (by the patient and the therapist) body in bioenergetic theory and practice is of recent vintage and, the entire topic deserves further elaboration. But for our current purposes, I will briefly deal with a philosophical background. It was through the advent of postmodernism that the existence of an objective view of the world, and with it the omnipresence of hierarchical, logo-centric, male-centric and rational interpretations of human nature and culture has been challenged. Co-constructed experience and co-constructed understanding, or 'meaning', by all players involved is favored over objective and deterministic views within a given hierarchy. In Bioenergetic therapy, this would e.g. mean that the therapist does not become an arbiter of objective truth via his/her knowledge of character structure and body-reading, but instead holds just one view of the goings on in the therapeutic encounter. This view, together with the patient's view rooted in her/his subjective experience and also the therapist's subjective experience would lead to a co-created meaning or understanding of what is happening. Meaning' (or reality, or understanding, or truth) is thus always objective and subjective, a social construction, sensitive to time and context. Relationality, with its emphasis on subjectivity, intersubjectivity and mutuality as opposed to objectivity and hierarchy has certainly some roots in postmodernism. An in-depth review on the connection between relationality and postmodernism is provided by Mills (2004).

for the richness of the clinical repertoire of traditional body oriented psychotherapy to become more evident and to unfold more fully. In addition to the traditional focus on the more fixed and defended characterological body, the focus is now equally on the bodily experience in the immediate interaction in the therapy dyad, the body 'in action' within the interaction, the body in the present moment, the communicating and interacting bodies of patient and therapist, within a somatic dyad.[5]

The relational view has now become firmly established in body psychotherapy, but only recently has body psychotherapy, including bioenergetic analysis, begun to consider the implications of neuroscience to its domain (Koemeda & Steinmann 2004; Lewis 2004, 2005; Klopstech 2005a, 2005b, 2008; Resneck-Sannes 2005, 2007; Koemeda 2007). On one hand, the implications require a re-evaluation of some of our own core concepts, such as catharsis, charge and self regulation and imply some re-shaping into broader concepts, e.g. extending Reichian self regulation into the broader concept of mutual regulation.

But the implications are potentially larger in different and unexpected ways. It becomes increasingly clear that neuroscience has fundamentally changed the view of what matters in psychotherapy and that it is breaking up the long standing privilege of languaged process over body process, giving both equal importance. "For the first time from outside of body psychotherapy, the body is treated as an active and necessary protagonist for understanding development and process in psychotherapy" (Klopstech 2008, p. 119). As an aside, body process is our area of expertise which, if "advertised well", might create substantial interest from mainstream verbal therapies in body oriented thinking and interventions (Klopstech 2008).

The Rediscovery of the Body in Psychoanalysis

The expansion that psychoanalysis experienced from the emergence and its embrace of relationality was accompanied by a changed view of the body

5 As is frequently true with new syntheses, there is now the danger that the relational emphasis will swamp out the knowledge and techniques that are contained in the characterological and energetic understandings.

and its role in analytic process. Subjectivity focuses on feeling and subjective experience and therefore, necessarily, on the body. The experienced body, as we refer to it in bioenergetic analysis, becomes the subjective body, and the "bodily rooted self" (Aaron 1998, p. xxvii) in psychoanalysis, moving it from the kitty corner of analytic theory towards the limelight. Intersubjectivity is not only about two minds intertwined but about two bodies intersubjectively intertwined, Therefore both the patient's body and the therapist's body contribute to the relational body The 'relational body' in psychoanalysis is both; it is physical and subjective, like Aaron's bodily rooted self and it is a "complex construction" that is "interpersonal and fluid" (Harris 1998, p. 39, 43). And Dimen (1998, p. 68) brings relational and body-oriented concepts together by pairing up enactment and embodiment, as they "have in common their habituation of the inarticulate" i.e. the unlanguaged body.

To summarize, the integration of relational concepts has contributed much nuance to the theory of **body psychotherapy** and more 'bodies' to pay attention to in the clinical process, while the interweave with neuroscience provides links to the mainstream. The integration of relational and neuroscience concepts into **psychoanalysis and psychotherapy** has brought the physical body into awareness and language, and potentially into actual treatment.

Multiplicity and Selectivity

Initially, there was insufficient attention paid to the body, and now there may be 'too many bodies' to pay attention to. There is a "dizzying array of languages for the body … [that] expresses an excess of meaning the body stands for, contains, generates" (Dimen 1998, p. 65, 66). This newfound multiplicity requires selectivity and centering in order to be of any use either theoretically or practically. In my own view and clinical practice, I have adopted an approach that can be summarized by the somewhat awkward label of 'centered multiplicity of bodies'.

Multiplicity addresses the issue of inclusiveness. The body in modern (and postmodern) psychotherapy needs to include the objective physical body with its emotional and energetic (i.e. arousal and vital) dynamics,

with its history and its character structure. But it also needs to be viewed side-by-side with the subjective and the intersubjective body that allows for communication, co-creation, and enactment. And there needs to be room for the interactional body, the body in action and inter-action (one can consider awareness, reflection and symbolization as action (Harris 1998). Obviously, others also argue for a multiplicity of bodies. Cornell, a psychoanalytically informed body-centered psychotherapist, speaks of the body in relation to itself as well as the body in relation to others (Cornell 2007) and Dimen, a relational psychoanalyst, sees multiple bodies forming "a crazy quilt of overlaps, mismatches, and novelty, the stuff of excitement, anguish, sanity and madness" (Dimen 1998, p. 74). All these bodies take up residence in our consulting room as soon as patient and therapist meet, even if they are denied conscious entry.

While I argue that it is necessary for psychotherapists to have multiple perspectives on the body, this alone is not enough. The complexity of multiple bodies can be awesome, and, with all the various bodies vying for attention, an element of choice has to be present. Multiplicity needs to be paired with selectivity. Specificity and centeredness need to smartly counterbalance multiplicity so that creative and productive multiplicity does not turn into headless/mindless proliferation. It seems to me that each of us, in our way of attending to the body, has explicit preferences and implicit predilections which are based on our training, our philosophical outlook, our professional readings, our professional identification and, of course, our own bodily organization and it's issues. Which specific body -or bodies- takes center stage at a given moment, a specific day, or during a particular phase of treatment, depends on the preferences (which I consider a conscious matter) and predilections (which I consider more elusive to consciousness) of therapist and patient. These preferences and predilections shape which conceptualizations of the body speak to us and which do not, and which body oriented interactions (in the broadest sense of the word) become part of the therapeutic encounter. Selectivity via preferences and predilections establishes the mix of choice and enactment, a blend of the explicit (conscious) and the implicit (preconscious, unconscious), from the pool of multiple bodies.

I would like to believe that we, as therapists, have come to know the various bodies well, in their many incarnations, and that we invite them

into our consulting room, as well as into our personal lives. But the complexity of multiple bodies is awesome and I wonder, even with selection and focus, how we can deal with this multitude. I believe the best we can do is to stretch our professional comfort zone and to gain some familiarity with 'the other bodies', the ones that, for whatever reason, we tend not to appreciate. Becoming familiar presupposes being curious and informed rather than judgmental and rejecting. With curiosity and the familiarity that comes through knowledge, we can allow for different bodies to 'show up' and for any enactment to have it's pull, while still making a conscious choice within the therapeutic dyad along the lines of 'which body is it'. This means for non-body oriented psychotherapists to overcome their discomfort and fear of the actual body, specifically bodily expression of emotion. It also means for body psychotherapists to abdicate the power of being the ones who know about "the body" and instead give more credence and attention to the co-creations within the somatic dyad. It is this stretch of comfort zones that might help to anchor the emerging somatic paradigm more firmly in psychoanalysis and psychotherapy. In body psychotherapy, it might facilitate the necessary process of creating nuance.

Clinical Perspectives: Body-in-Language

I will present a clinical illustration of how I attempt to juggle multiple body perspectives. For purposes of identification, my home base is bioenergetic analysis leavened by psychoanalytic understanding and neuroscience findings.

The illustration focuses on possibilities of 'what to do with the body beyond talking', and will take a multiple-body perspective. There will be my conscious choices of which 'body' to focus on, but there will also be present my reacting to and interacting with my patient's choices. The example is presented in the form of small segments from several therapy sessions. The segments are cursory and moment-focused, and I call them clinical moments. The clinical moments revolve around a body metaphor brought into the therapy process by my patient Susan. This metaphor is the way Susan brings her body into the sessions.

In a recent session, Susan talks about her body as "being a house with many windows". All the while, she keeps pointing to her chest rather vigorously, as if to claim ownership. My immediate association is an image of Susan from an early time of her treatment when there was obviously 'nobody home', 'no body home' in the woman who was in my office then: her chest was sunken, her handshake limp, her face rather grayish and her eyes half closed, eyeballs rolled up and eyelids fluttering. This earlier woman was quite different from the one sitting in my office right now, perky and with a direct gaze, speaking about being a house with many windows.

Her metaphor is rich with many different components. There is the 'house' standing for ownership, belonging, for structure and for boundaries. And there are the 'windows', actually many windows, standing for openings, views, and eyes; for looking out and for looking in, looking for a relationship to the outside world. The togetherness of 'house' and 'many windows' in the metaphor evokes a simultaneous sense of stability and openness, maybe vulnerability from openness; the gesture of pointing to the chest, the seat of the "I", at least in the Western hemisphere, accentuates the ownership. Obviously, this metaphor presents multiple experiences of and perspectives on the body with many opportunities for choice and exploration. Within the context of multiplicity and selectivity, I will point to some of the routes we followed in subsequent treatment. The sequencing of interactions corresponds to the actual sequence of the way they occurred in the therapy.

Initial clinical moment: There is the relational body psychotherapist in me that has an immediate response of delight, and a question to go with it: "Sounds inviting to me! Does your house have a door?" "Of course, Angela", my patient responds, opening her arms and extending her hands – without being consciously aware of the gesture, as she later tells me. I stretch out my hand, picking up on the perceived verbal and bodily invitation with a body response of mine, no words. She takes my hand without hesitation. There is no limp handshake this time, there is somebody home, welcoming me in.

Explication: In the moment-to moment-interaction I pick up on the relational content of the metaphor, the openness expressed by 'many windows'

that feels to me like an invitation, maybe? This assumption, put as a question, leads to a spontaneous physical interaction, bringing both our gestural/relational/touch bodies into the foreground. In the further course of the session, my patient's characterlogical body surfaces, when we both talk about how difficult it has always been for her, given her family context, to trust and reach out. Alternately, viewing our spontaneous physical interaction as limbic resonance would pay attention to the neuropsychological bodies in our dyad. And, of course, our talking about what happened involves the languaged body. This course of action is a typical example of modern body-oriented psychotherapy, including bioenergetic analysis. The relational bodies, the energetic/physical bodies and the neuropsychological bodies share the stage in roughly equal amounts without giving ideological authority to any single perspective.

Second clinical moment during one of the subsequent sessions: Remembering her half-closed, fluttering eyes of the past, I ask her what the windows look like. She laughs and says that, of course, the windows are very clean and sparkling, testament to her strict Irish-German upbringing. But, she adds, these are her own windows in her own house, not the ones in her parents' house, and she would do the cleaning because wants to, not because she has to.

<u>Explication:</u> By using my memory of her 'past body' from our early therapy process, and, being struck by the contrast, I arrive at a question that addresses the body image in her metaphor. My emotional body is curious about a specific aspect, the windows, in Susan's metaphorical body. Susan's association about her upbringing brings us right into the midst of biographical material, i. e. a much earlier body from childhood. This is a direction that any non-body psychotherapist could easily follow; verbalizing and exploring further the metaphorical body, developing it into a narrative body.

The third clinical moment a couple of sessions later: This is more in the spirit of classical body psychotherapy. I invite Susan to explore her house further, particularly the view from every window. Although **I** invite an exploration, the method of exploring will be **her** choice. She chooses to get down on all fours, crouching, to look through the basement windows. Then,

she sits on the floor for the ground floor windows, then on a chair for the first floor windows, and then stands on her feet for the upper floors. Finally she is up on her toes to look out of the attic, feeling "on top of the world", but also a little unstable. In this manner, she inhabits all of her house; using her whole body, while being able to, and actually wanting to, look at the 'outside' world. There is somebody home and she feels at home.

Explication: In this scenario, Susan implicitly builds on the grounding work we had experimented with in many previous sessions. She starts looking out of the windows from the "ground", providing herself with safety and security for the daring endeavor of actively looking out at the world outside of herself. Active looking at the world, especially at people, even staring them down, has been an important part of her therapy process up to this point. All of this is classical bioenergetic process – the patient experimenting with her energetic, moving body – following basic principles such as grounding and working with energetic blocks, in this instance an eye block. Gestalt therapy or psychodrama, or any verbal therapy that makes room for experimentation with the moving body, might have followed a similar route by asking the patient to explore her house, though without paying attention to underlying energetic principles.

Body Metaphors in Clinical Process

I have deliberately chosen clinical moments involving a body metaphor because body metaphors are particularly suited examples of how the body appears in language. They are immediate examples of the 'languaged body' and the subjectively experienced body. At the same time they offer easy access to other bodies: in the above instances, the energetic body, the moving body, the relational body, the touch body, the developmental body and the biographical body.

It is my belief that body metaphors are not worked with frequently enough with sufficient depth, and are thus an underutilized area of psychotherapy, even of body psychotherapy. This is unfortunate since the immediacy, the knowledge and empathic potential contained in their imagery provide potent vehicles for dyadic interplay. They need little explanation,

but lend themselves to rich exploration, deep into biography and far into associations. This applies even more so to 'hardcore' body metaphors than to personal body metaphors such as Susan's. Hardcore body metaphors are phrases and expressions that have distilled essential meaning about the body in its everyday action and appearance and that, through this distillation process have become part of common language, part of everybody's language. Examples of such universal metaphors, familiar to any bioenergetic therapist, are: to lose one's head, to keep one's feet on the ground, to be thin skinned, to have a voice, the eyes are the mirror of the soul, etc. These are different from Susan's metaphor, which is an individually created one and not a hardcore or universal one.

Body metaphors, both individual and universal, are powerful forms of communication and instruments of limbic resonance, and the multiplicity of bodies they bring into the consulting room is obvious. Thus, they provide an easy treatment approach from somatic, verbal and relational perspectives. In this sense, body metaphors are at the contact boundary between body psychotherapy and "not-primarily-body-oriented psychotherapy", blurring the boundary between the two.

Final Remarks

Body metaphors are a good playground for multiple bodies. By definition, they are about the unlanguaged body and the languaged one, and by choice –of patient and/or therapist –, they involve the relational body as well as the neuropsychological one. But body metaphors are only one example involving multiple bodies in treatment. For most of the topics and issues that my patients bring into the office, a variety of bodies are present and vying for attention. It is my hope that we, as therapists, through the continuing process of smartly adopting each other's concepts, keep making room for the body in all its incarnations in our theoretical frames and in our consulting rooms.

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Borderline Character Structure Revisited

Vincentia Schroeter

Summary

Review and revision of borderline character type etiology and dynamics from bioenergetic point of view. Exploring revisions and offering new theories related to body-type, age, major blocks, and continuum on developmental phases chart from object relations schema. Included are views from prevailing theories in psychology and within bioenergetics as well as from a current scientific study.

Treatment aspects are discussed and relational interventions included.

Keywords: Borderline, dissolution panic, cooperation, rageful, boundaries,

Introduction

While co-writing a book on techniques related to character structure (Bend Into Shape, with co-author Barbara Thomson, available in 2009), I reviewed what we have in our local bioenergetic training curriculum on the borderline character type and by extension, BPD (borderline personality disorder). I found the following problems:

1. Unconvincing View of Parent-Child Dynamics.
2. No Single Clearly Agreed Upon Body Type.
3. No Agreed Upon Age of Primary Childhood Wound.

4. No One Main Area of Major Block in the Body.
5. No Single View of Where the Borderline Fits on the Continuum of Character Types.

In turning a critical eye to what is available in the IIBA curriculum on BPD, I acknowledge that our lack of clearly defined characteristics from a bioenergetic perspective is symptomatic of the larger psychological community, which also struggles with this diagnosis. Before turning to examine the five areas above within the IIBA curriculum, I review the current theoretical standards in the field.

Summary of Current Standard Theories of BPD

"BPD is one of the most controversial diagnosis in psychology today … Since it was first introduced in the DSM (Diagnostic Standards Manual), psychologists and psychiatrists have been trying to give the somewhat amorphous concepts behind BPD a concrete form. (www.palace.net/-llama/psych/bpd.html)

A. **Kernberg –** His view of what he calls BPO (borderline personality organization) is the most general and consists of three categories of criteria. The first and most important has two signs, the absence of psychosis and impaired ego integration – a diffuse and internally contradictory concept of self. Otto Kernberg is quoted as saying, "Borderlines can describe themselves for five hours without your getting a realistic picture of what they are like." His second category is called, "non-specific signs" and includes low anxiety tolerance, poor impulse control, and a poor ability to enjoy work or hobbies in a meaningful way. The third category which distinguishes borderlines from neurotics is the presence of "primitive defenses". Chief among these is "splitting" or seeing a person or thing as all good or all bad. They have problems with object constancy in people, with a poor sense of continuity and consistency, and cannot see a person over time as part of an integrated whole. Other primitive defenses include magical thinking (beliefs that thoughts can cause events), omnipotence, projection of unpleasant characteristics in the self onto others and projective identification, a

process where the borderline tries to elicit in others the feelings s/he is having.

B. **Gunderson –** He is a psychoanalyst whose view of BPD is the most scientific, focusing on differentiating the diagnosis of BPD from other personality disorders. He constructed a clinical interview to assess borderline characteristics in patients. Gunderson's criteria in order of importance are:
   - ➢ Intense unstable interpersonal relationships in which the borderline always ends up getting hurt.
   - ➢ Repetitive self-destructive behavior, often designed to promote rescue.
   - ➢ Chronic fear of abandonment and panic when forced to be alone.
   - ➢ Distorted thoughts or perceptions, particularly in terms of interactions with others.
   - ➢ Hypersensitivity, meaning an unusual sensitivity to nonverbal communication.
   - ➢ Impulsive behaviors that often embarrass the borderline later.
   - ➢ Poor social adaptation – not knowing or understanding the rules regarding performance in job and academic settings.

   Use of Gunderson's revised (in 1989) test, called DIB-R has led researchers to identify four behavioral patterns they consider **peculiar** to BPD: abandonment, engulfment, annihilation fears; demandingness and entitlement; treatment regressions; and the ability to arouse inappropriately close or hostile treatment relationships.

C. **Linehan –** In contrast to the symptom list approaches taken above, Marsha Linehan has developed a comprehensive sociobiological theory. She theorizes that borderlines are born with an innate biological tendency to react more intensely to lower levels of stress than others and to take longer to recover. In addition to these innate qualities they were raised in environments where their views of themselves were devalued and invalidated. These factors create adults who are uncertain of the truth of their own feelings. Linehan created a treatment protocol called Dialectical Behavioral Therapy (DBT). Controlled studies found success in DBT which teaches clients skills of mindfulness, interpersonal effectiveness, distress tolerance, and emotional regulation.

D. **Herman** – Some researchers including Judith Herman believe BPD is a name given to a manifestation of post-traumatic stress disorder. When PTSD takes a form that emphasizes heavily its elements of identity and relationship disturbance, it gets called BPD; when the somatic (body) elements are emphasized, it gets called hysteria, and when the dissociative/deformation of consciousness elements are the focus, it gets called DID/MPD (dissociative identity disorder; multiple personality disorder). Others believe the term "borderline personality" has been so misunderstood that trying to refine it is pointless and the term should be done away with. (www.palace.net/-llama/psych/bpd.html)

This brings us back to what we have in our literature within the Bioenergtic community. I came across some writings in our field on borderline issues but most of them are only on treatment techniques, and I want to concentrate more on theory or ways of understanding borderline issues from a bioenergetic perspective.

Summary Within Bioenergetics of Writers on BPD

Louise Frechette wrote an excellent article from the 1990's called, "The Borderline: In search of the True self" (Frechette, 1995). She provides a clear summary of current theories on borderlines from writers outside of Bioenergetics, and provides many valuable techniques for working bioenergetically with borderlines. Bob Jacques' provides a summary of older theories from the beginning until the mid-eighties in "The Borderline Character and Bioenergetic Analysis: Taming the Wild Diagnosis" (Jacques, 1987).

Louise takes into consideration the prevalence of abuse in the history of borderline clients, particularly sexual abuse. She refers to the work of Saunders and Arnold who developed the concept of "traumatic bonding" to describe the intense attachment the borderline has with a significant person, where love, dependence, and bad treatment co-occur. Louise also cites the views of Jerome Kroll, who feels all borderlines suffer from PTSD and who thinks they should all be re-labeled as "PTSD/borderline " patients. (Frechette, 1995, p. 9)

Others whose articles on borderline dynamics appear in some of our

IIBA training material include Scott Baum, Eleanor Greenlee, Bob Coffman, Michael Brennan and Odila Weigand.

I will present various views related to each of the five areas of concern stated at the beginning of this paper and provide three ideas of my own for your consideration in furthering the dialog in the ongoing search for deepening our understanding of the borderline personality.

1. The Parent-Child Dynamic Revisited

I will start with my search to get a better feeling for the parent-child dynamics that have never made much sense to me. I was taught that the parent clings to the child and does not allow the child to separate. But this seems simple, not realistic, and never gave me an energetic sense of what this must be like for the child. Without that I have trouble feeling enough empathy for the child. So I consulted with two bioenergetic therapists more sure-footed when it comes to walking in the shoes of the client trapped in a borderline world.

Consultation With Scott Baum

I consulted with Scott Baum (personal communication), who has written extensively on this subject and has as a mission helping others understand borderline dynamics from an energetic point of view. Scott feels the borderline age is young, like from birth to 3 months. Their body collapses in the middle, around the diaphragm. To help me understand exactly what happens, he role-played a hostile parent verbally attacking the baby for wanting to withdraw. I (Vin) was the baby. My experience led more to my understanding of the borderline dilemma than anything I have done before. Feeling like I was punched in the stomach, I did contract in the middle immediately while being yelled at. I wanted to withdraw but felt trapped and was not allowed to withdraw, so my defense was not like schizoid withdrawal. I was not allowed to escape. I felt like my only option was to lash out impulsively to discharge distress but I was too afraid to do so. This is the first time I felt what we call, "borderline rage". My experience was,

"You have me trapped, cowering and scared and you won't let me contract or withdraw, so it makes me want to bite you." The impulse to lash out by biting was very strong.

Consultation With Paula Buckley

The following are some notes from a consult with Paula Buckley (personal communication), who often teaches on borderline personality for our training society in San Diego. Paula says, " You diagnose a borderline by what they do to you. Their energy is intense, you feel turbulence in you and a sense that it comes from them (the client)." Paula warns that if the therapist is unaware of his or her own counter-transference, they won't know this turbulence, and it is important to be aware of it. "Their energy is too permeable. It is leaking, sending the energy into the therapist, and pulling the energy from the therapist." Paula emphasizes the main focus must be on the therapeutic alliance with the borderline client.

The most important thing I learned from Paula was to reconsider my previous view that the parent of the borderline behaves outwardly anxious and only clings as the child moves toward separation. This had been what I was taught and somehow it never seemed to completely ring true as an accurate picture of the parent/child dynamic. Paula said, "The parent who can't show panic at the child's separation will behave in a hostile and punitive way toward the separating child or cling to the child. This hostility is a defense against panic." This view of the parent made more sense to me and seemed more complete. An anxious, indeed panicked parent may not appear scared, but will behave with hostile control. This view of the hostile parent was confirmed later by Scott's role-play with me which I describe above.

Now I had more of a sense of what the parent was like. They hide their panic beneath their hostility. Paula also emphasized that in therapy there will be projective identification, which is when the client throws an un-owned undigested affect at the therapist unconsciously, and the therapist has a strong somatic experience of that affect. It occurs to me that the parent we are drawing here may have done this to their child. This parent projected their un-owned panic out in rage that the child had to swallow whole and feel trapped by.

2. Borderline Body Type Revisited

Unlike the other bioenergetic character types, the view on borderline body varies. Elizabeth Michel completely left out the borderline in her 1997 anatomy book written for Bioenergetic therapists called, Bent Out of Shape (Michel, 1997). She did mention that Lowen names it as one of the sub-types on his continuum of narcissism. There is no separate chapter with body dynamics particular to that character in her book because her book is based on Lowen's character types and Lowen never wrote a book on borderlines, like he did on all the other types. So we do not have Lowen to lean on and have to fit the dynamics we know into his theories or be responsible in studying on our own and developing theories on where they match or where they diverge. A goal of this paper is to add to this task of building a truer picture of the borderline.

In our local curriculum we have only a *blank* page illustrating the typical body-type of the borderline because there is not one agreed upon overall pattern of body-type for the borderline character. It also indicates that they may vary in body constellation. Bob Coffman (bioenergetics training material) believes they appear more like an oral or a schizoid in body type. Many of us have also seen borderlines who look more like narcissists, masochists or rigids in body type. So if our theory is that you can read one's character by their body, this seems to not hold true with the borderline.

Here is the first of my theories in this paper. This one provides a possible rationale for the fact that no one body type for the borderline exists. **I have contemplated that borderline is not even a character type, but rather a level of development within each character type**. This means a person may be any character type, but within that type, operate at a lower (psychotic) to middle (borderline) to higher (neurotic) level of functioning. For bioenergetics that would help explain why borderlines have no agreed upon body-type or an overall gestalt of muscular holding patterns that are assessed by typical "body-reading" techniques. If this is the case, while you see in front of you a schizoid, oral, narcissist, masochist, or rigid, if they operate "at a borderline level", which can be determined as most agree, by the way they treat you in the relationship, then you can take into consideration the main issues of that character type, but overlay what we all agree are borderline issues. A borderline level of functioning would look like the

symptoms from the current mental health diagnostic manual such as the current DSM IV defining the borderline personality disorder (BPD). The person has a history of unstable relationships, history of acting out rage, is demanding and entitled, litigious, and has poor boundaries.

3. Borderline Age Revisited

A. Scott Baum says the age of developmental wound is in first 3 months of life, which puts the borderline in same timeline as schizoid (zero to 6 Months old). In his paper, "Living on Shifting Sands", Scott writes that the ability to sense external as well as internal phenomenon is compromised profoundly due to a "childhood filled with terror, dread, deprivation and overstimulation." (Baum, 1997)

B. Bob Coffman says the age is between 6 months and one year, and that the borderline is between the schizoid and the oral (which he puts at 18 months). Coffman feels the symbiosis failed as the child was unable to "incorporate" the mothering qualities. So the client is stuck in the symbiosis, dependent on the caretaker, without having "incorporated' the ability to self-soothe. He feels there are two types of borderlines, a withdrawing "distancing" borderline, who acts more like a schizoid and a dependent clinging borderline who acts more like an oral.

C. The object relations chart from Althea Horner's book Object Relations and the Developing Ego in Therapy (Horner, 1979) is based on Margaret Mahler's developmental schema (Mahler, 1975). Mahler's phases and Horner's revisions are included in chart form in this paper. During the Rapprochement crisis (from around 16 to 24 months), the child struggles to make sense of their awareness of their own smallness following their relative power in the practicing period of 9 to 14 months. The baby discovers that the world exists outside of mother; that she is a separate being from him and he now feels vulnerable and fragile. Unable to reconcile the two aspects of being both small and dependent with beginning to feel bigger and more independent some children regress to earlier phases. According to Horner's schema of pathology, narcissists retreat back and get stuck in

the grandiosity and omnipotence of the practicing period, as they fail to integrate these two aspects. Borderlines regress all the way back before differentiation (5–6 months), back to symbiosis with the caretaker, as they fail to create a cohesive sense of a separate self.

D. I am developing a theory that the age is between the schizoid and the oral, which is 6 to 9 months. The reason is because the back is trying to develop from a lying down to sitting (tripod) and then to pulling up to standing. In Mahler's schema this is prior to the grandiosity of the practicing period (9–14 months), where the child gleefully explores their world oblivious to danger. It is the age when the baby moves from primarily a lap baby to one who sits up and begins to crawl, with more and more accuracy. **He gets away from the parent better than he could before. Real locomotion away from the parent starts in this age** and it **is the dynamic of a parent threatened by separation that is the crux of the borderline issue**. It isn't that this threat doesn't happen earlier. Like Scott says, in the first three months the parent might be threatened by the child moving his head to the side away from the parent. It also happens later, through the grandiosity of the 9 to 14 months practicing period, and the rapprochement of 16 to 24 months when the back gets strong, the baby walks well, and the energy gets moved into the anal phase.

The reason I choose 6 to 9 months as a possibility is due to **back** development. Babies have weak backs at this age that are in the process of strengthening. They have moved from the "C" shape curl of the newborn, to a flexible back for pushing up and crawling to a stronger back and abdominals needed for sitting (around 6 months) and then extensors and upper back for pulling up to standing (around 9 months). Imagine all this is going on naturally and then you get yelled at to "pay attention to me" by a panicked rage-filled parent. You clench and contract from the shock eliciting a fight/flight response. You are not allowed to withdraw in fear so you feel trapped, causing an impulse in you to want to fight. Babies this age are very easily expressive emotionally; they cry frequently, express frustration easily and have low frustration tolerance. These baby characteristics match borderline states, I think. Also borderlines are needy and dependent, also typical of the normal 6–9 month old baby.

T. Barry Brazelton in his book <u>Touchpoints</u>, (Brazelton, 1992), writes that babies at 8–9 months achieve the ability to control their back muscles

to the point that allows them to sit up without support. They move from the "tripod" sitting with arm support of 6 to 8 months, where they could sit up, while leaning their hands on their legs. Based on Piaget's studies, Brazelton also writes that babies do not usually achieve object permanence until between 9 and 10 months old. This means when mother leaves the room, he has no faith she will return which immediately causes anxiety. Also separation anxiety occurs to babies this age, when they have had enough consistent parenting that they give up charming everyone with their smile, and often become clingy with one parent and won't go easily to strangers.

Here is a list of borderline characteristics that match a baby this age:

- Impulsivity;
- Intense fluctuations of affect;
- Intense rage reaction;
- Intense reaction to separation (no object permanence prior to 9 months and separation anxiety 7–9 months);
- Dependent on soothing outside self for comfort and affect regulation;

4. Major Block in the Body of the Borderline

If you entertain my idea that the borderline may be fixated at the age of 6 to 9 months then the major area of blocking in the body goes with the body development at that age. As described above the baby this age is beginning to strengthen their back in preparation for sitting on their own, then for pulling to standing. This work to sit and stand and become balanced in both involves new skills using the large and small muscles of the back. In bioenergetics we view the segment as incorporating both the anterior (front) and posterior (back), or all the way around the body from the front to the back. Therefore if the back is the major block then the front or anterior side of the back is also part of the block. This would then involve both the diaphragmatic and abdominal segments of the body. Recalling earlier my reaction in the role-play with Scott Baum as the anxious and hostile parent, I felt like I was "socked in the stomach", wanted to withdraw or collapse but was not allowed to. These emotions are felt energetically in these same areas of the body. My stomach contracts, but my back stiffens as I feel trapped, can't withdraw and then feel the impulse to lash out aggressively.

Personally, it felt like an anterior/posterior split in the middle of the body and helps me understand the poor impulse control of the borderline from an energetic point of view. Perhaps not every borderline has this same experience but this may provide a possible area of exploration energetically with clients, by examining the diaphragmatic and abdominal segments as the possible major areas of blocking in this character type.

5. Where Does the Borderline Fit on the Continuum of Character Types?

According to theorists outside Bioenergetics and those inside, notably Louise Frechette, Bob Jacques, Scott Baum, and Bob Coffman, all agree on what a borderline acts like in relationships. However, the origin of when the main wound occurred varies. Using both bioenergetic character types and Mahler's developmental schema I will define all the possible times the wound could have occurred. Knowing what age the main wounding occurs tells us where they fit on the continuum of character types. I will make an argument for how it could have occurred at various ages.

Developmental Phase When Damage Occurs in Relation to Character (see Mahler chart):

The damage could have occurred in the first months of life, when the baby needs to be welcomed securely to feel they have a right to be here (schizoid core issue). It could have occurred in the next few months where the warmth of the symbiotic attachment is paramount (oral issue) or later during the practicing stage of eager exploration with crawling and walking, where the need is to have parental support in the exploration (narcissistic issue). It could have occurred still later in the rapprochement stage, where the baby returns back to cling after the grandiosity, realizing he is small in relation to the big world and the parent does not allow the ambivalence between neediness and independence (masochistic issue). It could occur during the Oedipal phase, where the support for expression of love and sexuality needs to be supported in a non-exploitive way (rigid issue).

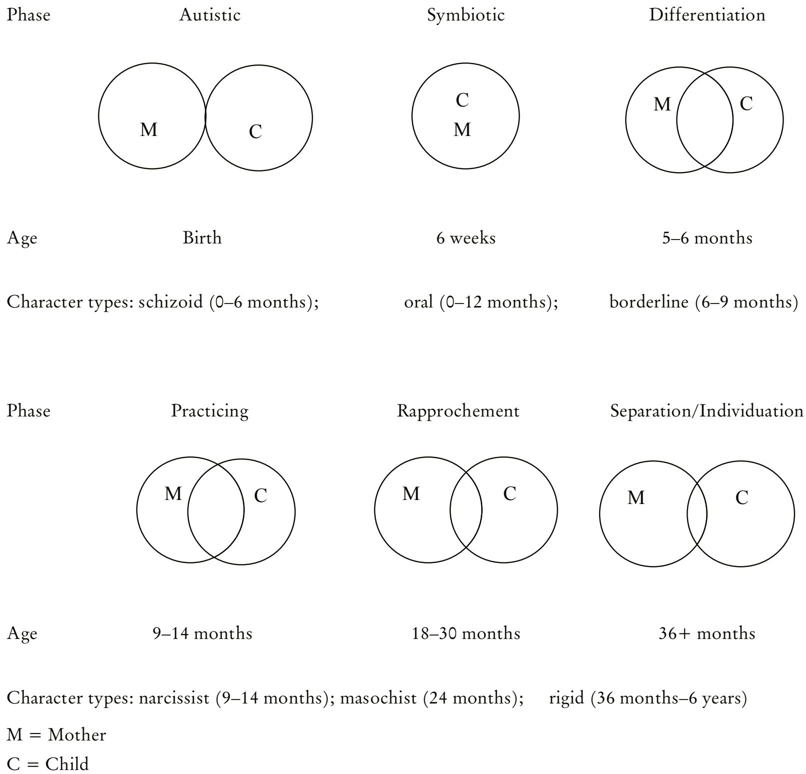

figure 1: Mahler Developmental Chart

Ways to Turn Away Across the Developmental Continuum

We all agree that the parent was threatened by the child's independence and somehow demanded the child stay close, and even clung to the child, in an anxious and/or angry way. It occurs to me that this dynamic could have occurred at any of those above ages, because nescient independence begins at birth with the turning of the head or eyes away from the caretaker, when the baby needs to go inside, and stop engaging with the parent for awhile. That is done at that early age a lot with sleep cycles in the symbiotic stage.

At differentiation (5 months old) the child pulls his head back to get a good look at who is holding him and explores the face, at the beginning of sensing the other as a separate being.

At the practicing stage the energy is to excitedly explore the world ("the world is my oyster"), and feel natural grandiosity and relative imperviousness to pain and failure (e.g. learning to walk and falling and getting right back up, with minimal need for comfort). At this stage a parent who is threatened and demands attention, will curtail the energetic move to explore by holding onto the child longer than the child wants and insisting on less exploration and more closeness to the parent. This is a parent who needs validation of their worthiness by being loved by the child.

In the third age (18 to 36) months of the rapprochement period there is often a crisis where the awareness that "I am little and the world is big" dawns on the previously happily grandiose child, plummeting them into a minor depressive state. Though this is a normal state this rapprochement "crisis" requires that the parent allow the sometimes-torturous ambivalence in the child between their need to be close and their need to be distant. The parent of the borderline, having never worked through this ambivalence herself, cannot hold onto to her separate sense of self in order to bring the needed patience and understanding to the child. She threatens him and hampers his working through of the struggle, successfully contributing to the core borderline issue of a split in the personality. This split becomes an ongoing style of anxious attachment that vacillates between entitled regressive neediness with no sense of the effect on the other and impulsive, rageful acting out when those needs are not met or mirrored precisely. In Horner's schema, at the rapprochement crisis the **borderline fails to create a cohesive individuated self and regresses back to behavior of the symbiotic stage (see Horner chart).**

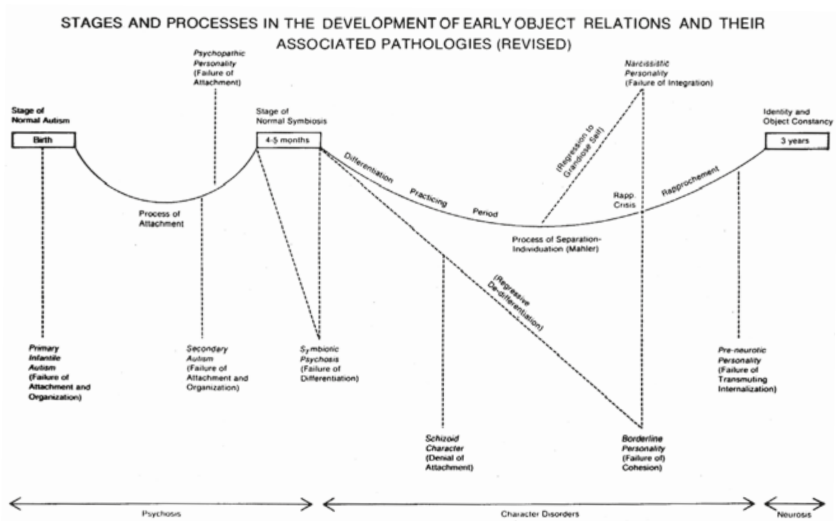

figure 2: Horner chart

So whether this pattern began in infancy and continued through these developmental stages, or primarily occurred in one stage more than the other and was part of a regression, the borderline dynamic becomes a core issue for some people. One can get stuck in a symbiotic phase or regress back to it from a more individuated stage and still become borderline.

Treatment

Regardless of the varying views on the borderline within the bioenergetic community, people agree with the treatment protocol. The client is prone to "dissolusionment panic", feeling they could dissolve without external support. A "failed symbiosis" with mother causes this distress. They feel like their sense of self will disintegrate if they lose the object (caretaker). The borderline will cling to avoid this loss of self, will disorganize at abandonment, lose a cohesive self-sense, and react with rage at a therapist he cannot differentiate from the mother. As Bob Coffman says, "The child merges with the mother and the borderline merges with their therapist. This failed symbiosis is where the work of therapy begins whether you want it

to or not." This is an important warning that the work with the borderline is based on critical aspects in the therapeutic relationship. These critical aspects are that the therapist must be willing to allow the client to merge with them enough to incorporate some abilities the therapist has to manage anxiety and self-soothe, and that all interventions must emerge out of the relationship. It may help to appreciate this if you think of the borderline client as that 6 to 9 month old that I posit they are developmentally. Just like a baby of that age, they will disorganize at abandonment, and cannot function without outside support. Once they attach to you, they will need to lean on you to begin their therapeutic journey.

General Cautions to the Therapist:

1. Do not start with standing, charging or grounding in the legs. The client needs to ground in the relationship with you before they can proceed to this level.
2. Do not react to their rage with your own, but do set limits if they behave abusively toward you.
3. Create a frame within which you create a safe, consistent and clear-boundaried holding environment, that includes all the contracts and expectations around fee, lateness, amount and time of phone calls, etc.
4. Make your limits clear from the beginning on the boundaries of the relationship.
5. Seek consultation if you become overwhelmed with the demands of your client.

Tension Patterns in Breath, Ground and Energy:

1. Breath

The anxious contraction, with difficulty containing in the diaphragm makes the person's breathing tight. They could breathe in the chest with a tight diaphragm, like a snorting bull when rageful; or have the inflated chest of

the narcissist or rigid, when feeling entitled. The split in the middle creates the most constriction, with little capacity (air) to contain feelings. The breathing is mostly contracted laterally (out to the sides), and is not deep. The abdomen may feel diffuse, so breathing will be shallow there also.

Bringing the breathing down to the diaphragm and abdomen will help deepen the breath.

2. Ground

The person can look solidly attached to the ground but quick flares of anger and quick dissipation of energy reveals they are not grounded. They "fly off the handle" easily, so they don't feel safe on the ground or they would be able to contain outbursts better. Grounding work begins by feeling safe in the relationship rather than grounding in the legs. It is useful to create ways to use the body of the therapist in relationship to help ground, such as placing your feet over the feet of the client. Be sure to watch their response to see if they feel more grounded or less so. Adjust your grounding techniques based on the client's response.

3. Energy

Their energy system seems to vary. They can have high energy and be very engaging, but they can't sustain that high energy level and can get rid of it very quickly. Much of their energy is bound by anxiety. There can be major splits in the body, either between the upper and lower halves, with a tense midsection, or between the head and body. Acting out occurs often because the anxiety cannot be contained and gets expressed impulsively to relieve this anxiety by discharging the pain. In the parent-child dilemma, the child was trapped in feeling rage and fear at not being allowed to separate so he or she stays merged with the parent. Expressing this rage can allow a sense of separateness, and perhaps provides an experience of freedom from the incorporation of a rage-filled panicked parent. They need containment work to build their separate self which leads to increased tolerance and trust toward others.

Relationship: Patterns, Research, and Techniques

Relationship Patterns

Borderlines have poor boundaries and very little sense of the other as a separate person with separate needs from them; they act entitled to be taken care of in whatever way they want. They get rageful and don't know they are barraging others with their negativity; they can switch from mean to regressive and needy quickly, with no middle. A rapid fluctuation back and forth often occurs. Once another sets boundaries for them they are often relieved and respond well, as they lack a good internal sense of when to stop. For example they have trouble knowing when to stop reaching, needing, yelling, or pulling. They drain others but do not seem to know it.

Research Reveals Poor Ability to Cooperate

Why don't they seem to know that they are draining for others? A recent study may help shed light on this question. In a research article entitled, "Rupture and Repair of Cooperation in Borderline Personality Disorder" (Science, 2008) the authors reported that, "Individuals with BPD showed profound incapacity to maintain cooperation, and were impaired in their ability to repair broken cooperation …"

In the anterior insula part of the brain the level of cooperation was much reduced in BPD's as compared to healthy individuals. The authors used an economic exchange game and neuroimaging to provide a glimpse into the neural mechanism underlying the breakdown of cooperation in people with BPD. In the psychology section of that same volume of *Science,* in an article called, "Trust Me on This" the author summarizes from the research referenced above that "BPD is associated with abnormal activity in the brain region associated with monitoring trust in relationships." (Science, 2008). They explain that the anterior insula is traditionally associated with sensing the physiological state of the body, but strongly reacts to uncomfortable occurrences in social interactions, such as unfairness, risky choices, frustration, as well as responding to the intentions and emotional states of

others. **This implies that those with BPD may have difficulty cooperating because they lack the "gut feeling" that the relationship is in jeopardy.** The correspondence of these brain findings with current psychotherapeutic practice is remarkable in that therapists sense this lack of skills in interpersonal regulation and work to build these skills in their BPD clients.

A labile, fluctuating, erratic, sometimes rageful, demanding and needy presentation without a sense of cooperation with the other is "normal" for a 6 to 9 month old. The research above may help you appreciate how devoid the person is of trust and cooperation, and therefore how much in need they are of your help in building those skills. Therapists may ask themselves, "What would a baby of this age need from the parent?" This helps you start with empathy and connection, ignore the provocations, understand the anxieties and help move the client from symbiosis to creating their own skills at self-regulation.

Relational Techniques

A. Even though they could not move beyond merger (to establish a healthy individuation), they could never relax within the symbiosis with their mother. Create situations where they can begin to relax with you. Start with a safe, consistent environment, and a solid stance of compassion with firm but calm limit setting.

B. Hold their head and massage the occipital region with them monitoring and making eye contact. The purpose of holding is not to gratify and have them stay there forever, but to soak in some of your goodness, without their needing to panic, so they can move on to incorporate that "goodness" as a part of themselves, and heal the "bad/good" split. Once they are able to feel nurtured they often can move away more toward individuation.

C. Sit on a couch or a mat. Have the client lie down on the couch and curl the front of their body around your back. You cradle their head and feet. (see Figure 3). I had a borderline client who requested this type of holding at the end of every session in order to feel grounded. She was always more organized and insightful after this technique. Notice that the middle of their body, the abdomen, is in direct contact

with the warmth of your back. As you invite them to breathe, you are supporting the abdominal segment, which as I stated earlier in this paper, I think is the major block in the body.

figure 3

D. In dealing with an attack or resistance from the client, I use Martha Stark's technique for dealing with resistance by making a "conflict statement stating both sides of the dilemma, and following whichever one the client responds to" (Stark, 2002). For example, a client attacking could be challenged, "You are really needing me to hear how mad it made you that I went on vacation, even though you know that it isn't realistic to expect me to be here all the time." The reverse order would be, "Even though you know it isn't realistic for me to be available all the time, you really need me to know how angry you are that I was gone on vacation." If they continue to be angry, you mirror the anger. If they respond that it isn't realistic, you mirror that. If they continue attacking and you feel abused, tell them firmly but calmly

and not with a sense of being overwhelmed, "I am feeling abused by you, I need you to stop. I do not allow anyone to treat me like that." Look at them firmly as you set this boundary and maintain eye contact. Breathe slowly in the abdomen and diaphragm and sense your strong back. In this way, you are unlike the rageful panicked parent. You are firm, calm, but with a clear boundary. You have done what they weren't allowed to as a child. They could not create a boundary with a parent, and you have modeled for them a healthier way to respond to distress rather than rage back at the other person.

Summary:

Revisiting the borderline personality reviewed the thinking of various theorists on the general dynamics and etiology of the borderline. Inconsistencies within the IIBA training material were examined. Aspects reconsidered included the parent-child dynamic; the body-type including a new theory about why there is no single body-type agreed upon; the age of the borderline wound, including a new theory about both age and the major block in the body. Fitting the borderline on the continuum of character types was examined using developmental charts from Mahler and Horner. Treatment cautions preceded dealing with breath, grounding and energy in the borderline client. Citing a new research study confirming BPD traits was followed by specific interventions for dealing with the relationship issues in treatment from a bioenergetic point of view.

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Rekindling Pleasure: Seven Exercises for Opening your Heart, Reaching Out and Touching Gently

Bennett Shapiro

Summary

The purpose of this article is to help you open your heart, reach out, touch gently and by doing so gain more pleasure in your life.

Section I, *Introduction*, outlines the normal biological pattern of opening your heart, reaching out and touching gently. It introduces a developmental model explaining how internal conflicts are formed that could inhibit the pattern in yourself as an adult and thus reduce your pleasure.

Section II, *Seven Energetic Exercises*, explores internal conflicts through a sequence of exercises that aims to reduce muscular, energetic and emotional inhibitions and increase pleasurable sensations. The exercises are useful both in a therapeutic setting and as self-help.

Section III, *Rekindling Pleasure in an Ongoing Relationship,* demonstrates the importance of seeing your partner as a source of pleasure, and adapts six exercises from Section II for self-help use to address problems that arise in your relationship.

Keywords: heart, reaching, touching, pleasure, energetic, exercises

Section I: Introduction

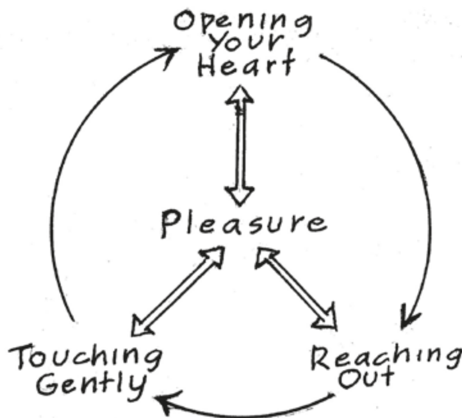
Recently, my heart opened for a period longer than several days, for reasons still unclear to me. I was struck by the difference in my life. I vowed to create some exercises to help my heart to open when it was closed. I also wanted to deepen my relationship with my wife Millie. The new exercises, outlined in sections II and III, have helped me considerably. My clients also found them useful. Their appreciation for the exercises helped to fuel my motivation to write this paper.

The normal biological pattern for opening your heart, reaching out and touching

This paper was stimulated by the concept of the *normal biological pattern.* I use this term in line with Alexander Lowen:

"Since parents are the source of food, contact and sensory stimulation that children need … the *normal biological pattern* … [is for] babies and children [to] look to their parents as a source of pleasure and reach out to them with love …" (Lowen, 1975)

Additionally, it is my observation that in any deep emotional connection (including with pets), the more you *open your heart* to the other person, the more you will want to *reach out* to them and the more you will want



to *touch* them *gently*. There is also a circularity to these actions; that is, touching gently can lead in turn to opening your heart more deeply and so on around the circle at a deeper level (the single-ended arrows in Fig. 1).

Each of these actions – opening your heart, reaching out and touching – is both cause and effect of *pleasure.* If somebody is a cause for pleasure for you, you will want to touch them and, in turn, touching them will give you even more pleasure. Likewise opening your heart to someone will give you pleasure, and if someone gives you pleasure, you will open your heart more to them (the double-ended arrows in Fig. 1).

This normal biological pattern can become inhibited in us as adults for different reasons. One cause of inhibitions to this pattern is internal conflicts, and it is such conflicts that I wish to explore here. As a background to understanding these conflicts, I will introduce a developmental model that is based upon and extends Alexander Lowen's schema of concentric layers protecting the core/heart of the person (Lowen, 1975).

I have found it useful for my clients' ease of understanding to personify Lowen's protective layers, and in this paper I use the term *Defenders* to describe those layers. The concepts of *Natural Child* and *Adult*, which I have added to Lowen's schema, are derived from Eric Berne's *Transactional Analysis* (Berne, 1964). For ease of client understanding, I have grouped these terms – Natural Child, Defenders, Adult – under the general category of "sub-selves."

The term *Natural Child* is a personification of our life force, the core of our being. We are born as the Natural Child; it is our birthright. It is the source of our heartfelt/aggressive instincts, impulses and feelings, which flow outward from our center, seeking satisfaction, fulfillment and pleasure in the outside world. Our Natural Child lives only for the present, not the past or future; it is all "here and now." (Exercises 1, 2, 3, 4 and 7 feature the Natural Child.)

The term *Defenders* personifies a sequence of protective layers (sub-selves) that begins to form developmentally in infancy and childhood, when our Natural Child experiences shocks and injuries for which it is biologically unprepared. As adults, our Defenders usually suppress the Natural Child's instincts, impulses and feelings, because the Defenders fear that the environment will find these expressions unacceptable, as they were unacceptable to our parents/early environment. This decreases our desire to open up our hearts, reach out and touch. Also, when the energy of this

suppressed energy gets trapped, it festers inside us and leads to negative, devilish feelings. Thus the Defenders have both protective and destructive aspects. (Exercises 2, 3 and 4 feature the Defenders.)

One of our Natural Child's instincts is the striving for pleasure. But when our Defenders are in survival mode, our focus is only to be relieved of stress, pain, anxiety, depression, etc. Then we have little time for pleasure, and we grow numb to its loss. However, if we are not in a state of pleasure, we are in a state of pain, whether we perceive it or not. If we are living in pain, we have contracted in fear, which closes our hearts, pulls in our arms and reduces loving touching.

The term *Adult* is the personification of our Observing Ego; it is the last sub-self to form in the development of our personality. Our Adult's responsibilities are to lead all the other sub-selves, to be in touch with the reality of the inner world (the sub-selves) and the outer world/environment, and to mediate between the two worlds. Unfortunately, in many of us, our Adult is weak and/or not present enough. In this case, the Adult can easily be usurped by the Natural Child, whereby inappropriate impulses are expressed out to the world. Or the Adult can be overwhelmed or usurped by the Defenders, whereby the Natural Child's impulses, even if appropriate, are further suppressed, leading to even more festering energy and more negative devilish feeling. Therefore one of the chief tasks in our therapy is to strengthen our Adult so that it can more truly lead our sub-selves instead of being overwhelmed or usurped by them. (Exercises 5, 6 and 7 feature the Adult.)

Since our internal conflicts are often projected onto our relationships, it is important to explore first some of our internal conflicts through the exercises in Section II. Then in Section III we'll deal with the problems that emerge when two people, each with their own internal conflicts, interrelate.

Section II: Seven Energetic Exercises

Exercise 1, "Your Natural Child – Opening Up, Reaching out and Touching," helps you experience the aliveness, openness and uninhibited expression of your Natural Child. Step 9 helps you focus on pleasurable sensations in your body.

Exercises 2–7 assist in recovering different qualities of your Natural

Child. These qualities can then be utilized or expressed appropriately by your Adult. Exercises 2–7 explore and begin to resolve muscular/energetic/sub-self conflicts that can inhibit your normal biological pattern of opening your heart, reaching out and touching gently. Resolution of these conflicts can allow you to experience more pleasure in your relationships.

Each exercise includes goals, illustrations, step-by-step directions and self-assessing questions. Only 10–15 minutes per exercise are required. However, associated therapeutic issues may arise and can be explored in the same session. The exercises are to be done in order, 1 through 7. If you wish to change the order, read the introductory comments in the earlier exercises so that you know what you are skipping. Exercises 2 and 3 should be experienced in the same session.

A word of caution: most of the exercises are emotionally and/or energetically demanding; therefore, they should only be attempted with the aid of a trained Bioenergetic therapist. After experiencing an exercise you can repeat it on your own for self-help.

Exercise 1: Your Natural Child – Opening Up, Reaching Out and Touching (STANDING)

Alexander Lowen defines pleasure as "The perception of an expansive movement in the organism – opening up, reaching out, making contact." (Lowen, 1975) This exercise demonstrates the strength of the striving for pleasure in your Natural Child as it reaches with all its heartfelt intensity out to life – to touch and be touched. The key is to let your tongue hang out limply from the corner of your mouth; this stops the ability to form words and makes thinking more difficult. Hence it is ideal for bringing up the preverbal Natural Child. Note: Figure 2 resembles a physical position outlined in my 2008 Bioenergetics Analysis article. However, this new exercise involves the important additional action of Touching, awareness of the role of the Defenders as inhibiting agents, and the strong specific emphasis on perceiving pleasure.

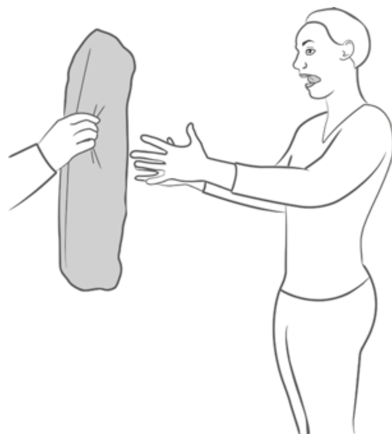
The goal of the exercise is to give you easy access to the core vitality, spontaneity and emotional freedom of your Natural Child. The exercise can evoke a lot of fun and feelings of great aliveness and bodily warmth when the core energy reaches the periphery of your body.

Equipment: A wall or closed door to lean against and a pillow.

1. 'Ground' so that your feet feel firmly on the floor; your legs may start vibrating; then lean against the wall, heels about 8 inches out from the wall.
2. Imagine you are a little toddler in a playground with children your age; you see a little friend slowly coming toward you with a big smile on his/her face, tongue hanging out the corner of his/her mouth, and reaching out to you. Simultaneously: Let your tongue hang out the corner of your mouth (as in Fig. 2), open your eyes with excitement, smile and make an "Eh–eh–eh" sound (or whatever sound comes naturally).

Keep leaning against the wall for balance, lightly pressing your shoulders and buttocks against the wall so that your back arches slightly. Note: it will help to support your expression if your therapist faces you and lets her tongue hang out like yours.

3. Your therapist now holds up a pillow vertically, just out of your reach; the pillow represents your little friend, to whom you are reaching and whom you wish to touch (Fig. 3).



4. Slightly bending your elbows and rigidifying your arms, wrists, hands and fingers so that they shake with tension,
   - ➢ *On inhalation*: reach out to your little friend with charged (not limp) arms and hands, as in Fig. 3. Smile with your tongue out and your eyes open with excitement.
   - ➢ *On exhalation*: Close your eyes and slightly retract your arms.

   Note: if you increase the rate of your retracting and reaching, your arms may begin to move involuntarily forward and backward.
5. Press the balls of your feet against the floor to increase your excitation and send more vibratory movement up your body. As you keep reaching, your body may wish involuntarily to bounce up and down with all the excitement – just let it happen!
6. At this point, your therapist should move the pillow within your reach; let your hands grasp the pillow and involuntarily do what they want with it.
7. When you've had enough reaching out, bend over and sense the feelings in your legs and your feet as they meet the floor. You may wish to do some good-humored laughing about your experience as you are hanging down and 'grounding.'
8. On standing, hold a pillow to your chest if you are feeling vulnerable. Were you able to experience involuntary movement? Did you enjoy the feelings of excitement? Do you feel considerably warmer, freer, more alive, yet more relaxed? Or did you feel guarded/restricted in

letting go freely and involuntarily to the excitement? What were your emotional feelings and physical sensations when you could finally touch your little friend? Also, did you feel embarrassed letting your tongue hang out? If so, it could have been your Defenders saying, "Don't look like a fool." If you wish, you can now share all the above feelings with your therapist, or do so after Step 9.

9. To perceive pleasurable sensations in your body, there are two requirements: an openness in your body to allow a downward flow of energy, and the capacity of your Adult to perceive the flow.

   Bioenergetically, pleasurable sensations include warmth, tingling, streaming; perceiving energy flowing through a part of the body not previously a source of pleasure; letting down, relaxing; feelings of aliveness; wanting to be involved in life; a deeper connection to your body.

   ➢ If you are feeling vulnerable, hold a pillow to your chest, arms crossed over the pillow, hands curling around the pillow edges. Close your eyes to focus on sensations in your body.
   ➢ To keep your energy flowing, slowly bend and straighten your knees in rhythm with your breathing. (Rhythm is an important part of pleasure.)
   ➢ On *inhalation*, think, "I can feel my body." On *exhalation*, think, "… and I can feel its pleasure." Or shorten the words to: "I can feel … and I can flow," or just: "Feel … flow."
   ➢ You may need to moderate the intensity of the energetic charge/discharge in order not to lose perception of the pleasurable sensations. An internal or external sigh of pleasure is helpful.

Exercise 2: Charging your Hands/Arms by Struggling for Control (STANDING)

Our Natural Child's movements out to the world are innocent, joyful and spontaneous (as experienced in Exercise 1). However, our Defenders, fearful that our Natural Child will be injured, are determined to protect our Natural

Child by controlling and damping its impulses, instincts and feelings. And so there is an enormous struggle within us: the Natural Child's feeling, "I want OUT!" against the Defenders' feeling, "You stay IN!" One of your hands will represent the Natural Child, and the other hand will represent the Defenders. The fingertips of your two hands will press against each other in a struggle for supremacy, as in Figure 4. Note: Figures 4 and 5 resemble a physical position in my 2008 article whose sole purpose was to charge the arms, wrists and hands. However, in my new exercise, the two hands also represent the struggle between the Natural Child and the Defenders; there is a verbalization to that effect.

The goals of this exercise are to energize (and therefore honour) the Defenders' attempts to protect the Natural Child and also to charge our fingers, hands, wrists and arms so that we can more fully feel them.

1. 'Ground' yourself so that your feet are firmly on the floor; your legs may start vibrating.
2. Hold your hands in front of your chest, and strongly press the *fingertips* (not the hands) together, as in Fig. 4.

Turn your fingertips in towards your chest, as in Fig. 5, and keep pressing the fingertips strongly against each other.

(The charging of your shoulders/hands/arms is necessary because reaching out is sabotaged if your hands are limp/flaccid.)

3. Imagine one hand represents your Natural Child trying to move out into the world, and the other hand represents your Defenders trying to stop your Natural Child's movement:
   ➢ *On inhalation*, imagine yourself as the Natural Child. Think, *"I want OUT!"* and push strongly with that hand against the Defenders' hand, which resists it.
   ➢ *On exhalation*, as the Defenders. Think, *"No way: you stay IN!"* and push strongly against the Natural Child's hand, which resists it.

   Note: Throughout, keep your eyes glaring as you look at your fingertips pushing, and keep your lower jaw forward with determination. There should be a slight back-and-forth bending at the wrists as the hand that is being verbalized seems to be overwhelming the other hand. Keep pressing the fingertips until your arms quiver. When your shoulders, arms, wrists, fingers and thumbs are all tired, bend over and 'ground' your feet and legs.
4. On standing again, close your eyes and let your arms and hands hang down alongside your body. Focus your feelings on your arms, hands, wrists and fingers. Do they feel warmer, larger, suffused with

blood and energy? If not, you may need to repeat the above steps 3 and 4.

5. You may feel some twitching in your fingers, wrists, arms and shoulders. Gradually rotate your hands faster and faster, and at some point make a decision to let them move involuntarily. Making a continuous sound and keeping breathing will help you 'let go' to the involuntary movement. If you could allow this to happen, do your fingers, wrist and arms feel looser, freer, tingly? Did you feel the energy invested in the struggle between Natural Child and Defenders?
6. To perceive pleasurable sensations in your body, see Step 9, Exercise 1.

Exercise 3: Releasing Anger in your Hands/Arms through Involuntary Movement (SITTING)

We saw in Exercise 2: Struggling for Control that our Natural Child's spontaneous impulses to reach out to the world were thwarted and consequently have been inhibited by the Defenders. Generally, the movements that are more inhibited are those for reaching out assertively to possess, to embrace lovingly, and to touch gently. The inhibitions lead either to a muscular rigidity or its opposite, muscular flaccidity, in our shoulders, arms, wrists and hands. Emotionally, we feel frustrated/angry, or passive/victimized/hopeless. Bioenergetically, we first have to release the inhibitions in our aggressive movements; only then can we express the tender caring and loving movements. My experience is that surrendering to involuntary movements is the most reliable, easiest and quickest method of releasing muscular tensions and their associated emotional feelings.

The goal of Part A of this exercise is to surrender to your Natural Child's anger/rage at being restricted in its assertive reaching. The goal of Part B is to surrender to the assertive reaching itself. (The caring tender movements will be explored in Exercise 6.)

Equipment: a chair without arms.

Prerequisite: Do Exercise 2: 'Struggling for Control' *immediately* before doing this exercise.

Part A

1. 'Ground' so that your feet feel firmly on the floor; your legs may vibrate.
2. Sit in the chair, feet parallel and hip width apart, heels directly below your knees. Imagine you are angry at not being able to reach out to possess what you desire.
3. Make claws with your hands and hold them six inches in front of your face, shoulder-width apart. Rigidify your fingers as if you were enraged and were going to tear at someone with your fingernails. Let your lower jaw come forward with defiance and your eyes glare with rage.
4. Alternately claw with one hand and then immediately with the other hand.
   - ➢ *On inhalation,* simultaneously: draw one elbow back so that your hand is alongside your head; raise the corresponding knee (for example, left elbow, left knee) so that your foot rises about 6 inches off the floor (see Fig. 6); and tighten your arm and leg so that the charge will build up.

   - ➢ *On exhalation*, simultaneously: extend your arm forward but keep it still slightly bent, so as not to lock your elbow. Make a

tearing motion downward with your clawed hand. Stomp the corresponding foot on the floor; see Fig. 7.

Tighten your arm and leg so that the charge builds up.
Now immediately do the above movements and breathing pattern with the other hand and foot.

5. Repeat Step 4 several times to coordinate the hand/foot alternation and the breathing pattern. If possible, imagine there is some resistance both in retracting and extending your arm and with the clawing downward – this will help charge your arms and fingers. Do likewise with your feet. Your therapist should steady the back of your chair in preparation for Step 6.
6. Slowly pick up speed as you repeat Step 5, until you feel so highly-charged that you could get carried away by the intensity of the feelings. Then make a *conscious decision* to 'let go' and surrender to involuntary hand-clawing and foot stomping (similar to a temper tantrum). Be sure to keep your claws, even when you are letting go of your arms. Making a continuous sound and keeping your breathing going will help you to 'let go' to involuntary movement.
7. Afterwards, your therapist might offer you a chest pillow for any feelings of vulnerability.
8. Stand up and 'ground' into your feet and legs.
9. On standing, close your eyes and feel your shoulders, arms and hands. Do they feel freer, looser, warmer, more relaxed, heavier, more con-

nected to your body? Do your legs feel likewise? Emotionally, do you feel more relieved, more spontaneous? Did you feel embarrassed by your anger? (If so, it could be your Defenders saying, “Shame on you for having such a tantrum!”)

10. To focus on perceiving pleasurable sensations, see Step 9, Exercise 1.

Part B

One of our earliest movements is to reach out aggressively for food and bring it to our mouth. However, the message from our Defenders is, “Don’t be greedy!” Now that some rage has been expressed in Part A, you can experience the ravenous instinct in its purer form by imagining you are a hungry wild animal bringing food to your mouth with your claws. Or you can stay with the image of being a one-year-old in your high-chair.

1. Turn your claws, palms facing each other (your therapist should steady your chair back):
   - *On inhalation*, simultaneously: Pull your elbow back; open your mouth as wide as possible and show your teeth; open your eyes and raise the corresponding foot.
   - *On exhalation*, simultaneously: Make a sweeping motion with your arm, a bit out to the side as well as forward, so that the claw gathers in the food and brings it to your open mouth in one sweeping motion; stomp the corresponding foot as your claw reaches your mouth.

   Now do the above movements and breathing pattern with the other clawed hand and foot.
2. As in part A, alternate the sweeping motions, going faster and faster until you make a *conscious decision* to let your arms go out of control, but still keeping your claws.
3. Stand up, hang down and ground yourself. What are your emotional/physical feelings? Do you feel more awake, warmer, stronger? Did you feel embarrassed about your uninhibited reaching and taking? Did you feel, “It’s all mine”? How were your feelings different from doing Part A?
4. To focus on perceiving pleasurable sensations, see Step 9, Exercise 1.

Exercise 4: Closing Yourself or Opening Yourself (STANDING)

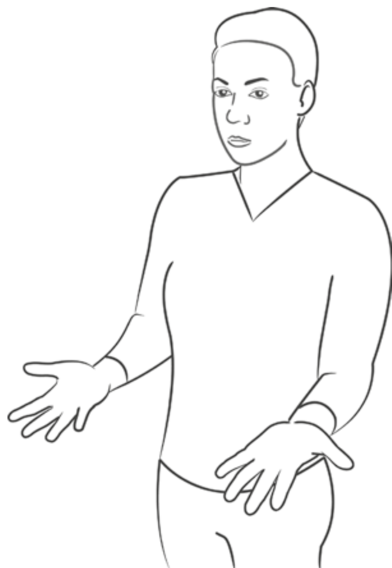
In this exercise, you alternate between feeling safe in closing yourself from the world, thus saying "No" to it, and then taking the risk to open yourself to the world, so as to connect with others and have excitement, fun and pleasure – in effect saying "Yes" to the world. In the closed position, the Natural Child (your thumbs) is enclosed and protected within your curled fist, and your arms and fists protect your heart. In the open position your heart, sensitive palms and forearms are exposed, and your Natural Child (thumbs) is free to move as it wishes; moreover, your palms are open to receive whatever the world has to offer.

The goals of this exercise are to strengthen our Adult, honour our Defenders and encourage our Natural Child to emerge. The goals are accomplished by alternating between the polarities of safety ("No") and risk ("Yes"), augmented by the curling and uncurling of your arms and hands, in rhythm with your breathing. Note: For detailed information about polarities, charging of arms and hands through curling and strengthening the Adult, see Shapiro, 2008.

1. Ground yourself so that your feet feel firmly on the floor; your legs may vibrate.
2. Bend your thumbs and curl your fingers loosely around them. Imagine that your enclosed thumbs represent your Natural Child protected by your Adult.
   - ➢ On *exhalation*, keep your elbows at your sides, bring your curled hands with enclosed thumbs up to your chest, and rest them on either side of your sternum (see Fig. 8).

Close your eyes and think, *"I can close myself."* As if your Natural Child was resisting the movement to close yourself to the world, tighten your arms as they move upward.

➢ On *inhalation,* swing your forearms down so that they are parallel to the floor, with your hands open, palms facing upward and thumbs extending outward. See Fig. 9.



Open your eyes and think, *"… or I can open myself."* As if your Defenders were resisting the movement to open yourself, tighten your arms as they move downward.

Your arms should almost quiver with tension/charge as they move upward or downward against the resistance.

3. After you have learned to coordinate all the above activities with your breathing, you can shorten your thoughts to just "Close" as you raise your forearms and just "Open" as you lower them.
4. If you wish more excitement: on exhalation, bring your jaw forward to protect your Natural Child; on inhalation, open your eyes wider and reach with your lips; also you can say the words "Close" and "Open" out loud instead of just thinking them.
5. After 15 or 20 breathing cycles, you might begin to feel your arms and upper body quivering as the alternating between safety and risk builds up the energetic charge/discharge.
6. After you've had enough closing and opening, hang down and 'ground' yourself.
7. If on rising you wish to feel pleasurable sensations in your body, see Step 9, Exercise 1.
8. Share with your therapist your experiences. In particular, what were

your emotions and bodily feelings about your Adult protecting the vulnerability of your Natural Child, and your Natural Child's feelings about being protected? Your feelings about your Adult alternating between escorting your Child out into the world and then bringing it back to safety? Did alternating between closing in and going out make it easier to do both? Did you feel uncomfortably vulnerable with your sensitive palms and forearms exposed? Was it easier closing up from the world than opening out to the world? Does your answer surprise you? Were you previously aware that you had a clear and conscious choice to be closed or open to the world?

Exercise 5: Touching for Reassurance (STANDING)

To be touched gently, reassuring and lovingly is our birthright. It was a necessity for our survival as infants and small children. Unfortunately, in our culture very few of us receive enough nurturing touching in our early childhood development. (See Montagu, 1977.) Accordingly, many of us are starved for such touching, and some of us have long ago denied our basic need for it. But for all of us, touching and being touched is an ongoing need for our fulfillment as human beings. (The need for our pets is just one example.) The connection between touching and a loving heart is embedded in our language; for example, we say "I felt really touched when you said such-and-such to me;" and if it was an even more moving experience, we say, "You touched my heart." Sadly for some of us, it is only when we are in distress that we become acutely aware how deep our need is to be touched and held lovingly by others. If deprived by the touching of others, one outlet some of us turn to is wringing our own hands as a way to soothe our distress.

The goal of this exercise is to experience the power of being touched gently. The exercise is simple but can be strong. It's best that the client knows they will be touched, because if they had been abused in the dark as a child, being touched when they weren't expecting it could trigger a traumatic response.

1. 'Ground' yourself so that you feel your feet firmly on the floor; your legs may start vibrating. Have your therapist stand about four feet away, facing you.

2. Hold your elbows at your sides, forearms and hands parallel to the ground; turn your palms upward – the position of supplication. (See Fig. 10.)

Close your eyes and keep them closed throughout the exercise.

3. Say out loud, quietly and softly, the word “Please.” (If this is difficult for you to say out loud, just *think* it.) Try not to associate your pleading with any particular need that you may have; the word ‘please‘ can be enough to give you the feeling of pleading, and the deeper your feeling of pleading, the more powerful can be your experience.
4. If your arms start moving forward involuntarily with each succeeding plea, just let it happen.
5. At some point, when your therapist senses you are feeling your pleading, she should gently put the palm of one of her hands into the palm of one of your hands. (See Fig. 11.)

6. Immediately after seeing your bodily response (or even the lack of it), your therapist should place the palm of her other hand on the back (bottom side) of the hand of yours that she is touching – thus enclosing your hand between her two hands.
7. Feel the emotional impact your therapist's touch has upon you; note any changes in your breathing and your shoulders. Now (with your eyes still closed) compare the feeling of difference between the hand your therapist is holding and your other hand, which is not held.
8. To perceive pleasurable sensations in your body, see Step 9, Exercise 1.
9. Share with your therapist your emotional reactions about this whole exercise. If you felt this was an important experience, can you see yourself taking the risk to move out more often into the world to touch and be touched? Which person(s) or even pets might find it meaningful to be touched more by you? If you are in an ongoing relationship, do you touch your partner often? Are your touches heartfelt? Do you feel you are being touched enough lovingly?

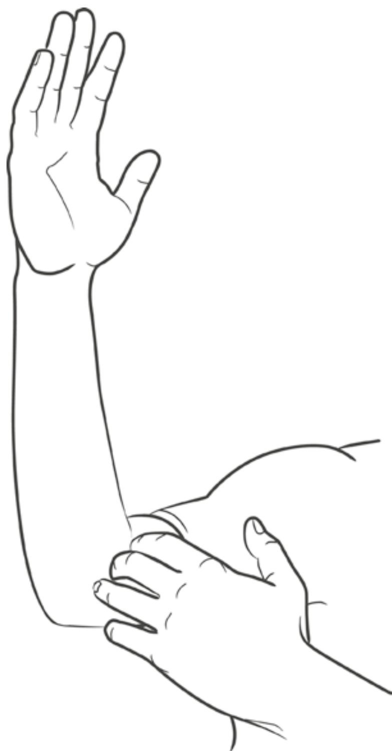
Exercise 6: Sensitizing your Hands/Arms for Pleasure (SITTING)

Our capacity to feel pleasure is vitally important. As Lowen says, "The primary orientation of life is toward pleasure and away from pain … Pleasure promotes the life and well-being of the organism." (Lowen, 1975)

The goal of this exercise is to perceive pleasure by focusing on the sensation of a gentle caress through the stroking of one hand and forearm by the fingertips of the other hand.

Equipment: a chair (with arms preferred) or a table on which to rest your elbow, if possible.

1. Sit in the chair and rest your right elbow on the chair arm, on the table, on the side of your belly or on your thigh by leaning forward. It is important to be as comfortable as possible, and not to be distracted by contact with clothing, outside noise, etc. – except perhaps some gentle music. If you are wearing long sleeves, roll up your right sleeve above your elbow, so that your forearm is exposed.
2. Raise your right forearm vertically, with fingers comfortably extended, palm facing to left. Start with the fingertips of your left hand at your right elbow (Fig. 12) and close your eyes.



➢ *On inhalation*, in one continuous languid motion, slowly stroke the fingertips of your left hand *up* your right forearm, wrist and

palm, finally resting on the fingertips of your right hand (Fig. 13).

Focus on perceiving your right arm and hand. Think: *"I can feel."*

➢ *On exhalation*, in one continuous languid motion, slowly stroke the fingertips of your left hand *down* the fingers, palm, wrist and forearm of your right arm. Focus on perceiving pleasure in your body – it will help if you visualize pleasure as a downward flow in your body, echoed by the downward stroking motion of your fingertips. Think: *"… and I can flow."*

3. Repeat Step 3 as often as you like, but at least long enough to find an easy rhythm between your breathing pattern and your stroking. (Rhythm is an important part of pleasure.)
4. When you've had enough, stand up, hang down and 'ground.' Stand again, with your arms hanging down by your sides. Do you feel any more relaxed in your body, more 'down' into your legs and

feet? Any difference between the two arms? Between the two hands?

5. To perceive pleasurable sensations in your body, see Step 9, Exercise 1.

Exercise 7: Opening Your Heart with 'Thank You' (SITTING)

It's an old Bioenergetic dictum that "once your heart is open, everything is open." A good example of this is being in love – your muscular and energetic holdings diminish, you harbor little negativity toward others and are radiant to behold.

This exercise focuses on opening your throat and heart; the salutary effects may last for several hours or even a whole day. The exercise also illustrates that our Adult and Natural Child can communicate with each other; but whereas our Adult's language uses words ("Thank you"), the Natural Child's language uses excitation and involuntary expression. Note: Figures 14 and 15 resemble two physical positions in my 2008 article, which, however, were for a different purpose (examples of "Accelerators") and did not accompany a detailed exercise for opening your heart, as this exercise does.

The goal of the exercise is to experience pleasure by being more physically and emotionally open, both in your throat and heart.

Equipment: A straight-backed chair without arms and 2 pillows, one firm and one soft.

1. Sit in chair, feet parallel, hip width apart, your feet directly below your knees. If desired, put a firm pillow between your back and the chair back, and hold a soft pillow to your chest, arms crossed over the pillow and hands curled loosely around the pillow edges.
2. The therapist should position herself behind your chair, with one hand supporting the back of your head and the other hand on your forehead supporting your ego.
3. Imagine thanking your Natural Child for its optimism, excitement, spontaneity and open-heartedness – as evidenced in Exercise 1.
   ➢ *On inhalation* (Fig. 14), simultaneously: open your eyes, throat and mouth and lean back against the chair; to open your chest

both lengthwise and laterally, let your head go back gently, extend your arms downward and backward, about 18 inches out to each side, palms up and fingers extended; arch your back gently by pressing your buttocks and shoulders against the chair back, this will help open your throat and chest even more.

Your therapist should allow your head to go back as far as it wishes on inhalation but support some of the weight, so that you don't feel stressed in the neck.

➢ *On exhalation* (Fig. 15), simultaneously: imagine that your Natural Child is looking at you, and *in gratitude for its openness, energy, excitement and spontaneity, say out loud to the child, "Thank you!"* – then close your eyes and mouth; reverse the arch in your back; let your head come forward gently, chin almost to chest, while your arms cross over the pillow and hands curl tightly around the pillow edges; if possible, make a sighing sound as you come forward.

As you squeeze the pillow, let your tongue come out limply at the corner of your mouth and make a gleeful, gloating little laugh: "Eh–eh–eh" as your Natural Child delights in being appreciated by your Adult. Or you may feel more like crying – just do whatever comes naturally.

Repeat all of Step 3 at least two or three times.

4. Option: To increase your energetic charge and strengthen your child's delight, extend your exhalation, which will deepen your inhalation (this might have already happened naturally).
5. After expressing enough gratitude, stand, hang down and 'ground.'
6. To focus on perceiving pleasurable sensations in your body, see Step 9, Exercise 1.
7. On standing again, do you feel more openness in your throat/chest/heart area? More alive, energetic, positive toward life in general? More

present, less vague, less spacey? More capable of opening to life? Look around the room and perhaps out a window at the outside world. Do you feel more expansive? Finally, as you move through your day, note whether you have different feelings towards people or situations you encounter; also note whether people respond to you differently than usual. Does your increased expansiveness feel pleasurable?

Exercise Variations

a) For deepening your feelings of gratitude toward your Natural Child, keep your arms open while exhaling; doing this several times, with very short inhalations, will probably lead to crying.
b) Instead of thanking your Natural Child, you can thank God, the Universe, a person or a pet.

Assessment

- ➢ Which exercises in Section II were the easiest? Which gave you the most difficulty/anxiety? Summarize your emotional/physical reactions from having experienced the exercises.
- ➢ Where do you experience difficulty – Opening your heart? Reaching out? Touching others?
- ➢ Discuss with your therapist where you have the most difficulty in the three key areas noted above. Can you see yourself doing some therapeutic work in these areas? Can you and your therapist design a self-help program for you to follow?

Section III: Rekindling Pleasure In Your Ongoing Relationship

Al Lowen once said to me, "What gives you pleasure, you love, and what you love is beautiful." This statement certainly applies to the beginning of an ongoing couples relationship, where there can be the intense pleasure of falling in love and relating sexually. Sadly, for many couples, after the 'honeymoon' period is over, the negative of this statement would seem more

applicable: Whatever doesn't give you pleasure, you don't love, and what you don't love isn't beautiful. For if we find less pleasure in our partner, we will touch, reach out and open our hearts to them less. (As sexuality can be such a complex issue in an ongoing relationship, it cannot be thoughtfully presented in this short article. It will therefore have to be reserved for a future paper. However, to experience my basic exercises for reclaiming sexuality, see Shapiro, 1993.

Having created and experienced the exercises, one day I had the following realization: If I could see my wife simply *as a source of pleasure* (emotionally, physically, intellectually) then I could let go of a lot of emotional baggage that I had accumulated over 35 years of marriage. This realization made it much easier for me to approach my wife in a fresh way and open up more to her. A change in attitude has made a significant difference in our relationship.

When I shared my insight with those of my clients who were in ongoing relationships, they also found this attitude important for them. As one of them said, "I feel relief – this gives me hope."

Therefore, I believe the most important step you can take to improve an ongoing relationship is simply to *view your partner as a source of pleasure for yourself*.

Viewing Your Partner as a Source of Pleasure

To help make a shift in how you view your partner, close your eyes and imagine seeing your partner across the room standing or sitting in a chair smiling at you:

➢ Can you, at least temporarily, let go of the emotional baggage you have accumulated toward your partner, e. g. feelings of hurt, rejection, disappointment, betrayal, mistrust, resentments and fear of experiencing more of the same in the future?
➢ Can you now view your partner simply as a potential source of pleasure – emotionally, physically, intellectually, spiritually? (In the beginning of your relationship you probably viewed them as this way, or you wouldn't have fallen in love).
➢ Can you fantasize what you would feel toward them if they were indeed a source of pleasure? Would your heart open more often to them? Would you want to reach out more frequently to them, want to touch them more gently and lovingly?

Ongoing Relationship Problems and Suggested Exercises

Whether or not you can view your partner as a source of pleasure, problems frequently occur in ongoing relationships that, if unaddressed, result not in pleasure but in pain. Listed below are some of these problems (as they would be stated by clients), some comments of my own, and some exercises that may help to resolve the problems. Since the exercises are an adaptation of those in Section II, you will need to experience the original exercises before attempting these adaptations. Remember: If you wish to experience pleasurable sensations at the ends of these adapted exercises, you need to follow the instructions in Step 9, Exercise 1.

Problem A: "I Feel Depressed in my Relationship; it's not Getting any Better, at Best, it's Boring; at Worst it's Painful, not Pleasureable."

This exercise is the easiest, quickest and most fun way to reawaken good feelings for your partner.

Self-help adaptation of Exercise 1: 'Your Natural Child – Opening up and Reaching Out': Sit in a chair and imagine your partner, instead of a little toddler friend, coming towards you. If you wish, put a pillow in a chair facing you. (An alternate position is to lie in bed with your knees up, feet on the mattress.) Remember to let your tongue hang limply out of the corner of your mouth as you reach out excitedly to your partner. Another form of this exercise is great for improving the 'waking up blues' – go into the bathroom and see yourself in the mirror as your little friend.

Problem B: "I Like to Think my Partner and I Are Compatible, But We Struggle a Lot for Control. I Don't Seem to Realize We've Been Struggling Until it's Too Late."

If you can energize your struggling for control, you will not only 'charge' your hands and arms, but you will also honor your Defenders who fear losing control. All this will help bring your struggling to consciousness instead of denying it. Then, the next time you begin to struggle, you'll be

able to recognize it, and you'll have a choice whether to take a different course of action.

Self-help adaptation of Exercise 2: 'Charging your Hands/Arms by Struggling for Control': Imagining one hand is your partner and one hand is yourself, have the fingertips of one hand press against and resist the fingertips of the other hand.

You may also need to express anger; if so, adapt Exercise 3 by imagining your partner facing you.

Problem C: "I Am Always Carrying Around a Low-Key Resentmen Towards my Partner. What's it About? How Do I Get Rid of it? For Sure There's no Pleasure in it!"

If your Defenders are living in fear of being hurt by your partner – that alone could make you angry. If your Natural Child has the impulse to open its heart, but the impulse is shut down by the Defenders, that also could make you angry.

Self-help adaptation of Exercise 3: 'Releasing Anger in your Hands/Arms through Involuntary Movement': Imagine your partner is sitting or standing in front of you – the target of your clawing.

Problem D: "I Am Defended and Closed to my Partner; I Don't Want to Open to Them. "

If you fear being hurt by your partner, you have to feel you can protect yourself before you can take the risk to open out to them. (You have to be able to say "No" before you can say "Yes.")

Self-help adaptation of Exercise 4: 'Closing yourself or Opening yourself': Imagine your partner standing in front of you. Alternate between thinking "I can close up and protect my Natural Child from you" (as you protect your heart) and "I can risk to open up and have pleasure with you" (as you open your vulnerable chest and, *with palms facing each other, reach to your partner*).

Problem E: "I Scarcely Touch my Partner Anymore. I Am Reluctant to Do so; it's as if my Hands Are Numb. However, I Touch my Dog and Cat a Lot and Really Enjoy That!"

The following exercise could reawaken feelings of reassurance and/or feelings of relaxation as well as the potential for pleasure with your partner.

Self-help adaptation of Exercise 6: 'Sensitizing your Hands/Arms for Pleasure': Instead of stroking only one hand/arm, alternate the stroking – first the left hand stroking the right hand and forearm, and then the right hand stroking the left hand and forearm. Let one hand/arm represent yourself, the other arm/hand represent your partner. In effect, you will be giving your partner pleasure, and then your partner will give you pleasure. It's important to coordinate the rhythm of stroking with the rhythm of your breathing.

If you wish to do this exercise in bed (it helps getting to sleep) or at the office, it is easier and/or less conspicuous to stroke only down to your wrist; this will avoid having to roll up your sleeve.

If your partner is amenable to participating with you in Exercise 5, *Touching for Reassurance*, both of you may find it deepens your appreciation for each other.

Problem F: "I Was so in Love at the Beginning. I Know at Some Level I Still Love my Partner, But I Can't Seem to Get Back to That Feeling, No Matter How Hard I Try."

Opening your heart to your partner is an important way to reawaken your love, and it will also give you the deepest pleasure. Moreover, when your heart is open you will find yourself naturally initiating pleasurable activities together, which will help keep your love flowing. (Of course, there are situations where it may not be advisable to open your heart towards a partner – e.g, if he or she behaves abusively towards you.)

Self-help adaptation of Exercise 7: 'Opening your Heart with Thank You': Thank your partner instead of thanking your Natural Child. You can thank your partner for many things – e.g., helping you open your heart to intense love at the beginning of your relationship. If you wish, the chest pillow could represent your partner whom you embrace as you exhale. If

your neck gets tired, don't lean your head back so far. Or do the exercise in bed – but then you really need to press your shoulders and buttocks against the mattress to arch your back.

Assessment
Reflect upon your emotional/physical reactions from having experienced the adaptations of the exercises for couples in Section III.

In your relationship with your partner, where do you experience the most difficulty – opening your heart? Reaching out? Or touching them? Or is it difficult to see them as a source of pleasure, or be able to perceive sensations of pleasure with them?

Can you share your findings about *yourself* with your partner? Can you get feedback from them on how they perceive *your* problems? (Caution: do not use that discussion to analyse your partner's problems!) Can you then take their view of you and your own self-assessment to your therapist for deeper therapeutic work? Can you and your therapist design a self-help program for you to follow?

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Helping Children Discharge Negative Aggression

Dennis McCarthy

Summary

This article examines the need for children in treatment to be able to discharge negative aggression and describes various means of helping them do so. Through case material and anecdote I focus on the capacity for dynamic play therapy to facilitate pulsation, obvious in the child's play configurations and their bodies in movement. Every child I work with engages in the expression of negative aggression to some extent and this aggression is often in and of itself a significant component in solving the myriad problems they bring with them. This text is largely influenced by the work of Dr. Alexander Lowen as well as the thousands of children I have worked with.

Keywords: discharge, pulsation, sandplay, filter, monster.

A Case of Working with Aggression

The seven-year-old girl sitting beside me at a small wooden table is making a figure out of clay and smashing it repeatedly with a large rubber mallet. I have invited her to do so and she has taken to it with enthusiasm. She alternately has imagined the figure was her twin brother or her father. She is clearly thrilled by this unbridled outpouring of rage. She laughs loudly, not something this once very serious child was prone to do. In the next session it

will be a girl at school or perhaps her teacher, who "smiles at the class when she is angry" that bites the dust. Her smashing of clay figures eventually will evolve into smearing the clay into the table with great intensity and this action will be pivotal to the resolution of her problems.

At around five years of age she had developed a phobia of dogs that had become quite severe. The phobia arose without any obvious provocation from the outside world. I would say it arose as her organism's means of crying out for help. Then she began periodically biting her brother and this precipitated her parents calling me. Her parents described their daughter as seeming self-possessed but cut off from others. She was also prone to unprovoked outbursts of rage. She was content to play by herself for hours on end and seemed uninterested in or intolerant of other children. Her father, an admitted control freak, found his daughter's stubbornness hard to take. Her mother admired the innate strength she saw in her daughter, wishing she had been more so when she was a child, but she was aware that the episodic explosions it manifest in didn't really satisfy her. Her daughter's usual serious, rigid demeanor and lack of friends also concerned her.

Anna's initial play sessions took place in the sandbox where she made elaborate worlds with the miniature figures I have on hand. In sandplay the child is encouraged to manipulate the sand and then add figures to it to depict a world. This world may come to life, evolve or even fall apart once it is made. Anna's initial scenes reflected her intelligence and creativity, yet the worlds depicted therein had rigidity to them despite their strength, just like her. They were filled with potential, depicting different aspects of life such as play, work, war, commerce and even mystery in separate sections all circling a central lake. She gave them titles such "The World" and then "The Whole Wide World". As the titles increased in size, the scenes became fuller of life and potential. Yet something fundamental was missing that would integrate the fragments of life shown and really energize the scenes.

With the introduction of clay and permission given by me to smash it, the missing or suppressed life force began to show. It was her smashing of clay figures that shifted everything, especially when she reached the smearing stage. During this smearing phase she began to fight with her father at home and picked fights with me in her sessions. She began to assert herself with her brother with words rather than in the infantile manner of biting. She was struggling to integrate the power of the smearing and needed to

push against others in order to do so. Her father tolerated this with my support and came to admire her for it. I encouraged it in our sessions. The intensity of her smearing and the catharsis it represented was at the same time playful. Unlike an adult experiencing and expressing a similar rage, hers was accompanied by great laughter as well as pent up fury. I would say it was furiously triumphant.

This paralleled a phase in her sandplay where the worlds melted and blended slowly into one soupy mess. She had regressed, loosening the rigid structure of her body along with it. When the worlds she had created and dissolved eventually reorganized they were more dynamic, less symmetrical. In her life, she became more consistently assertive, more able to make mistakes and more content with herself and as a result with her peers. Her musculature had both softened and solidified. She was no longer phobic of dogs, but rather came to like them, as she had integrated the aggressiveness of the dog bite into her person. One could conjecture much about her symptoms and her family situation, but ultimately what changed things was her ability to rage, aggress and then let it go. It is important to note that Anna did not experience her regression as disturbing, nor did it manifest as such. She regressed in the service of the ego and she immediately benefited from this, aggressing in her life as a result.

Safe and Satisfying Aggression: The Boy with Wings

In my play therapy practice with children I find that the bulk of my efforts and the key to my frequent and dynamic successes comes from encouraging and facilitating the safe and yet satisfying expression of negative aggression. Every child I see, regardless of their symptoms, their family situations, or their age and gender, spends a fair amount of time in the course of treatment in pounding, smashing, tearing, and in other active forms of discharge. It comes out in everything they do once they are certain that I really welcome it. This is done in the context of play and usually has an element of humor and often results ultimately in a purely creative expression. Often times an image will emerge literally from the playful discharge that is positive and powerful.

One boy with a potentially terminal neuromuscular disorder, after being

told the prognosis, spent many sessions venting his fury about his possible demise. Then in one session he asked me to help him draw a large pair of wings, with brightly colored wing tips. We made them collaboratively and in total silence. After they were done he had me hide them away in a safe place. The shift in him was amazing after this event, with a new positive attitude and a resolution to do everything possible to survive. But these wings came out of weeks of negative discharge that was quite brutal at times. For children who have been abused, neglected, or otherwise traumatized or children with neurological issues the phase of negative discharge can take much longer and it may need to happen again and again. Our ability as therapists to encourage, tolerate and help contain this negativity is of course central to its efficacy.

Play Material

Drawing Monsters

I begin treatment by inviting each child to make a drawing of what they would look like if they turned into a monster. I encourage them to imagine they have drunk a magic potion and that their body is transforming from the inside out into that of a monster. Then I ask them to draw this monster they have become. This is always embraced readily even by the lost timid and fearful of children. The walls of my office are decorated with the results of this query. These monsters are in and of themselves a form of discharge, and are also a portal into the inner world of the child. The monster speaks their language and they respond in kind. I am inviting the child to bring all of themselves into the therapy space and relationship, including the ugly, scary parts.

The Deep Sandbox

There are several play materials that offer effective means of discharging negative aggression, as well as helping children express and integrate the

new energies that arise when this aggression has been expressed. A sandbox that is roughly 1 and one-half feet deep and 2 and one half feet wide offers a means of constructing, destroying and reconstructing forms. It is not only the scenes and stories that children create in it that have meaning but also the actual shaping and use of the sand itself. The shallow box used in traditional sandplay does not allow the expression of deeper emotions as easily in my experience. When children are truly engaged in the process, the sand's depth can be used to replicate the depth in the psyche and in the musculature, and then they can access the defenses and blocks that have been erected. As they manipulate the sand, children often have a very obvious physical reaction to it. They pass gas, sweat, and sometimes they even pant. Just the act of squatting by the sand and putting their hands into it deepens their breathing. They often have to run to the bathroom. Things get stirred up.

Scenes can be created with the use of miniature figures and these may express in pictorial images and stories the pent up negative emotions, giving rise and form to them in children who have been unable to express them. The sand offers a grounding material for these emotions that helps solidify the new energies rising to the surface. So many children fear that their rage will destroy the whole world if unleashed; yet in the sandbox, the world can be made and destroyed and re-made. The sand being contained in a box actually intensifies its effectiveness, helping to contain what happens therein. The material itself is like a filter, a version of the psycho-muscular one all children need to develop in order to self regulate and in order to be a self. Lowen talks about the need for the filter that self-assertion creates in children. (Lowen, 1970) The sandbox is a great space in which children can develop this filter.) The entire process of expressing negative aggression activates this filter. Because children prior to puberty become what they play, each experience potentially affects all of who they are, both body and psyche. The division between the two is still thin in most children, even in guarded ones like the girl above.

Many therapists focus too much on what all the many little figures that children select and use in their sandplay may mean. They get lost in interpreting them, missing the energy that these symbols contain and what they help the child access. The stories these figures are used in and what these might allude to is of course of interest but their ultimate meaning is in the aliveness they bring to the surface.

Clay Facilitates Transformation

Clay is a frequently used material in my work as it too is both self-affirming in its use and allows for the "form to formlessness to form process" so crucial in therapy with children. This form shifting is an expression and experience of pulsation for children, and this often is apparent in the shapes they make as well as the effects it has on them organismically. One popular form of clay play involves the child and myself each making monsters out of clay and doing physical battle. Although this allows for a great deal of vengeful play on their parts, the very nature of clay allows for a continual **regeneration**. The forms can be made and remade endlessly. Children become less afraid of their impulses and their anger.

Drawing Replicates Pulsatory Experience

Drawing, if used creatively, can replicate this pulsatory experience as well. My office walls are covered with monster drawings in which children have imagined themselves as monsters and drawn them. I think these monstrous images are what make most children comfortable when they come into my office for the first time. Rather than being put off by these monstrous images children sense that the monstrous parts of themselves are also welcome in the space, perhaps the only place in their life where this is so. Because the monster is often one of our first creative acts as children, we are attached to them even as they repel and frighten us. In observing a series of monster drawings by the same child over time I often witness an expansion and contraction of the form. It is quite amazing to see how this impulse towards pulsation emerges again and again. I have devised numerous drawing games that allow for negative aggression to be expressed, and as with clay and sand, the destructive play always eventually becomes a creative expression and experience.

Physical Play

More purely physical play activities allow for a variety of means of discharge and expression. I offer gross motor forms of expression such as pounding,

leaping, stomping and storming. I also offer fine motor forms of raging, such as chopping clay using a butter knife or a miniature guillotine, which is the most popular item in my miniature collection.

Fear of Thunderstorms

Recently a child began therapy with a terror of thunderstorms, a fairly common fear that can easily become a phobia as it had for this boy. I invite children who have developed such a phobia to "become the storm" using movement, percussive instruments, and movement. They experiment with being the thunder and especially with being the lightning. I invite them to climb on to chairs and leap down with a great crashing thud as I accompany them with drums and rattles. As they learn to tolerate the energetic charge of the storm, which they do remarkably quickly, other aspects of their lives change as well. They take up more space. They calm down but at the same time increase their ability for self-expression and communication. Children rarely think it odd that I am asking them to storm. It makes complete sense to them.

This particular boy had a variety of problems that all stemmed from his mother's post-traumatic memories of sexual abuse that surfaced while she was pregnant with him. The boy struggled to accept his own aggression, unconsciously associated with his mother's negative experience of male aggression. He was also afraid of ghosts and of roosters, which one could easily associate with his mother's childhood. His storm phobia was the most immobilizing symptom so we tackled it first. It abated immediately upon his storming with me. The ghosts he so feared began to disappear as he drew them for me and they took form, increasing in elaborateness as they decreased in their negative grip on him. In giving form to the formless he came to be less afraid of his own imagination. The roosters also lost their charge when the boy's own aggression became more integrated.

Combining Play Material and Physical Play

Many children will use a variety of these materials and forms while others will focus exclusively on one. But it is the job of the therapist to sense

what is needed and what most satisfies this need and then to facilitate this through permission, containment and even at times provocation. The safe and satisfying discharge of negative aggression is an essential element to in-depth work with children that most therapists either don't use or openly discourage. There is a tendency, at least in the U.S., to ask children to "talk" about their feelings and then get over them. Any aggression is deemed counter-productive. Dynamic play therapy involves working playfully with the symptoms, the thwarted impulses, and the blocked aliveness present in all children with problems, and meeting the child where they are rather than asking them to meet us where we are.

The Case of David

Eight-year-old David began therapy in the midst of his parents very ugly divorce. He entered my office in our first meeting with weighed down shoulders and great sorrow etched in his face. I asked him to draw himself as a monster and after sitting with his paper and pencil for some time he drew a huge dragon-like creature with multiple rows of teeth. He was excited by what he had made. Then he used clay to express the aggression and rage that the monster drawing had stirred up. The level of fury of his clay play surprised me. Over several weeks he made numerous figures out of clay and devised ever more intricate ways of torturing them. He chopped up sticks and pounded them into various body parts. He made coffins out of clay lined with sharp sticks and then embedded clay figures in them. His parents, who often saw the results of his play when they came in afterward, were shocked by such sadistic impulses. Where had all this fury come from they wondered. Yet with very little help they realized that their son had felt similarly tortured by their fighting. They understood that he had felt poked and stabbed by the vicious and cruel things they said to each other. It woke them up and as they made efforts to curb it, David's play lost its intensity. His body had changed drastically. Not only were his shoulders relaxed, but also he moved more loosely and seemed to take up more space as he strode into the room. His face reflected confidence rather than sorrow.

Aggression and Regression

The Boy Who Stopped Eating

The word aggress is the opposite of regress so we must assume that some if not a great deal of aggression will be expressed along the way. Even alluding to play that expresses aggressions and/or rage satisfactorily can bring about a shift, such is the power of this with children. One very angry and very blocked young boy had basically stopped eating in a battle of wills with his parents. He used a guillotine in his first sand scene without realizing what it was. He thought it was a food slicer. When he learned it was a device for chopping heads he was initially very shocked. He was very proper and proper children did not use such things. While he held it in his hand, hesitating for some time over whether to use it, I mentioned that some children actually made their sisters out of clay and used it to chop their heads off. I knew that the birth of his younger sister had precipitated his angry but constricted state. He replied that he would never do such a thing, but with a smile on his face he put it back in the sand and incorporated it into his scene as just what it was, a head chopper. He went home that day and began to eat again. It was a first step towards resolving his issues but a significant one. Done in the spirit of play, each aggressive or rageful expression or even, as with this boy, the allusion to aggression can shift the child energetically.

This type of play facilitates discrimination, that all-important ability to distinguish what is us from what is not us. It allows for the "no".

> "The no functions like a psychological membrane, such as the skin, in its purpose. No prevents the individual from being overwhelmed by outside pressures. It allows for discrimination. It allows for impulse control. It defines the ego boundaries of an individual. It helps filter out what is good from what is bad for the organism. It affirms what is "I" from what is "not I". Lowen (1970)

Baby Talk in the Service of Growth

Unlike therapy with adults in which naming the emotion and understanding its origins is important, it is imperative that children express and discharge

this aggressive fury in a playful form. When done properly this can bring about brief regressions. I often find that children leave my office and for a few hours or even a day may speak "baby talk" at home. As I warn parents that this may occur and that it is in the service of growth, they are usually not too concerned and are sometimes even thrilled as it is often accompanied by a reduction or disappearance of symptoms.

Play therapy that allows for the discharge of negative aggression facilitates pulsation. It is often apparent in the child's play configurations as well as in their facial expressions, their pallor, and their movements. In play, once a child has begun to unblock, the structure of their creations actually moves session by session or sometimes within one session between contraction and expansion. One boy brought toy figures with him each time he came to see me that he never actually used. They served some totemic function. Each week they got larger, until one day he came in carrying a dragon that was bigger than him. Then they began to shrink in size until he stopped bringing them all together.

Pulsation

Pulsation in the Sandbox

Pulsation may happen in a child's use of the sandbox. Their play may slowly spill over the edges and out into the room and then suddenly contract back into the center of the box. There is always a shift in the story line when this happening or the appearance of a new character or symbol or form. This expanding and contracting is quite awesome to witness and very frequent when play is therapeutic, though often not noticed by many therapists. For example, I saw a series of slides by a sandplay therapist of sand scenes made by a four-year-old girl who had been sexually molested. The therapist was very attentive to the need for the child to express rage, although she did not offer a direct means of venting it. And yet in this girl's scenes one saw week by week the configuration of the sand and the figures in it move from a contracted use of the central space to a wide-open expanded use of the whole sandbox. It looked like slow motion explosions! During this

period there were obvious signs of healing in her life as well. Interestingly, she would create a sand scene that was full of snakes preceding the expansion in the play configurations. Snakes are for most children a symbol of positive instinctual energy moving in them in new ways, as in the concept of kundalini in yoga. They often appear in the sand or in clay when real movement is happening within the child's body and psyche.

Pulsation and the Twin Brother

In the midst of writing this article I had a dynamic session with an eleven-year-old boy who had spent much of his time pounding on the mattress in my office. When our time was up we went into the waiting room where his twin brother was waiting with his mother. This twin has a very serious seizure disorder and had recently had brain surgery to attempt to correct it. He was lying exhausted on the couch but my patient urged his brother to come in and try using the racket. He assured him he would think it was "cool". The twin dragged himself in and began to pound on the mattress. It immediately revived him and we all watched in amazement as he leapt into the air prior to each pound. His mother assured me with tears in her eyes that her son had never exhibited such behavior. She was thrilled to see him act so dynamically.

The boy began to alternate his pounding by including a conga drum that stood nearby: two hard hits on the mattress and one very gentle tap on the drum. He was like a mime or a dancer as he switched from aggressive to gentle movements. What began as a purely aggressive exercise ended in a purely creative one. He left refreshed and happy.

Aggression and Play

This paradoxical mix of humor and fury, of negative aggression and positive play that coexist often in the same moment are what I think makes play therapy hard to fathom for most therapists. They aren't sure where to look or what to make of this or how to allow the two opposite impulses to be entwined. Yet they are for most children. Again, the beauty of play

therapy is the potential for children to "play" with new ways of expressing and experiencing themselves just as children play with weight shifts and balance when they learn to walk. Falling down and getting up again are a central part of the process. All growth happens more easily when done in a spirit of play. Even the expression of rage in the right context with a therapist who can contain and redirect the energies therein can be a playful, and even joyful, endeavor.

True Playfulness

In his book *Toys and Reasons*, Erik Erikson cites Plato's *Laws* as formulating the best definition of play. It is an apt description in the context of these pages. He sees the model of true playfulness in the need of all young creatures, animal and human, to leap.

> "To truly leap you must learn how to use the ground as a springboard, and how to land resiliently and safely. It means to test the leeway allowed by given limits, to outdo yet not escape gravity. Thus wherever playfulness prevails there is always a surprising element, surpassing mere repetition and habituation, and at its best suggesting some virgin chance conquered, some divine leeway shared. Where this happens it is easily perceived and acknowledged."
> Erikson (1977)

Parents Response to Children's Aggression in Therapy

I find parents never challenge my encouraging their children's expression of negative aggression. Perhaps it is because happier they always emerge from my office in a happier state. Perhaps they are relieved themselves by their child's discharge, which can create an opening, a possibility of change even in them. Since I work in private practice the bulk of the children I see come from families that are less dysfunctional. The children's problems may be severe and yet the family is more capable of tolerating and even supporting change. But I have in the past worked in clinical settings with more low functioning children and this type of play applies to children who show up there as well. The process is simply slower and

often impeded by inconsistent visits and/or interference from the family. But the capacity to discharge negative aggression along with the strong emotions embedded in it and recover or discover one's sense of self as a result is the same.

How Modern Culture Constricts Discharge in Children

I have noticed a very large increase in children's need to discharge over the past ten years and I attribute this to the fact that children spend almost no time out of doors in spontaneous play. When children did, they had the possibility to discharge through normal play, which is one of the functions of it. This obviously did not solve all problems but it did help. It gave children greater access to their bodies and the positive sensations that arise when we are moving freely. But as children spend virtually no time outside and very little if any time in active, unstructured play, they become more bottled up than ever. Public schools limit children's time outside, often insist that children have no physical contact with each other and even limit how they move, all in the service of crowd management and aggression control. The use of video games and cell phones in ever younger children as not simply a desire to fit in on the part of both child and parent but also as a means of keeping children contained, further cuts children off from themselves. The result of all this constriction on the child's developing body and psyche is obvious, resulting in children with a far greater need to discharge negative aggression safely.

The Innateness of Aggression

Aggression is a fundamental part of being human, much maligned and thwarted but ever present regardless. In Konrad Lorenz's epic study *On Human Aggression* he documents the innateness of aggression in the human psyche *a priori*. It doesn't have to be provoked by inner frustration or outer threat. He proposes that aggression erupts spontaneously and requires some form of regular discharge. He also found that the ability to form something akin to a personal bond occurs to the degree that aggres-

sion is felt and expressed between fellow human beings. Lorenz believes the ability to bond with others and the ability to express aggression are a part of the same pattern. Certainly in my experience with children this has been consistently true.

Anna's Psychic Filtration

When Anna, mentioned in this article's opening paragraph was able to aggress she did in fact form stronger bonds with her parents and brother and began to form healthy peer relations. She was also more connected to herself. After smearing clay and making a soupy mess in the sand she went on to create a very moving scene in the sandbox. She made a well in the midst of a village. The well led underground to the nearby ocean and it was a filter for cleaning the seawater by funneling fresh water into it and taking out the bad water. She described in remarkable detail how this filter worked and made the sea unpolluted. She was describing a psychic filtration device created in herself by her playful yet deeply cathartic aggressive discharge.

Controversy over Cathartic Play in Therapy

The idea of cathartic and/or aggressive play is very controversial. Many therapists strongly discourage it, seeing it as encouraging out of control behavior rather than functional adaptation. In a recent issue of the International Play Therapy Journal there was an article condemning the use of something called a "Bobo doll" in clinical settings as a means of venting violent negative emotion. (Drewes 2008) The article also condemns all forms of cathartic play in the process. There is no mention of Bioenergetics in the article or in the many references, and it seems that the intention of most of the studies cited was to disprove the approach. It may be that beating a Bobo doll is not a good idea, especially if done with the wrong children by the wrong therapists in the wrong setting.

Discussion

I do think that to encourage the type of play I have been describing is not to be done lightly. Engaging in one's own dynamic therapy process is important. The child needs to feel safe and sheltered in the therapy space and in the therapeutic relationship. And the therapist needs to be in control of what happens, guiding it and even provoking it, while remaining focused on integration and grounding. I feel my way with the child, sensing what they need and what they can handle as well as how best to engage them. Understanding the paradoxical nature of play therapy is essential, in which humor and deeply disturbing emotions can be present together and in which the child moves from aggression and destruction of form to creation with the support of the therapist. The materials used need to offer the capacity for grounding, such as sand, clay and movement. To engage in this type of play with children who are too disturbed to benefit from it would be unwise, but when we are really attuned to the child we will not make this mistake.

Because I work in private practice the parents who bring their children to me are doing so of their own volition and usually because they care and/or their child's symptoms have become loud enough that they have heard the cry for help which symptoms often are. But I do work with many children with serious problems or potentially serious ones, and most of the children I see can handle some form of aggressive play and benefit from it immensely.

All children need to discharge negativity as well as to find a healthy means of expressing the positive aggression that is part of their aliveness.

Therapy with children should not only make room for this but I believe it should potentially be the centerpiece of the entire process. If we encourage children to not be afraid of themselves, to view the various emotions, instincts and impulses they struggle to master as part of what makes them human, then they are free to be themselves. True compassion and love, so absent in our world, arise out of this.

> "The essential requirement to cure psychic disturbances is the re-establishment of the natural capacity to love." (Wilhelm Reich)

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Dennis McCarthy is a licensed mental health counselor in New York State with over thirty years experience working with children and adults. He was initially trained as a dancer and a dance therapist. He studied Bioenergetics for many years with Al Lowen and Anthony Rullo among others. He is the author of numerous articles as well as two books, "*If You Turned into a Monster"…Transformation through Play: A Body-centered Approach to Play Therapy* and *Speaking about the Unspeakable: Non-Verbal Methods and Experiences in Therapy with Children*, both published by Jessica Kingsley.

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The Role of Bioenergetic Supervision in Bioenergetic Training

Alex Munroe

Summary

Supervision plays a key role in a trainee's movement towards certification as a Bioenergetic Therapist. It is therefore important to clearly understand and discuss the components of Bioenergetic supervision. Some commonalities for supervision in psychology, social work and Bioenergetic Analysis are set out. Aspects of supervision that are unique to Bioenergetic Analysis are identified. The paper concludes with an exercise to help the reader experience some of the Bioenergetic concepts presented. The paper is a beginning attempt to contribute to this discussion.

Keywords: Bioenergetic Analysis, Psychotherapy, Supervision, Social Work, Training

While there is much written in psychology and social work about supervision, there is very little in the Bioenergetic literature. I could find only one article in the Bioenergetic Journal and there are 2 papers from the Black Butte (U.S.A.) Conference, but they are not published. This is an area that needs more exploration.

My purpose in this paper is to draw upon supervision concepts in other fields and apply this to Bioenergetic Analysis, as a way to contribute to the dialogue. I will briefly sketch the purpose of therapy, then describe the supervisory relationship, and conclude with a discussion of supervision in

more depth, including supervisory tangles. I will provide an exercise you can use to get the "*feel*" of the supervision process. My hope is to stimulate a discussion which will allow us to share ideas on how we can bring supervision more into the body; how we can put a bioenergetic stamp on supervision.

In this paper, I will use the term "*trainee*" to refer to the supervisee. All trainees are therapists and bring their therapeutic skills and experience of supervision to the Bioenergetic training. And while supervision is used long after certification is complete, its evolution and core themes are most clearly seen in the Bioenergetic supervisor – Bioenergetic trainee relationship. The pronouns *he* and *she* will be used randomly throughout the paper.

Goal of Bioenergetic therapy

The trainee helps to free the blocks to the client's pulsation and self possession by helping the client become more aware of the life of the body and to gain a deeper "*sense of self*". A "sense of self" will include the body self, with its language, wisdom, creativity and experience. Stanley Keleman talks about formative process in experience, where forming takes into account the person's need, awareness of the other and the context both are in. The trainee helps the client integrate the physical, emotional and cognitive processes that interact within the person and are a part of living. The trainee serves as a supportive human being through which the client can ground, feel support, and experience their ability to confront, in order for the client to connect more with his body. This allows the client to identify the fixed beliefs and behaviour responses that limit their creative response. The client can alter these *habit responses,* which can result in greater choice and more vitality for daily living, because it is "*body based*".

Bioenergetic Therapy seeks to bring about the conscious integration of mind and body by working with the unique relationship that exists between various levels of experience: *cognitive, emotional, physical, spiritual and energetic*. There are limits to what each client can do, and to the pace of change and healing that each client can manage, without their contracting against the change.

Core Skills to Learn

Basic therapeutic skills that are a part of all modalities are: beginning where the client is at, following the client's change agenda and moving at the client's pace. They are also key themes for the Bioenergetic trainee. In addition, specific Bioenergetic skills to be learned in the training program include:

- reading how the aliveness of the body is shaped,
- seeing how developmental deficits are structured into the body,
- reading how grounded the person is,
- assessing what realigning of the body is possible in support of increased aliveness,
- assessing what resources the body has to deal with flooding.

Learning the above is not without its problems and tangles. The trainee may misread where the client is at or may insert her own agenda (especially when the client's wound is similar to the trainee's). The trainee may move too slowly or too quickly because of misreading the client or not noticing the meaning the issue has for the trainee.

Central to the training process is that the trainee be a real person, be grounded in his body so that he can have his body as a therapeutic tool. This means he has his own style, personality, wounds, energy, therapeutic background of various modalities, exposure to various teachers and therapists who have all contributed to his being where he is right now.

The nature and purpose of Supervision

The Bioenergetic supervisor has a key role to play in this process of helping the trainee take the above mentioned unique mix of knowledge, skill and experience and link these to Bioenergetic concepts and healing tools. The supervisor-trainee dyad is a sub-system of the treatment system, influenced by and influencing the other components. At its core, supervision provides support for the healing process. In doing so, Bioenergetic supervision has much in common with supervision in general. Compare the following descriptions, one from psychology and one from social work, with a third from the Bioenergetic field:

Psychology

> "Originally understood as an educational process for developing knowledge and skills in clinicians, supervision now has a broader definition. The clinical supervisor is responsible not only for the educational aspects of supervision but also for administrative and supportive functions." (Taibbi, 1995, p. ix)

Social Work

> "Clinical supervision is an interactional process in which a supervisor has been assigned or designated to assist in and direct the practice of supervisees in the areas of teaching, administration and helping." (Munson, 1993, p. 10)

Bioenergetic Analysis

Supervision provides "… a supporting hand on the therapist's back to help him become a better therapist" (Campbell as quoted in Weigand, 1997, p. 13)

The Supervisory Relationship

Tamara Kaiser (1992) describes 3 components that are required for a successful supervisory relationship:

- ➢ Shared meaning (having a common approach to therapy, what it is, what the role of the therapist is and how people change; what is expected of supervision),
- ➢ Trust (creating a safe and respectful space, transparency and honesty); and
- ➢ How the issue of power and authority is addressed. (Kaiser, 1992, pp. 55–60)

These components provide the container that allows for growth of the trainee and will need to be continually monitored. They are dynamic rather than static states.

Goal of Supervision

Supervision is a process that helps the trainee step back from the soup of the therapy session and gain additional perspective. This stepping back helps the trainee notice several things: the nature of the client's process, how the trainee is using them self in helping the client heal, and how the trainee might add to and develop her skills in supporting the client's journey, whether it be by the client healing old wounds, by the client acquiring skills to better deal with developmental deficits, or by the client's re-learning to live *in* their body.

The supervisor supports the trainee's professional self and style, and helps the trainee incorporate a Bioenergetic approach into her practice. This requires the supervisor to "read" the trainee, much like the trainee "reads" the client. Some of the responses the supervisor is tracking are: what changes are there in the trainee's body as the story is told; how does the energy field of the supervision relationship change; how does the trainee draw upon her strengths or use her wounds as a guide; and what other modalities of healing does the trainee draw upon to compliment Bioenergetic work. Bioenergetic concepts are being incorporated into the existing therapeutic approach the trainee utilizes.

And, of course, the above "*core skills to learn*" apply to the supervisor: begin where the trainee is at; follow the trainee's agenda; and go at the trainee's pace. These all have the same potential pit-falls that the trainee faces in his work with the client.

The supervisor helps the trainee learn skills (i.e. acquire the *science*) **and** use their personality and style as a therapeutic tool (i.e. develop the *art*) that makes up the therapeutic process. The supervisor is working with the trainee's question: "Why am I feeling stuck?", "Is there another way to help the client?", "Why did this work?", or "I want to understand & see this person more clearly". Part of the answer to the question being brought comes through the trainee learning about Bioenergetic ways of seeing and doing and learning appropriate use of a Bioenergetic approach. A key tool the supervisor has is that of *teaching by example*. The supervisor's modelling of support, pacing, not imposing, and helping the trainee integrate Bioenergetic work with their other modalities, all model the *HOW* of the therapy process.

There is a level of commonality we have as Bioenergetic therapists in seeing and understanding energy and in how we move as therapists energetically. There is also a great deal of difference between Bioenergetic therapists. As a supervisor, I adhere to Bioenergetic principles and concepts while helping the trainee find his own way to use these concepts and principles. The outcome will be another unique Bioenergetic therapist.

Similarities Between Therapy and Supervision

The trainee sees more than the client is able to because of training and distance from the emotions of the presenting issue. The supervisor sees more than the trainee can see for the same reason. There is an advantage to informed distance – the trainee can feel *and* think. The trainee must be free to bridge the distance in order to empathically walk with the client, and to retreat enough to be a guide and offer perspective when this is appropriate. The supervisor also has the benefit of informed distance which must at times be bridged to support the trainee and to try and keep hold of the unique perspective the trainee has. The trainee's style and skills are the tools which are being used.

Parallel Process in Supervision

One resource for the supervisor is "parallel process", or the re-creation of the therapy "unit" in the supervision session. Working with parallel process requires the trainee and supervisor to think both intra-psychically **and** interpersonally … it is a relational way the client has to convey to the trainee, what the psychic struggle is like. (Mothersole 1999)

Ekstein and Wallerstein (1958) first used the term "*parallel process*" when elaborating on the work of Harold Searles (1955) and his discussion of the "reflection process". (Searles 1955) There has been increasing attention given to the unconscious re-creation of the struggle in the therapy dyad, and from there into the supervision dyad. The nature of parallel process is that through the unconscious needs of the client, the trainee is invited into a complementary role where the life struggle can be re-enacted, but

this time with a positive outcome. As the trainee becomes entangled in the therapeutic parallel process, she brings her struggle to the supervision session and a similar re-enactment is available. The trainee brings this *problem process* to the supervision session.

> "We must recognize the complex interactions between patient, psychotherapist and supervisor which bind them into a systemic network. In such a network it is … often difficult to know which way the mirror is pointing." (Mothersole, 1999)

There are 3 possible sources of "problem process" that the supervisor needs to assess: those that are client based (the client's wound is being expressed); those that are trainee based (the trainee's wound is being expressed); and those that are supervisor based (the supervisor's wound is being expressed). The supervisor and trainee both can benefit from working through this tangle – it will provide guidelines to the trainee's therapy needs, point to areas for skill development and help the trainee trust in their intuition and skills. It can benefit the supervisor in similar ways.

Parallel Energy Fields or "Resonance"

From an energetic perspective, both the trainee and supervisor are also responding energetically to the other person's field, like a tuning fork. People are continually noticing and responding to behavioural cues, body language, and non-verbal messages that are being sent out, in the "*dance of life*" (Hall, 1989). People also respond to the energy field that is present, as evidenced in the expression "*you could cut the tension with a knife*". The concepts of *parallel process, inter-subjectivity* and *projective identification* describe different aspects of this phenomenon. Just as the trainee can access his own body for cues as to the nature of the struggles of the client, so too can the supervisor access her body for cues in monitoring how the supervisor is being invited into the "dance of life". So, both supervisor and trainee have their *cognitive, emotional, physical, spiritual and energetic* frameworks to draw upon, which gives them the shared meaning to which Kaiser (op cit) refers.

The Authority Issue

Addressing the issue of power and authority in a respectful manner, is another important issue Kaiser mentions. With supervision in general, there is a difference in knowledge and skill that the supervisor has. The Bioenergetic supervisor has authority that derives from competence and is sanctioned by the professional society (IIBA). In an agency, the supervisor has administrative power as well. The agency supervisor is in charge of the therapy and is accountable to the agency. In Bioenergetic supervision (as in training in other modalities), the supervisor is *outside* this power position since the supervisor is not working at the agency, or the Bioenergetic trainee may be in private practice and is in charge of her own work.

> "… the nature and extent of the supervisor's authority is vague, unstructured, and limited in sanction. Even with student practitioners, authority is vague because the supervisor is often a remote representative of the [training program] … and because trainees are encouraged to prepare to be autonomous practitioners." (Munson, 1993, p. 36)

In Bioenergetic training the supervisor is part of the team (trainer, supervisor, therapist) helping the trainee acquire the needed knowledge and skill for certification. This power position needs to fit comfortably for the supervisor. The supervisor must be able to *"stay grounded"* if the *"supporting hand on the back"* is to be trusted by the trainee (another of Kaiser's criteria).

"Staying grounded" means changing the form of the supervision according to the needs of the trainee. The supervisory role evolves from being a teacher in the beginning, to being a guide, to then being a consultant, as the trainee's skill, competence, confidence and independence grows. (For an in-depth discussion of this process, see Taibbi, 1995) The power of the supervisor shrinks through these transitions, and the supervisor must be willing to follow the pulsation of the increasing development of the trainee.

Supervisory Tangles

If the supervisor has difficulty following the pulsation inherent in the lifecycle of the supervisory relationship, there is a block to the energetic flow

and armouring will occur. Also, problems can develop in the supervisory relationship because of supervisor stress, which leaves the supervisor vulnerable to old reactive patterns (character is always with us). The following are some supervisor-trainee tangles I am familiar with (both as a supervisor and as a trainee).

Showing off – here the supervisor's anxiety kicks in and the need to demonstrate skill takes over. Resisting an impulse to show off can be difficult, since the supervisor is helping the trainee do the work. It is the trainee's success and the supervisor can feel on the outside. Here, "… the narcissistic demands of the supervisor … [to] contribute insight about the session." have taken over (Weigand, 1997, p. 13). Or the supervisor may be reluctantly losing their teacher role, and be struggling to adapt to dealing with their excitement at seeing anew that is a part of the supervisory process.

Misreading difference as error (or deficit, blunder, mistake etc.). Here there is a divergence of shared meaning (Kaiser's first criteria for successful supervision). The supervisor may see what the trainee is doing as an error, when the trainee is simply taking a different approach. The trainee's approach may work for them but not for the supervisor – or the supervisor tried that approach and failed. This is particularly true on issues such as pacing, leading or following the client, or anywhere that Keleman's "accordion" concept applies. (Keleman) Much of what happens in therapy follows Winnicott's "good enough" concept. Is the trainee a "good enough therapist" to help the client grow? Is the trainee "good enough" to be certified? Errors in therapy either take the healing nowhere or harm the client, and repair is required. Therapy is full of errors; it is how we manage them that keeps the healing process going. Supervision is full of errors too, and facing them with the trainee helps keep trust, regains shared meaning and is part of the continual, and mutual, learning curve.

Collusion – avoidance of trainee and supervisor's counter transference issues. Idealization of an energetic trainee by the supervisor can blind a supervisor to helping the trainee see how his counter-transference issues are limiting the therapy. The trainee does not continue to grow, and his block to "seeing", "understanding" and "helping the client heal" limits his development. Another transference problem can stem from the line between supervision and therapy becoming blurred and the supervisor feels a-need to *do therapy* to help the trainee move forward. Or, the supervisor may feel

competition with the trainee's therapist and envy the great leap forward in the trainee's skill that can occur as a result of unlocking an old wound, or altering a "fixed false belief".

Fear of liability and judgement. The supervisor has the closest look at the trainee, over a lengthy period of time. Identifying to the trainee just what needs to be accomplished before certification, can be difficult. Articulating clearly what the gaps are that the trainee needs to address is difficult, since we are looking at a mix of science (knowledge, skill) and art (style, creativity, evolution). Speaking this within the boundaries of shared meaning, and respecting the trainee's uniqueness while allowing for both the trainee's and the supervisor's authority issues, adds to the difficulty.

The supervisor too has to deal with a power differential between international trainers and the supervisor's *self-perceived level of competence*, both as a therapist and as a supervisor. What if the trainee makes a mistake and is sued (and the supervisor sued along with him)? What if the supervisor is the only one who thinks the trainee is ready for certification? Is the supervisor aware of and comfortable with her response to the responsibility he (the trainee) has?

Below is an exercise that can help to "get the feel of" the concepts discussed above. As Bioenergetic therapists, we want to, and are familiar with, drawing upon the wisdom of the body to aid our understanding.

Exercise

- ➢ Think of a positive experience of receiving supervision. This can be where you felt seen, where you got useful information, where you were treated with respect, or whatever comes to mind. What do you notice in your body?
- ➢ Now think of a negative supervisory experience, where you didn't feel seen, where you didn't get useful information, where you weren't treated with respect, or whatever comes to mind. What do you notice in your body?
- ➢ Think about a client you are having difficulty with. Notice what is happening in your body.
- ➢ If you are a trainee (or a CBT using supervision-consultation),think

about what you want from a supervisor. What do you notice in your body?

- If you are a supervisor, think of a trainee bringing a tangled situation to you. What do you notice in your body? What will help you create a container that will be useful to both of you?

Protecting time to notice the above (often called "the practice of mindfulness") can help notice tangles. Our goal is not to be free from tangles, but rather, to notice them, to welcome them so we can work them through. We can then continue to grow and expand the ground of the art and science of Bioenergetic therapy.

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A Bioenergetic Clinical Case Study of Sarah

D. Emma Rhoads

Summary

This is a case study written as the final paper for my clinical training program at the New York Society for Bioenergetic Analysis. Our final year of training was focused on the study of transference and countertransference dynamics. The assignment for this paper was to present a case study including a clinical formulation of the characterological dynamics of the client's personality functioning, a bioenergetic body and character assessment, and an examination of the transference and countertransference dynamics within the treatment.

Keywords: case study, transference, countertransference, bioenergetic analysis

This paper explores the treatment of a young woman whom I shall call Sarah. Sarah was one of my first adult clients, after many years of experience working primarily as a psychotherapist with children. While Sarah appeared to be high functioning, this was only superficially true. Her psyche was in fact organized quite primitively, and her unconscious process dovetailed with my own in ways that left me feeling overwhelmed and ungrounded. It was a struggle for me to remain in useful contact with Sarah, and also with myself, during my encounters with her, and I found the case extremely challenging.

In her book, *Live Company* (l992), Anne Alvarez describes how therapists can distract themselves and their patients, by

"… resorting to elaborate detective-like reconstructions about the past causes of the patient's beliefs about herself. Links with the past … of course, are important, but they are no substitute for the study of the living interactions and of the often dangerous erosions of precious parts of the personality which may take place in these interactions."

This paper attempts to address some of the problems which arose in the transference and counter transference dynamics between Sarah and myself, which posed a great threat to "precious parts of the personality", (both Sarah's and my own), and explores how the course of treatment may have been impacted by these dynamics.

Identifying Information & Presenting Problem

Sarah initially sought out psychotherapy for help with a growing feeling of intractable despair, loneliness and lack of interest in her usual activities during the five or six months prior to beginning treatment. Medication had been recommended by a previous therapist she had consulted, but Sarah felt strongly that she did not want to use psychotropic drugs, and therefore decided to seek help elsewhere.

Sarah was trained as an artist and was a talented and accomplished painter, sculptor and draughtsman. She was active as an artist in a private way, but professing to have no interest in sharing her artwork with the public, she made her living as an administrator in an unrelated business.

Family History

Sarah was the eldest of five siblings, raised in a family who are followers of a separatist religious sect. Sarah's siblings all live close to home and are practicing members of the religious group. Sarah's family moved frequently throughout her childhood. These moves were made possible by the flexibility of her father's work, but instigated by his selfish desires, rather than the exigencies of his career, according to Sarah. Due to her family's frequent

moves, Sarah's friendships and group affiliations were disrupted over and over throughout her childhood.

Sarah described her father as a domineering and selfish man, completely self-involved and inconsiderate of the needs and feelings of the people in his family. Sarah described these traits in other members of his extended family as well. Sarah experienced her mother, (whom she described as coming from a family in which she was devastatingly lonely, deprived and subjected to repeated losses), as a frustratingly passive person who followed the dictates of her husband while completely disregarding her own needs and feelings. Sarah complained bitterly about her mother's inability to relate to her children as autonomous people with individual needs and emotions. Sarah described herself as having felt alienated from her family from an early age, and struggled with conflicted feelings of pride at her autonomy and rationality on one hand, and bitter feelings of rejection and abandonment, on the other. Every family must struggle to meet the needs of its members for both autonomy and connection in such a way that each member can feel bounded and contained within a psychic skin that permits connection and intimacy while also protecting identity and autonomy. This process was well beyond the capacities of any of the members of Sarah's family, who were already isolated from their surrounding community by virtue of their participation in a separatist religious group. The family's collusion in assigning to Sarah the role of the isolated 'other' was likely a function of a need, within the family system, for at least one member to assume the superficial appearance of functioning autonomously. Thus, the collective fear, within the family system, of annihilation due to separateness, isolation and abandonment could be managed by projecting these affects onto Sarah, who could at the same time act as the receptacle for her family members' unconscious longing/fear of healthy autonomy and individuation. This process may have permitted Sarah's other family members to persist in the mergers, enmeshment and self-abandonments which characterized their relations with one another. So, while Sarah felt scapegoated by her family, she was also continually choosing her role. And while actively pursuing, in both childhood and adulthood, a life separate from her family, she also thereby retained, and retains, her tie to them. Sarah's tortured feelings of being both unbearably separated from her family, and yet tied up and enmeshed with them, were essentially structured into her personality. The

attempts she made during her treatment to touch the feelings associated with this paradox created in her a panicked feeling of disintegration.

Unlike her other family members, Sarah did not feel primarily allied to her religious community, but more connected to the secular world of school and town. While Sarah was never outwardly rebellious, she describes herself as having felt frustrated from an early age by the feeling of separation from the world outside of her family/religious community, which was the inevitable result of living within a religious sect.

As a child, Sarah was an excellent student who threw herself into each new school she moved to with the intention to participate and achieve. She joined clubs, got parts in plays, and was popular among her peers. Sarah describes her friendships as limited and shallow, especially as she got older and became accustomed to being torn from her schools and communities. Sarah's parents tolerated, but did not make efforts to support Sarah's active participation in her school life. Gradually, in her teenage years, she began to inwardly reject the teachings of her religion.

During her treatment with me, Sarah complained bitterly about her inability, in her adult life, to establish the intimate, enduring, sustaining relationships, which she spoke tearfully of longing for. Her relationships with men had been characterized by power dynamics, each member of the couple attempting to gain and maintain the upper hand, and a lack of any real intimacy. In her friendships, Sarah described a pattern in which she became closely involved with a particular friend, often someone self-absorbed and needy, who then abandoned her when she or he found another venue for their needs, such as a boyfriend. Sarah spoke with bitterness and frustration about her inability to share her feelings with others and experience feelings of closeness – partly because she was unable to identify and articulate her feelings, and also because she found that the friends she chose tended to be quite self-involved. She complained that, over the past several years, she had become increasingly mistrustful of people.

Bioenergetic Body and Character Assessment

Sarah presented with a predominantly schizoid character structure, with oral and psychopathic traits also present. Sarah's body was in certain respects

well developed – she was tall, well rounded and shapely. At the same time, her body had a distinctly flaccid quality, with low muscle tone and a dull, damp pallor to her skin. Sarah had a general slowness to her, speaking in a languid drawl and draping herself on the couch in provocative poses, often exposing herself quite flagrantly in loose, low cut blouses and skimpy skirts. The languid, flaccid quality of her body was juxtaposed strangely by the frozen immobility of her joints, especially around her neck and the base of her skull. She barely breathed, and when she attempted to take a full breath the visible tension in her neck, tendons protruding monstrously through an angry red flush, was painful to witness. Sarah's face paled and reddened with the flux of her emotions, the skin on her face hardening and softening; her eyes often glittering with anger but also glazed by unshed tears. Energy blockage at her neck, the base of her skull and the ocular region stood out in contrast to her body below, which appeared superficially relaxed and soft, despite the tension around her joints and at her chest and back. Sarah described what felt to her like a bubble in the middle of her back, slightly to the left (behind her heart) where she experienced a persistent, unrelieved tension. Sarah frequently suffered from intense neck pain, originating from the left side of her neck, which radiated down her shoulders and arms, sometimes causing her so much pain that her stomach hurt and she was unable to turn her head. At the same time, she described not being bothered by the pain at all. On one occasion I suggested to Sarah that she try sitting up straight, her feet flat on the floor. When she did so, she suddenly appeared as a little girl, vulnerable and filled with grief.

The character dynamics guiding Sarah's personality functioning appeared to be predominantly schizophrenic. Her grasp of reality was tenuous, and she was not capable of meaningful self-reflection. Sarah often accused me, (in response to my occasional observations about how her early family dynamics might be impacting her current behavior/relationships), of blaming her for her problems. "This is not my fault!" was a leitmotif of her therapy alongside her insistence that she held herself responsible for creating the life she wanted.

Sarah's emotional life had a chaotic, undifferentiated quality. She once asked me, "How do you talk about emotions?" Sarah's relationship with her emotions had a primary-process quality. One physical manifestation of this infantile orientation towards herself and the world could be seen in

Sarah's inability to hold up her head when she attempted to relax her neck, even slightly, while taking a breath. At these moments, holding her head as it flopped limply in my hands, I was seized by a heartbreaking desire to take care of her as if she were a newborn.

Sarah's primitive orality was apparent in her unremitting longing for connection and sustenance, which she was barely able to recognize, let alone take in or metabolize, when it was offered to her in any form. Her low muscle tone and limited capacity to contain energy in her body was evidence of oral character traits. At the same time, paradoxically, Sarah's body had an intractable, brittle quality, especially around her chest and back. This brittle energy and muscle tension was juxtaposed strangely with the soft, penetrable oral quality of her skin and the superficial layer of tissue. The rigidity in her trunk did not appear to allow her body to contain energy the way it might in a rigid character structure. The tension in her trunk had more of the puffed up, swollen quality of narcissistic/psychopathic character traits made manifest in the body. These character traits could be seen behaviorally in the power dynamics that permeated all of Sarah's relationships, and the conflict between the desire to surrender and merge, vs. the need for autonomy, which was so evident in the energy she radiated, and her behavior with me in therapy.

Course of Treatment

Sarah was in therapy with me for approximately two years. An attitude of bitter, complaining oppositionality was present from the very first session, characterized particularly by questions, which she posed as an aggressive demand. Examples of these are: "How do you get past this?" "How can I become less impatient?" "How do I find a middle ground?" "What do I do about these friendships?" She was willing, reluctantly, to explore her childhood and family dynamics, but always returned to a whining demand for a solution, which was juxtaposed interestingly with her frequently repeated assumption of responsibility for creating the life she wanted and imagined for herself. Any active attempts on my part (beyond asking questions) to help her explore or more fully inhabit her emotions or her body, were usually refused, with comments such as: "If I try to do that, I feel that my

personality would disintegrate." During the initial months of treatment, Sarah occasionally surrendered to tears, but did not report or appear to experience any relief or self-connection through weeping. Several months into the treatment, Sarah began to announce herself as she entered the room, "Here I am, back again!" and when leaving her session she'd breeze off, always without eye-contact, saying, "Here I go, out into the world!" This was an indication to me that the therapy was beginning to function as a ground for her: a place she could believe existed, which she could leave and to which she could return again.

During the time she was in treatment, Sarah had several friendships with men who interested her, and also spent a lot of time talking about the various unsatisfying platonic friendships in her life. She talked about the painful isolation and lack of connection in her life, complaining that no one she knew prioritized her or reached out to her. She spoke similarly about her family members. Sarah talked about these matters in an angry, complaining, slow- moving drawl – punctuated by occasional hysterical, aggressive laughter, as she sprawled herself out on the couch, exposing her body often practically to the point of nudity.

About nine months into the treatment, Sarah reported a dream in which a catastrophe had occurred which threatened to destroy the city in which she lived. Sarah was the only person who seemed to be aware that the water supply would soon be poisoned by the sewage system, which had stopped functioning, the food supply would run out, disease would become rampant and people would begin dying. Sarah made a plan to escape, by foot, to a place in the country, several hundred miles away where food could be planted and a new life could be built in an uncontaminated environment. She was unable to convince any of her friends or the people around her of the imminent danger they all faced. Enraged and grief stricken, Sarah set off on her own to escape certain death and make a new life for herself. This dream indicated to me that Sarah had begun to make a commitment at least unconsciously, to her treatment with me, which involved the trek through, (and potentially out of), the inner devastation of her psychic landscape, even if that meant leaving family and friends behind.

About a year into treatment Sarah became involved in a serious relationship with a man, Frank, whom she described as largely caring and devoted, although struggling with intimacy and self esteem issues. Sarah described

great fear and confusion in the initial stages of this relationship, as she attempted to cope with the feelings of groundlessness and inner chaos evoked in her by simply sitting in the presence of a man who was not actively rejecting her, and whom she was not actively rejecting – a dynamic which had been present in all of her prior romantic relationships. As the relationship progressed, Sarah found herself struggling with intense frustration and anger, evoked often by fairly minor disappointments and misunderstandings between her and Frank. Bigger problems between them, such as his loss of interest in sex, she dealt with largely through denial.

As Sarah began addressing, in therapy, her immense frustration and rage at her difficulties managing her emotions within her relationship with Frank, she became more intense and aggressive in her demand that I offer her some solution. She described situations in which her impatience at minor annoyances, such as being kept waiting, would become so intense as to be intolerable. When I asked her to create a fantasy of what it might be like to surrender into her authentic emotions in these situations, she imagined dissolving into hysterical sobbing and raging. The longing behind the hysterics, as she described it, was for someone to see her, acknowledge her, care for her, be there for her and remain connected to her in a way that she was unable to experience (or, in her words, that "I can't find") in any relationship. The feeling of torment at this feeling of isolation Sarah described as a "free fall".

In one session, about 17 months into the treatment, when I made some reference to a connection between a current struggle and the family dynamics of her childhood, Sarah reacted with intense anger towards me, saying that she was finished exploring her past, that this exploration had yielded no result. "All you do is show me how bad it was – nothing changes. I can't remember the last time I was happy." She looked at me with eyes glittering with rage. Soon after this session, Sarah brought up the idea of coming to therapy less frequently. At this point her relationship with Frank was foundering, and they were talking about possibly breaking up. (Her question to me: "How do you work on a relationship?") She said she found that the anticipation of coming to therapy was beginning to produce feelings of anxiety and irritation in her, rather than the organizing, grounding (my words) function that she described it as having had for her earlier on. She proposed that she make her next appointment for three weeks hence. She

arrived for that session still questioning the use of therapy for her – problems with Frank having settled down for the time being. I spoke more than I had previously about how therapy could be a place for her to simply experience herself, rather than always focusing upon the solution to problems. Sarah replied, angrily, that the more I tried to get her to come back, the more she wanted to leave. She did not make a next appointment, saying she would call me. The next day, my office mate found a piece of graffiti, "fuck you, motherfucker", written on an obscure wall of the office. This could have been attributable to one of my adolescent clients, but I suspected Sarah. She has not contacted me since.

Transference/Countertransference Dynamics

Sarah's professed longing for intimacy and connection with others was tragically hindered and complicated by the threat of symbiotic engulfment and/or terrifying abandonment which such contact inevitably involved for her. Sarah acted out these fears within the transference with a combination of seductive behavior and dress, and an attitude of demanding, combative, whining bitterness and rage. In the countertransference, I experienced her energy as that of a dual-action magnet, repelling me and sucking me in towards her at the same time – the energy in both directions so super-charged as to make me feel as if I were unable to breathe or live. The air in the room, when inhabited by Sarah and me, often felt to me as if electrified, without oxygen and unable to sustain me. A dull headache would set in, I felt restless and agitated, and also pulled towards lethargy and sleep. I experienced this energy as almost entirely unrelenting throughout the therapy, although it abated somewhat when Sarah became involved with Frank (perhaps because that relationship was absorbing much of this energy). Other people in Sarah's life also appeared to respond dramatically to this attraction/repellent energy: she reported several occasions in which men with whom she was interacting casually in social settings suddenly grabbed her and kissed her. She also talked about calling every one of her friends on the phone to make weekend plans and not receiving a single return call. On several occasions, during our sessions, I found myself suddenly, unaccountably accosted by entirely unwonted images of body parts in sexual intercourse. I suspect that

this was a manifestation of Sarah's seductive, sexually charged but essentially non-emotionally contactful energetic charge.

During the course of treatment I had various experiences as I struggled to cope with the toxic charge I experienced in Sarah's presence. For several sessions, (after attending a weekend workshop focused on finding imaginative and physically experiential ways of making contact with our internal organs) I produced an image of Sarah's body inside the transparent body of an angel many times her size. I saw Sarah's head entirely held inside this transparent beating heart, which glowed with a tender, green light and pulsed with powerful, heavenly love. With each pulsation of this angel's heart I imagined the energy of Sarah's tremendous need, longing and spiteful rage being absorbed and neutralized.

In another effort to cope with my reaction to this suffocating energy, I attempted to absorb Sarah's energy into my belly and pelvis, rather than my chest and head. The result of this maneuver was an image and sensation of falling through space while being murdered and sexually assaulted, gripped by feelings of grief and terror. In a session following my first attempt at this particular maneuver, Sarah reported a dream in which a woman had been murdered. Sarah had information about the murder, but the family of the murdered women refused to allow access to the police or to the body of the murdered women, which they had stolen from the morgue to bury in private. Sarah's production of this dream following my countertransferential experience of her energy was an example of the primitive, primary-process forces driving Sarah's psychic process and the transference and counter- transference dynamics of the treatment. In other words, much of the meaningful, potentially healing contact between Sarah and myself was happening largely unconsciously for both of us.

Another important element within the transference and counter- transference dynamics of the treatment was Sarah's relationship with her own feelings of anger, and my response. Sarah was often angry, and was occasionally able to acknowledge angry feelings towards me or towards someone in her life. She was almost completely unable to acknowledge her anger towards her parents, however, especially her mother. At times, I suggested to Sarah that she might be feeling angry with her mother or father, (whom she talked about with great bitterness and disappointment) and offered her the opportunity, in various ways, to give words or voice to those feelings.

Sarah usually responded to these overtures with a denial of any feelings of anger, or with her fear of the "disintegration of my personality" if she were to allow herself to inhabit these feelings.

I had two dreams about Sarah, one about 5 months into the treatment, and another about two weeks after our last appointment. Both dreams shed light on countertransference dynamics in the treatment. In the first dream Sarah was the wife of my ex-husband. She was lying naked on a bed. Her eyes were almond shaped and evil looking. Her breasts, which were small and hard, had nipples shaped exactly like her eyes. I was standing behind her, beating her chest with some kind of a board, screaming at her, "You have no heart!" I heard a male voice behind me saying, "Her heart was fully functioning", meaning that it worked mechanically, even though it had no feeling. In the more recent dream, Sarah was my romantic partner and I was introducing her to my family. She was like an evil queen, driven to power, someone who would stop at nothing to accomplish her ends. She was playing the guitar and the banjo (I play guitar, and have always wanted to learn the banjo). I, and my nuclear family of origin, were doing all we could to cater to her, desperately concerned about her judgment of us.

These dreams speak to my identification with Sarah, my rejection and fear of the Sarah-like aspects of myself, and my aggressive/sexual impulses, both towards Sarah and contained in the Sarah-like aspects of myself. Throughout the treatment, I was largely unconscious of the operation of these dynamics within myself, and I had difficulty remaining fully alive, moment-to-moment, with Sarah, and experiencing myself and my responses to her in ways that I could make useful for her. For example, in my effort to cope with the extreme discomfort of being in Sarah's presence, I sometimes found myself repeating silently to myself, "I'm not angry at her, I'm not angry at her …" Such experiences were useful to me later when I could analyze the meaning of my response, (which I suspect was partly driven by my own efforts to cope with feelings of retaliatory anger towards Sarah, and probably also contained some elements of projective identification – Sarah's rage towards her parents, being unmanageable for her, was placed instead in me). However, my need to focus on my own emotional/physical preservation hindered my ability to track my own experience and use it to support Sarah in exploring her own moment-to-moment experience of herself in her interactions with me.

Sarah's psychic structure was organized around an angry, naïve insistence that she could have a real life, just like everyone else. Her notions of a "real life" were primitive and superficial at best, despite her considerable intelligence and sophistication. I identified closely with this experience of Sarah's, and struggle in many of the same ways. In truth, I suspect that I possess a more elaborated psychic structure than Sarah did, and am, unlike her, capable of experiencing (albeit tenuously) a boundary that separates, protects and allows for connection. My difficulty remaining grounded in these truths regarding my differences from Sarah, as well as our similarities, hindered me from using my own experience of the countertransference more productively in the treatment.

Due to my pull, within this treatment, to abandon awareness of my own boundedness and autonomy in my relationship with Sarah I was prone to a misjudgment of her as being more emotionally healthy and mature than she in fact was. At times Sarah involved me (and I participated in) lengthy, theory-oriented conversations about contemporary art, architecture and literature. On one hand, this may have helped her feel grounded and reassured, a "port in the storm" as I put it to myself. However, I suspect I was also colluding with Sarah in the false belief that we could both, metaphorically, let ourselves off the hook, when it came to the reality of how dangerous our work together was, to each of us separately, and to our relationship and shared project of Sarah's growth and healing.

As the treatment progressed, Sarah described how, since her descent into the feelings of despair that led to her seeking treatment, she had been progressively "losing track of who I am." She said she had gone from being a "strong, powerful, creative, interesting person to being bored, numb and totally isolated." Sarah functioned in a matrix of competitiveness and a stubborn demand that she experience the emotional security, freedom and expansiveness (in whatever primitive form she could conceive of such states) that she perceived to be possessed by other people, and by me. Her investment in appearing more intact psychically than she indeed was, dovetailed (perhaps catastrophically) with my struggle to represent myself (at least to myself, and also, in carefully titrated doses, to Sarah) as a powerful, autonomous person capable of inspiring both fear and dependency in Sarah. As I became better able to articulate to myself the emotions contained in my experience of toxic, electrified energy in the field between myself and Sarah, I experienced myself as feeling sexually

overwhelmed, weak, passive and despairing – as if my life blood were being drained from my veins. It was, and remains, difficult for me to differentiate between the various strands of experience and affect taking place within the transference/countertransference dynamic. In my role as a powerful, sexually energized maternal figure to whom Sarah could attach and depend, I functioned for her in two ways: as a stable, potential attachment figure, and at the same time as a succubus threatening merger and annihilation. The confusion of longing and murderous rage this aroused in Sarah, towards me, certainly impacted me and aroused my own responsive complexity of emotion and sensation. At the same time, the passive, de-energized sensations I experienced also belonged to Sarah: I was experiencing, via projective identification, her own horror, despair and weakness in the face of parental demands for merger and the annihilation of autonomous self-experience.

Sarah needed to relate to me within a maternal matrix and identify with my more fully developed ego. My difficulties inhabiting that role more consciously, hindered me from supporting Sarah with more grace and subtlety in managing the fear of psychotic loss of containment that such a relationship inspired in her. In her constant demand that I offer her a solution to her problems, Sarah was demanding that I truncate the process of her experiencing herself as dependent upon our relationship.

I suspect that Sarah's flight from treatment was driven by an unconscious attempt to ward of the decompensation which threatened her as she grew closer to me, and to the impending engulfment/abandonment which our connection represented. The potential dissolution of her relationship with her new boyfriend was also probably a complicating factor: if she abandoned me first, she could ward off her own fears of abandonment within a relationship of dependency.

I believe I also made the mistake of over-focusing, in the treatment, on family dynamics and past events. Much of the healing and growth that took place during this therapy happened due to unconscious process. Due to this same unconsciousness, I found myself engaged in the same type of power dynamic (dominance vs. submission) that characterized Sarah's relationship with her parents and her adult relationships as well. I question how I may have remained more awake in my own process, and therefore able to make the treatment safer and more supportive for Sarah, and perhaps thereby tolerable.

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Personal Musings on Countertransference in the Context of Becoming a Bioenergetic Analyst

Jacqueline Mills

Summary

This paper is a personal account of the author's understanding of her countertransference in relationship to a variety of clients. It was written during the second semester of her third year of bioenergetic training. Trainees were required to keep a journal of their process throughout the semester, noting specifically their awareness of their countertransference issues as they read the required readings and participated in the experiential exercises throughout the training weekends. The author explores ways in which her process in training and her process in her own therapy impact her growth and understanding of her countertransference.

Keywords: Countertransference, Shame, Narcissistic Wound, Projective Identification, Wounded Healer

As I entered my third year of bioenergetic training, I was in the disorienting and disruptive process of the breakdown of my character structure(s). And I mean in the throws of it. I understand that we are in that gradual process most of the time when we are working on ourselves but there came a point at which things as I knew them ~ me, as I knew myself ~ fell apart. Though I know this core transformation to be the goal of bioenergetic analysis, I really had no idea what I was getting myself into. I intuitively knew I needed to go where I have gone, plumbing the depths of my psyche, and

my psyche-soma. However, my knowledge of this process was, up to this point, intellectual, naive and a bit pompous.

The first weekend of the semester we read two articles that I want to mention and refer to. The first was on shame by John Conger (2001) and the second on narcissistic wounding and the therapist's resistance to working with the body by Robert Hilton (2007). This weekend brilliantly coincided with my losing about seven clients in my private practice. Three of those clients were newer and I had intuitively felt they might not stay (so the sting was not as bad). Whenever I feel this upon meeting someone I ignore it. Rationally, I do so because I want to believe they will keep coming so that I can make my house payment. The truth is that I believe, in my grandiose, infantile self, that I can help – *must help* – all who walk through my door. If I can't, I am at fault. The other two I saw long term and their treatments, in my mind as I write this, were complete disasters. The fact that I feel this way is symptomatic of my core organization. However, I do feel that my countertransference got in the way to such a degree that I believe I did damage. And that breaks my heart. Between the articles mentioned above and the experiential exercises in class, I now feel like I have a clearer sense of my countertransference to these clients and how (and how much) it impacted me and my work and my ability to facilitate my client's healing.

The essence of my core countertransference issue is this: If I don't save my mother from herself then I will die (physically or psychologically). Because my mother needs me, I cannot/will not be taken care of or protected by her. I will therefore be subjected to the hostility and hatred of my sister (and many other traumatizing people and experiences). I must be my sister's (and other's) play things, meaning, if I don't try to please them even though it is impossible to do so, then I am BAD and deserve every negative thing I get. I quote from my journal writing that weekend, "I feel like a failure watching the role plays. I shouldn't be a therapist. I know nothing. I have no skills. I fear/feel/know I have done damage. All of my work has been from my countertransference with just plain luck that I might help someone. I don't recognize traps clients set for me ~ I walk right into them believing I can be *the one* out of all of the people they have turned to for help, to make their world better." So what I see now is that if I help my clients feel their own despair I will die ~ that is the fear I am operating out of ~ that is the thought that causes me to freeze. They don't want to feel their despair

(and I don't want to feel mine) and if I help them feel it I fear I am bad. I take responsibility. I feel paralyzed, unable to know how to keep my clients focused on their experience while I stay present with myself and with them. Their resistance to their experience is my biggest trigger.

In his article entitled *The Body of Shame: Character and Play,* John Conger (2001) states, "Shame disrupts the formation of a primitive core self which is reflected in the body through a failure to ground, establish good boundaries, restricted breathing, a loss of emotional range and a weakening in our desire to be present." In my countertransference I especially relate to my difficulty in establishing good, solid boundaries for my most primitive clients to bump up against which facilitates their healing and growth. I have identified subtle ways in which I give and I now feel, versus knowing intellectually, how that comes out of my need to be helpful which protects me from my own fear of feeling helpless. Conger (2001) also wrote, "Shame occurs whenever we feel "outside", when we are uncomfortably separate," and, "Shame is the emotional experience of a break in our bond with others." Another piece to my countertransference then is the clients that trigger me the most are terrified of connecting or attaching. The relationship feels tentative and tenuous at best so disruption becomes devastation and there is no more relationship. Without the relationship I know that I will have no way to repair that rupture. I imagine myself from their perspective – from "outside" – and then feel deeply ashamed. The bond is broken and I stop breathing in fear, I disappear, and leave my client alone in their struggle. Then, I come back periodically trying to give them something, anything, to try to restore the connection but ultimately it is not helpful to them.

In his paper entitled *Narcissism and the Therapist's Resistance to Working with the Body,* Robert Hilton (2007, 1988) is speaking to the narcissistic wounds we carry and how they impact and influence our work as therapists, specifically, how we as bioenergetic therapists might avoid working with the body. This quote seems to speak directly to my journal entry mentioned above:

> "As psychotherapists, they had traditionally found a way to work so that their illusions of omnipotence would not be challenged and thereby they would be able to avoid feelings of inadequacy and the accompanying threat to their self-esteem. The role of psychotherapist was functioning for them as a narcissistic defense; that is, it was functioning in a way to help protect them

> from the wounds and injuries which they felt would be experienced were they to open up on a deep emotional level where they felt inadequate as persons and inadequate as bioenergetic therapists."

In the first training weekend of this semester (second semester of my third year of training), I was trying to help a fellow trainee via coming up with the right statement that would help him wrap his countertransference in a pretty little box and be done with it instead of helping him to stay with the truth in the moment. His truth in that moment was that he was confused and from that came the shift in his understanding about how his childhood wound was working in his countertransference and causing him to feel stuck. With another trainee, I froze when she began to speak about how horrible she felt about herself. I was trying to – I was going to – take her into her body and into her pain about herself (not the exercise and not necessarily therapeutic). Then the trainer came over to me and whispered in my ear, "Tell her she is OK and she is not horrible and incompetent and that you love her and you are here for her." I felt sad to have missed that, sad for my colleague, and so wanted to say that to her but I felt myself as frozen – I couldn't move at all. If it weren't for the trainer I would have taken her away from her core issue and deep into her feelings (and in my fear would have left her there with them) and then I would have had her up into her head, wrapping bows on packages of fear and shame and hurt to try to control those feelings and soften the blow.

In discussing the film *The Psychological Birth of the Infant*, Hilton (2007, 1988) states, "The child is extremely anxious if the mother leaves the room and yet he is quite often rejecting of her when she is present. If you try to help him, that's not good enough. The mother is made to feel inadequate because in this phase of development she does not receive any rewards from the child that affirm her as being "good enough." The child is engrossed in needing support in order to enjoy fully his own aliveness. The mother has to rely upon her own feelings of love and bonding with the child, plus the support of others, to sustain her during this period." I resonate with the need to have that kind of support in my own therapy and can see how my mother was unable to provide me with the support necessary to fully embody myself. Hilton (2007, 1988) goes on to say:

> "If the child is given a safe enough framework in which to explore these polarities of grandiosity and helplessness, he will be able to stay in touch with his body and discover within his own organism his strength and his weakness, his independence and dependence; he will be able to integrate into his body the limits of his grandiosity and his true vulnerability. The basis of the narcissistic wound is established when the mother is unable to provide boundaries within which the child is allowed to experience these limits, and is not able to participate with pleasure in the spontaneous movement of the child. This is true because the mother has unconsciously or consciously been using the bonding of the child in an attempt to heal her own narcissistic wounds, suffered at the hands of her own parents. The mother needs the child to affirm that she is of value to the child and thereby to repair her low self-esteem. This is done by the child either by staying attached to the mother or by allowing her to be in charge of his explorations."

I can see how I have done to my clients what was done to me – both as a child by my mother as well as by a previous therapist. Before, I could speak to not wanting to enact this dynamic because I understood it through trauma theory and from an intellectualized place. With my current experience of living these narcissistic wounds in my body and what I have done to compensate for them, I now feel when I want to act out this dynamic with certain clients and can at least stop myself, and perhaps even find a way to speak to it so that it is helpful to the client.

On the first day of the second training weekend of this semester the entire concept of countertransference felt overwhelming to me. The following is an excerpt from my journal after having discussed the readings with my training group, especially the chapter "A Psychoneurobiological Model of Projective Identification" from Allan Schore's (2003) book *Affect Regulation and the Repair of the Self.*

> "My countertransference is overwhelming. I feel, I want to say humbled, but that's not quite right. Its bigger and deeper and critical and judgmental of me. There's too much of me to keep track of ~ too much responsibility for me to carry ~ to have to know, moment to moment, whether what my client is bringing to me is about them or me or projective identification ~ is there a way I can feed this back to them that will help them, support them to find enlightenment and deepen their understanding of themselves? My sense that primitive clients are impossible for me has largely to do with the fact that I don't perceive them as that primitive and then when, in their attachment to me, I live

> out their primitive dynamic with them, its too late ~ I get hit by their negativity, rage and by their need to punish. Usually I can juggle my countertransference with other clients and know I am doing the best I can … and I know I will never know anything/everything. But with these clients I feel so powerless and helpless to ever see, know, feel and appropriately deal with client's projective identification. I feel doomed because I take too much responsibility for my part in things. I forget that projective identification exists as a phenomenon. I am always looking at how I am impacting them and how I could do better."

My understanding from what Schore (2003) discusses in his book is that projective identification is a communication. Typically it is a communication of what the client is feeling, what they are experiencing but cannot put words to or more than likely doesn't even know to put words to because the information is unconscious. What most therapists seem to experience are feeling states that "don't feel quite their own". My excitement about Schore's work, as well as infant research findings, is that these primitive states being communicated are bodily based, more sensory and affective. This gives me something a little more concrete to hold onto, to search for, as I sit with my clients and try to be an instrument through which they can know themselves.

Schore writes, "It has been observed that patients who utilize projective identification have "dissociatively cleansed" themselves of traumatic affects in order to maintain some form of relationship with narcissistically vulnerable others." From this, I take that some enactments I've engaged in are due to my own narcissistic wounds and I have protected myself from experiencing my shame either by colluding with my patients' tending to my needs or by articulating the dynamics from an intellectualized place. I have not been able to both sit with my own narcissistic needs and wounds as well as help my clients to sit with theirs.

In terms of my struggle to know whether or not my client is in a process of projective identification, I turn to this quote from Schore (2003), "I describe projective identification as an early organizing unconscious coping strategy for regulating right-brain-to-right-brain communications, especially of intense affective states. Because affects are psychobiological phenomena and the self is bodily based, the coping strategy of projective identification represents not conscious verbal-linguistic behaviors but instead unconscious nonverbal mind-body communications. This informa-

tion from developmental affective neuroscience and neuropsychoanalysis describes the fundamental psychoneurobiological mechanisms that mediate the therapist's capacity to access unconscious communications in order to know the patient "from the inside out". However, in my ongoing struggle to do things "right", this still leaves me with the question, "Then what? What do I do next? How do I do what *should* be done?" I can see just in my asking the question that I still believe it is possible to avoid enactments and ruptures. I so want to protect myself (and my clients) from feeling shame and failure and the experience of my patients looking at me with anger or hatred or fear. Yet, I do believe that with experience, I can recognize projective identification better, even if there is nothing to do about it when it happens.

The third training weekend of this semester brought back to me, in high relief, my lack of self-confidence. I continued struggling over the weekend with a sense that more seasoned therapists (more specifically, those who know the body) would see things that I have missed in my clients and therefore avoid the enactments I have participated in. I know in my head that all therapists struggle at times with their clients and I think that my idealization of those who have come before me gives me something to strive toward, I just have to be careful not to clobber myself with it. My continued theme for this third weekend sounded like this:

> "I don't trust myself to accurately assess my client's primitiveness or ego strength or core self-stability. I tend to resonate with their deep need and longing to be met because I tend to give what I need – the difference being that, in them, it triggers a malignant regression and in me it doesn't … then I get confused and scared, feeling completely responsible for their regression and then I'm not available to them because I don't know how to be with them in these primitive places because I've never been where they go even though I have my own primitive places."

This brings me to the next article we read by Michael J. Maley (1992) called *The Wounded Healer.* I found this article very insightful and helpful and reassuring. He says, "We make no progress toward wholeness without problems to address in our life." I breathe a sigh of relief when I read that. It helps me to develop self-talk that is kind and compassionate toward me. Maley (1992) also says, "The so called issues of the therapist can be looked at

as blessings or opportunities for learning rather than something to remove." Which is great except then I think to myself, "But my clients need me to guide them, to be farther along than them so that I don't get in the way of their healing." Of course, Maley (1992) has an answer for this worry of mine as well, "The experience of doing nothing but accepting and opening to *what is* also becomes a vital part of the transformation process. This part of the therapeutic process concerns itself with the experience of formlessness or space – an important subjective experience in the reorganization of the psyche that needs recognition." I know that my growing edge is to be able to sit with my clients in *what is* for them. I don't have to fix them. In fact, I can't fix them. My ability to tolerate my own pain and helplessness and fear allows me to hold a space for them in where they can sit with their feelings which in and of itself is healing for them.

The last thing I want to talk about in this paper is my experience of the exercise (developed by Robert Hilton, 1988) we did in the fourth training weekend. I had a very powerful experience of collapse, surrender, acceptance and expansiveness. Once again, the overlap of my personal process and where I am at in my therapy has rocked my world – the training deepening my understanding of my personal process and my personal process opening me up such that I cannot deny that which is revealed to me in the training weekends. I would say the theme in my therapy for the last 8 months or so is surrender (which, in the beginning, felt like defeat). I have had to let go of my expectations and acknowledge my feelings beneath my expectations – my longing, my fear, and my deep disappointment. This has allowed me to surrender to *what is* in my therapy – to both who I am and who my therapist is. I have had to confront both of our limitations and weaknesses in the face of each other, the dynamic we create together. Having this relationship in which to live out certain dynamics, old and new, has been the most profound experience I have ever had. So when it came time to do the exercise of giving up my specialness, of acknowledging that I can't give myself up anymore in order to be what I think others want, I was ready! I truly felt my pain and sadness. I felt my sense of specialness slip away, I felt my brokenness and my grief, and I felt a huge sense of relief, at which point my diaphragm opened up like never before. I then felt an expansive energy in my body, which most closely resembles my understanding of aliveness and joy.

I wish I could express on these pages how profound this last semester has been for me. It feels as if my personal process and my work in my individual therapy has overlapped with the topics and articles in the training weekends in such a way that I see my struggles illuminated beyond comprehension. I have spent much time during the training weekends in a "WOW!" kind of space, hoping that somehow I could remember what I was piecing together. Unfortunately, I find that I just keep growing, and holding onto these feelings and ideas is very difficult. I can only hope that at some level I am integrating the experiences and that my body and my heart will know them and know what to do. I think this is what Maley (1992) is talking about when he says, "I'd like to venture the idea that this sense of incompleteness as an experience of the body and the self-identity is, actually the true wound referred to when we talk about the transformational possibilities in finding our woundedness. This is the level of woundedness that really yields the most returns, and the ability to experience and work with the various dimensions of incompleteness in ourselves will give us what we ultimately seek in terms of feelings of wholeness and psychophysical integration." I am beginning to get glimpses of feeling whole and, since I cannot go back, I am hoping (sometimes it feels against hope) that things – that *I* – will only get better.

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