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

Letter from the Editor 7

Intersubjectivity in the Construction of Boundaries 9
Between yes and no
Patrizia Moselli

Containment, Holding, and Receptivity 21
Somatopsychic Challenges
Scott Baum

Traumatic Memories 49
A Neuroscience Perspective
Homayoun Shahri

From Body Structure to Bodies in Resonance 71
Evolution of the Therapeutic Relationship in Bioenergetic Analysis
Fina Pla

The Borderline Client, Shame and Somatic Counter-Transference 111
Ingrid Cryns

Letter from the Editor

Welcome to the 27th volume of Bioenergetic Analysis. We have five articles to read in an effort to create inspiration, offer information, and hopefully create dialogue that furthers the growth of psychotherapy in general and somatic psychotherapy in particular.

One thing all papers have in common is addressing the therapeutic relationship in the most modern terms. Patrizia Moselli's article is on intersubjectivity, as she ties in newer concepts that validate Lowen's early ideas about clinical focus. Scott Baum discusses containment and delves deeply from both a personal and professional view into the dynamics of the therapeutic relationship. Homayoun Shahri covers traumatic memory, including neuroscience aspects and includes clinical vignettes that concern the therapeutic relationship. At the 2016 PDW (Professional Development Workshop) for Bioenergetic therapists seeking to advance in the field, I was privileged to be on the faculty along with Helen Resneck-Sannes and Joerg Clauer. I very much enjoyed working with them and supporting our enthusiastic participants in their growth. Two of the presentations were so interesting that I asked the authors to turn them into papers to be considered for this journal. Both papers cover countertransference (CT), an important aspect of the therapeutic relationship. While Fina Pla reviews the evolution of CT within Bioenergetics, Ingrid Cryns, also includes CT as she presents in depth on BPD (borderline personality disorder). To submit a paper for 2018 please send it before September 1st, 2017.

I want to thank the authors, who worked hard, sometimes preparing multiple drafts, in order to bring their best efforts to you as the reader. People who were supporters of the authors and/or reviewers include Laura Partridge, Tarra Stariell, Virginia Hilton, Jörg Clauer, Bob Lewis, and my dynamic and tireless editing team: Maê Nascimento and Margit Koemeda. Maê and Margit also do double duty and translate abstracts. Other abstract translators include Sylvia Nunez, and Maria Rosario Filoni. Thank you for your contributions. This volume will be translated into French by a number of French-speaking colleagues from France,

Belgium as well as French-Canada, overseen by Claudia Ucros. The plan is to have this volume translated into French in time for our next Bioenergetic conference.

The next IIBA conference, in May 2017, is on the 60th anniversary of the founding (1957) of the institute by Dr. Alexander Lowen. The conference will take place in Toronto, Canada and will be on the theme of "reflecting back and looking forward". It will be a great mix of keynotes, workshops and social interacting with colleagues from around the world.

I hope you enjoy this collection of articles and find them a useful contribution to your thinking, both as a therapist interested in the therapeutic relationship and as a Bioenergetic analyst interested in looking for inspiration in your clinical work.

Vincentia Schroeter, PhD
San Marcos, CA. USA. November 20, 2016

Intersubjectivity in the Construction of Boundaries

Between yes and no

Patrizia Moselli

> "The therapist intuitively empathically resonates with the changing emotional states of the patient, constructing a context in which the clinician can act as a regulator of the physiology of the patient."
>
> *(Schore, 2003, pp. 93–94)*

Abstracts

English

This article examines intersubjectivity and infant-mother attachment issues in relation to psychotherapy. From this view it is argued that the therapist-client dynamics form the core of the therapy work. Boundaries are looked at through Bioenergetic concepts. The paper concludes with treatment techniques that increase healthy boundaries.

Key words: Intersubjectivity, boundaries, attachment, therapy dyad

German

Dieser Beitrag untersucht Themen der Intersubjektivität und der Mutter-Kind-Bindung in Bezug zur Psychotherapie. Aus dieser Perspektive wird behauptet, dass die Beziehung zwischen Klient/in und Therapeut/in den Kern der therapeutischen Arbeit bilden. Das Thema Abgrenzung wird mithilfe Bioenergetischer Konzepte betrachtet. Der Artikel schließt mit Behandlungstechniken, die gesunde Grenzziehungen unterstützen.

Italian

Questo articolo esamina la tematica dell'intersoggettività e quella dell'attaccamento madre-bambino in relazione alla psicoterapia. Da questo punto di vista si

sostiene che le dinamiche terapeuta-cliente costituiscono il nucleo del lavoro terapeutico e anche i confini vengono analizzati attraverso concetti bioenergetici. Il documento si conclude con tecniche di trattamento che rafforzano confini sani.

Spanish

Este artículo examina la intersubjetividad y los problemas de apego entre un infante y la madre en relación con la psicoterapia. Desde este punto de vista, se argumenta que la dinámica entre el/la terapeuta-cliente/a forma la base del trabajo de terapia. Los límites se analizan a través de los conceptos de la bioenergética. El ensayo concluye con técnicas de tratamiento que incrementan el desarrollo de límites saludables.

Portuguese

Este artigo examina a intersubjetividade e questões sobre o apego mãe-bebê com relação à psicoterapia. Coloca que, deste ponto de vista, a dinâmica terapeuta-cliente forma o núcleo do trabalho terapêutico. Focaliza, também, limites sob a luz de conceitos bioenergéticos. O artigo termina com técnicas de tratamento que acentuam os limites saudáveis.

Introduction

Research in attachment theory and intersubjectivity studies have provided us with useful elements to come into contact with the patient in a more rich and articulated way. Today, these studies have made it possible to build a theory that, starting from "here and now", allows us to look at each other and ourselves, being able to grasp more information and have more elements to seek a synchronicity with the person we face. This further develops our empathy and professional abilities.

In psychotherapy we encounter two personal worlds, which have a mutual and reciprocal influence on one another. The observer is also the observed. Each of the two organizes and is organized by the other continuously, and the empathic bond (or its lack) works in both directions (Finlay, 1999). This complementarity does not mean that therapist and patient-client are equal, but that they have an equal influence in building up a shared field where it is possible to discover and create the therapeutic process in which one is "with" the other.

The Parent-Child Dynamic

At the turning point that we are experiencing in these times, "to be with ..." constitutes one of the main themes charged with more meaning. At a psychological

level, in fact, "to be with ..." was revealed as key to understanding the human condition as a matrix of our identity. Intersubjectivity evolved, in part, through the outbreak of observation and experimental research regarding the first interactions between child and parent. The results of this research led to some important theoretical conclusions, which cannot but have an effect on the method and technique of psychotherapy. The origin of the mind is relational and it is based on the mother-child dyad. Therefore in the child, who is active from birth, the intrapsychic evolves concomitantly in the intersubjective field.

The experience of the mother-child dyad is creative and constructive and based on emotional exchange. It is through the procedural memory that interactive patterns are represented and preserved, becoming a constant in all the relational experiences of the subject. Life means relationship and could not exist without both biological and emotional aspects from the moment of conception. The intrauterine experience of the child seems to be the chemical-visceral sensory-basis of all those emotional patterns, connective and motoric, that will grow later, since he is from the beginning, in connection with the mother by absorbing the parental heritage, both in the positive functional side and the negative and dysfunctional one.

From this perspective the learning process begins before birth through a constant communication with the mother. The child's motivation to be in relationship with others is guaranteed by what Shaffer calls, "structural and functional predisposition" (1977), guaranteed by the presence of a sensory apparatus that shows an already tuned child, who is able to implement models of perceptual-affective inborn action. The child can adjust the quantity and the stimulation level to which he is subjected through the mutual contact with the mother or through behaviors with which he begins to differentiate himself (looking away, closing his eyes, showing a look without expression) (Tronick, 2007).

The mother-child relationship appears as a highly organized whole, in which the ability to self-regulate relative to common purposes plays an important role. These skills are the characteristic of a Self that emerges based on proprioceptive abilities and on the experience of being an acting subject. The child has an innate motivation to process and sort the information that derives from the environment and is built by both partners in the relationship. Recent studies have shown that these characteristic patterns of mutual influence between mother and child are the basis for the emergence of the representation of Self and later on they come to constitute the unconscious or memory structures. Children are equipped from the birth with complex skills that allow them to act competently, i. e., to understand and respond selectively to social stimulation. This indicates that in addition to an active search of connecting with others there is also an innate differentiation between themselves and the environment.

So, from the very first primary phases we no longer have a vision of a passive, autistic, undifferentiated child but an organism that begins an early dance "of yes and no" in the movement of life and, therefore, it also changes the reference point

of clinical intervention. The purpose of therapy cannot be only reparative, i. e., an intervention which aims to repair the patient-client's experienced shortcomings, or confrontational (excessive attention to the patient's defenses), but must take into account the **structural capacity of the subject who interacts with reality through maps and personal categorizations**.

Intersubjectivity and the Therapy Dyad

The changing process within therapeutic work takes place inside a relational system consisting of the patient-therapist dyad, organized on the basis of complex dimensions that some approaches define as transference or other co-constructions between therapist and patient. Then we can look at therapy as a particular intersubjective field in which both patient-client history and that of the therapist merge. **The core of therapy is located and concentrated at the center of gravity between them and not only in the so-called, "patient's pathology"**. Client and therapist form an inseparable whole in which transference and counter transference are never totally objective and uncontaminated and they prove to be co-specific processes.

In the "here and now" of the therapeutic encounter, while the relationship gradually takes place, all these elements become more evident and allow the therapist to be even more aware of the patient's intersubjective history and to pay attention to those parts of the implicit procedural memory that are so important and not very accessible to his awareness.

Intersubjectivity is also based on the idea that psychotherapy is a dialogue in which each participant shapes the experience of the other. It then becomes something more than a neutral interpretation made by the therapist of the patient's narration and more than an action of the therapist who commits himself to leading the therapeutic change. Patient and therapist together form an indissoluble psychological system and this system constitutes the empirical field of the psychoanalytic demand (Atwood, Stolorow 1984). If in the system of mutual relationship between child and adult, affection is the main drive, this becomes the primary motivational force in building the Self. This opens a new perspective on the explanation of pathology, which arises and takes shape within an interactive context, in which a child's affective states are experienced as a threat/failure of the relationship's regulation and therefore also for the organization of the Self. In fact, defenses are mechanisms built within a specific interpersonal context that protect the child from vulnerability and disorganization.

"Fundamental processes governing the non-verbal interaction remain the same throughout life " (Beebe, Lachmann, 2002, p. 20).

What happens, for example, when in a relationship the child has a particular feeling or state of mind?

- The mother reacts to the child.
- The child observes and reacts to the mother's response and towards her.
- It activates an automatic simulation of the mother's response in the child's mind
- The response of the mother is congruent = improves bonding and the child develops a sense of Self.
- The response of the mother is not attuned = the simulation of child-activated maternal reaction is disjointed from Self, threatening his integrity. The False Self develops.
- The child introduces in his False Self reactions that are inconsistent with his biologically determined True Self (Ballardini, Siab course material).

"Matching experiences of affection and interpersonal timing are coded in implicit and procedural form and can contribute to the child's or adult's expectations to be understood, reciprocated, or be on the same wavelength with the other person" (Beebe, Lachmann, 1988). In this perspective, therapeutic intervention is designed as a technique aimed at helping the patient-client to recognize the patterns of interaction on the basis of which he built his identity, to achieve a cognitive-affective understanding of the origin of these patterns, their functionality and the processing of the underlying fears that maintain them.

The therapist-patient relationship, from neutral, and aseptic, became increasingly an intersubjective relationship, from person to person (Rogers, 1961). Intersubjectivity which helps growth in psychotherapy is in the therapist's ability to be both a "container", which accepts and welcomes the patient-client for what he/she is, mirroring him/her (empathic ability), as well as a person capable of putting limits and boundaries that are not perceived as judgmental or disorganizing by the patient, but as a reassuring and flexible boundary where the True Self can emerge. It is only within a secure relationship and in a warm relational environment that one can allow the other to have a mental processing system to address existence in a more functional way and build flexible boundaries that turn into the ability to respond appropriately to the movements of life. **When we lose our boundaries we perceive others as intrusive**. The lack of boundaries may make us more open, but also vulnerable and helpless, exposing us to the judgment of others. Clear boundaries and authentic choices allow us to be active in our process of self-definition of identity. In Kaes' words, "Not one without the other and without the whole that constitutes and contains them, one without the other but in the whole which combines them" (p. 6).

Body as Container

Bioenergetic analysis suggests that the intersubjectivity's container is the body: the field in which two subjects vibrate through their bodily/emotional experi-

ences. The relationship is felt through the body, perceived by the body. It is indeed through contact, body-to-body, skin-to-skin, that the child begins to learn the first communicative patterns and skills that allow him to interact with the environment and will accompany him throughout his life.

The therapist's ability to "be" in his own body is a fundamental precondition to stay with the other, as the patient-client does not only react to what the therapist "says," but to his tone of voice, his way of looking at him/her, his movements. These are the elements that are essential in the setting to enable the patient to feel in a safe relationship. Giving basic attention to the intersubjectivity means, from the point of view of Bioenergetic analysis, to put emphasis on aspects of procedural memory recorded in the patient's body in order to re-enable the potential for new contacts and new relationships.

> "When this kind of mutual love is achieved with your clients, a spontaneous body movement begins in them. This movement is the expression of the real body self, which is re-emerging from the environment by contact. Their 'No' begins to change into a 'Yes' to themselves and life. At the beginning this 'Yes' may be nothing more than a child's finger which explores the contact of your hand; a breath that suddenly comes from the relaxation of the diaphragm; a tremor in their lips, as if emerged a reflection of previously repressed sucking" (Hilton, 2007).

Intersubjectivity and Bioenergetics

Intersubjective aspects have always been present implicitly in Bioenergetic analysis which, from the legacy of Reich's work, has from the beginning, looked at the training of the person starting from the relationship with a caregiver. For sure Bioenergetic s drew a big asset from the ability to reflect on these interactions in a richer more articulated way. Mainly, the part that we have been able to develop as bioenergetic analysts is how emotional aspects of anatomy are reflected in and have influence within the relationship. The use of the techniques cannot be separated by a meaningful and transformative work within the relationship, because it sheds light on emotions that are validated within the relationship itself and allow the person to take them back through a process of mutual adjustment. Both processes, intrapsychic and body, exist simultaneously and they can enrich and fill each other's deficiencies from a theoretical and practical perspective. These are processes that include rather than exclude themselves (Finlay, 1999). Attention to intersubjectivity is, therefore, a dimension that transformed over the years the practice of "classical" Bioenergetic analysis, which was harder in the aspect that the work was more focused almost entirely on the energetic aspect.

Today we work on the body with a new comprehension of "what is appropriate", taking into account the various stages of development and the type of trauma, believing firmly that only through contact and full awareness of one's body can one meet the other (ibid). To meet the other, without merging or confusing ourself with him, we must have a clear perception of our boundaries: our "Yes or No to life" therefore arises from the perception of having boundaries well defined but open and flexible.

Boundaries and Bioenergetics

In the ongoing diagnostic process and in therapeutic work, it becomes more important to be able not only to make a diagnosis based on observation of the patient (for us, as Bioenergetic analysts, also based on observation of the body) that keep us close to him but external to the dyad, but also to pay attention to how we vibrate in his presence, to recognize which of his/her internalized objects lives through us. It is also important to understand the models of attachment, which have been present since the first session. We look to see if the patient in his/her history was able to build up boundaries that define his/her identity without imprisoning them or if there are holes in these boundaries or if these boundaries are absolutely insufficient for healthy living. Attachment patterns and boundaries are not the same, evidently, but are strongly interrelated, as they are with the individual history. The concept of boundary in terms of Bioenergetics is the interface of energy charge that is created between the child's movement and the appropriate response of the parent. If there was "good enough" response of the parent, the boundary will be stronger but also sensitive. Essential boundary formation occurs during the first six years of life. Once formed, the healthy boundary provides a steady stream of pulses from the center to the periphery and vice versa.

Thin-Skinned and Thick-Skinned Boundaries

Boundaries may be rigid or weak. In the vital body, energy charge flowing is revealed by the appearance and skin color, the brightness of the eyes, the spontaneity of gestures and tonicity or relaxation of the musculature. Weak, porous boundaries, ones that are too flexible, are what we can define as "thin-skinned", meaning easily overwhelmed by our or others feelings.

On the issue of boundaries, Lowen highlights two defense mechanisms of the schizoid type: "retreat-collapse", leading to what is called flaccid schizoid and "holding together", leading to the rigid schizoid. The body of the "flaccid" schizoid is similar to the "soft child" one. It is often overweight (a way perhaps

to give themselves a boundary) and the fear of being annihilated pushes him towards collapsing and makes him disorganized. To not feel victimized, many develop a narcissistic compensation. The opposition, the "NO" that forms as a result from collapsing, is both muscular and psychological. It is a way to avoid becoming energy charged and to hold the charge. Individuals lacking in energy charge meet necessarily their alienation. Or we can have weak boundaries from too much rigidity, inflexibility, and become impenetrable to others' and one's own feelings. These boundaries could be termed "thick-skinned", which is typical of Narcissists.

Treatment for Healthy Boundaries

To establish healthy boundaries we need simultaneously to strengthen our assertive and aggressive impulses and abandon some of our character defenses. In the setting of Bioenergetic analysis, we work on five fundamental components to build up boundaries:

- grounding;
- contact;
- charge/control;
- surrender to bodily reality and confront fears;
- physical/emotional growth and increase of pleasure (Ballardini, educational materials Siab)

In this case, the main work in Bioenergetic analysis will be building a significant relationship capable of repairing, nourishing and healing, but above all to allow the other, through movement, to learn a new way to upload and store their energy in order to tolerate their existence and their contact with others.

The metaphor "experienced" in bioenergetics treatment means to be able to both scream our "no" and live totally the abandonment to the contact. Through Lowen's character types, we can observe how each character organizes its own boundary, and which bodily techniques can help the individual to break up their character and muscle rigidity and really face the encounter with the other. A good bioenergetic therapist has clear in his/her mind that the technique and the movement cannot replace his/her ability to contain and accept the psychic suffering without distancing from it (avoiding mode) or being swallowed by it (ambivalent mode). An effective therapist uses his/her "yes" and "no" in harmony with the other in the therapy's dance.

> "The process culminating point happens [...] when in the therapeutic session patient and therapist come to the point of being able to perceive themselves as 'individuals' who meet (and) discover that their hearts beat

with the same rhythm and their bodies vibrate at the same level and that [...] may happen through eye contact or some other form of contact" (Lowen, 1994, p. 117).

Summary

In the earliest stage of the infant's life, the mother's look is critical. It can be a look that makes him feel welcomed and accepted in the world or can scare him, threatening his "motivation" to survive. This look as well as other ways we contact the newborn (touch, embrace, comfort) represent important nonverbal messages with which an infant learns to adjust his emotional states, constituting a fundamental part of implicit memory. In the paper, opening with an overview of recent studies on intersubjectivity, the author shows how studies conducted from infant research and neuroscience seem to validate the insights of Reich and Lowen, exploring the issue of boundaries, which can be considered "the energy interface" of characters.

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Patrizia Moselli, Psychotherapist, Director of S. I. A. B. (Italian Society for Bioenergetic Analysis) and Past President F. I. A. P. (Italian Federation of Psychotherapy Associations), BOT member of SIPSIC (Italian Society for Psychotherapy), IIBA International Trainer, Faculty and BOT member (IIBA). Senior trainer also in the person-centered approach, she worked with Carl Rogers in facilitating intercultural encounter groups in Italy, Ireland and Hungary.

Author of the book, "The Wounded Healer. The psychotherapist's vulnerability" (last reprint 2015) on countertransference. Co-editor of the volume, "Clinical dimensions and theoretical models of the therapeutic relationship" (2009). Editor of, "Our affective sea. Psychotherapy as a journey" (2010). Collab-

oration, as author, for the "National and International Psychotherapy Dictionary" edited by Salvini and Nardone (2013). Many of her essays are published in Italian and international magazines and she's the author of several scientific articles.

Containment, Holding, and Receptivity

Somatopsychic Challenges

Scott Baum

Abstracts

English

This paper is about some principles in the organization of the psychotherapeutic space. These are central, basic principles, which are necessary for the space to work as intended. These principles include: the primacy of the welfare of the patient; the therapist's ability to prioritize the experience of the patient; the necessity that the therapist be versatile in the dynamics of holding and engagement; and that the therapist have a grasp of her or his personality dynamics, how they may intrude into the therapeutic space, when that can be harmful and what to do if the intrusion is destructive. A perspective derived from principles of Bioenergetic Analysis is shown to be useful in elaborating the dynamics of the space. This paper is also about the challenges posed by the requirement to establish an environment based on these principles. This construction demands a great deal from therapists. At the end of the paper I will propose that facing these challenges and the work to meet them offers a model for psychotherapy and also for relationships more broadly.

Key words: containment; holding environment; therapist receptivity; somatopsychic analysis; therapeutic space

German

Dieser Beitrag befasst sich mit einigen Organisationsprinzipien des psychotherapeutischen Raums. Es handelt sich um zentrale und grundlegende Prinzipien, die notwendig sind, damit der Raum wie beabsichtigt wirkt. Sie umfassen folgende Aspekte: die Vorrangigkeit des Patientenwohls, die Fähigkeit der Therapeutin, die Erfahrung des Patienten zu priorisieren; eine Einsicht der Therapeutin in die

eigene Persönlichkeitsdynamik und wie diese den therapeutischen Raum beeinflussen kann, unter welchen Umständen dies abträglich sein kann und was zu tun ist, falls diese Durchdringung destruktiv wirkt. Es wird der Nutzen einer Perspektive gezeigt, die von den Prinzipien der Bioenergetischen Analyse abgeleitet wurde, um die Dynamik des Raums zu erörtern. Der Beitrag befasst sich auch mit den Herausforderungen, die sich stellen, wenn man eine Umwelt gemäß den genannten Prinzipien zu gestalten versucht. Diese Aufgabe verlangt dem Therapeuten einiges ab. Abschließend wird gesagt, dass sich diesen Herausforderungen zu stellen und an deren Erfüllung zu arbeiten, ein Modell für Psychotherapie und ganz allgemein für Beziehungen anbietet.

Italian

Questo articolo tratta alcuni principi dell'organizzazione dello spazio terapeutico. Si tratta di principi di base centrali, necessari affinché lo spazio funzioni come previsto. Questi principi comprendono: il primato del benessere del paziente; la capacità del terapeuta di dare priorità all'esperienza del paziente; la necessità che il terapeuta sia versatile nelle dinamiche di holding e di impegno; e che il terapeuta abbia consapevolezza delle proprie dinamiche, di come queste possono intrudere nello spazio terapeutico, quando possono essere dannose e cosa fare se l'intrusione è distruttiva. Una prospettiva derivata dai principi dell'analisi bioenergetica ha dimostrato la propria utilità nell'elaborazione delle dinamiche dello spazio.

Questo articolo affronta anche il tema delle sfide poste dalla necessità di creare un ambiente basato su questi principi. Questa costruzione chiede molto ai terapeuti. Alla fine dell'articolo suggerirò che queste sfide e il lavoro per farvi fronte offrono un modello per la psicoterapia e anche per le relazioni in senso lato.

Spanish

Este artículo abarca algunos de los principios en la organización del espacio psicoterapéutico, los cuales son centrales, básicos, y necesarios para el espacio de trabajo previsto. Dichos principios incluyen: la primacía del bienestar del paciente, la capacidad del terapeuta para dar prioridad a la experiencia del paciente, la necesidad de que el terapeuta sea versátil en la dinámica de contención y dedicación, y que el terapeuta tenga un entendimiento acerca de la dinámica de su personalidad, cómo puede inmiscuirse en el espacio terapéutico, cuándo éste puede ser perjudicial y qué hacer si la intrusión es destructiva. Una perspectiva derivada de los principios del análisis bioenergético parece ser útil en la elaboración de la dinámica del espacio. Este artículo también plantea los desafíos que presentan los requisitos para establecer un entorno basado en dichos principios y cuya construcción exige mucho de los terapeutas. Al final del documento propongo la idea de que el enfrentarse a estos desafíos y el trabajo que se requiere para conseguirlo

ofrece un modelo en términos más generales para la psicoterapia y también para las relaciones.

Portuguese

Este artigo trata de alguns princípios na organização do espaço psicoterapêutico. São princípios centrais, básicos, que são necessários nesse espaço, para se realizar o trabalho como se pretende. Esses princípios incluem: a primazia do bem-estar do paciente; a capacidade do terapeuta de priorizar a experiência do paciente; a necessidade do terapeuta ser versátil nas dinâmicas de dar acolhimento e de estar comprometido; e que o terapeuta tenha compreensão das dinâmicas de sua própria personalidade: de como elas podem interferir no espaço terapêutico, quando podem provocar danos e o que fazer caso a interferência seja destrutiva. Demonstra, também, que uma perspectiva derivada dos princípios da Análise Bioenergética pode ser útil na elaboração das dinâmicas do espaço. Este artigo refere-se, também, aos desafios impostos pela exigência de se estabelecer um ambiente baseado nesses princípios- trabalho esse que demanda muito dos terapeutas. Minha proposta, ao concluir o trabalho, é a de que o enfrentamento desses desafios e a tarefa de elucidá-los oferecem um modelo de psicoterapia e também para as relações num sentido mais amplo.

Introduction

Case Example: A supervisee in the China training program in Bioenergetic Analysis tells me about her patient. His reasons for coming to see this therapist at this time are somewhat vague. He wants to feel his body, his insides, in an immediate and integrated way. The therapist tells me that he immediately reminds her of a friend, whom we both happen to know, a very tightly constricted man, very withdrawn into himself even when he is in contact with another person, whose mother also committed suicide when he was young, as this patient's mother did.

This patient came to see this therapist to avail himself of an approach to psychotherapy that also used active techniques stemming from an understanding of the subtle relationship between somatic structure and process and psychic structure and process. The therapist observes him and sees a man in his late thirties who is tall and thin. His shoulders stoop forward, his belly protrudes, and his legs are stiff with locked knees. His left shoulder is noticeably higher than his right. His head and neck are thrust forward in a way the therapist describes as a "goose neck." Overall, he gives the impression of someone staving off imminent collapse.

The therapist offers him movements and postures that are expected to intensify his contact with himself and with the environment around him, movements familiar to bioenergetic therapists as part of increasing groundedness. This is

done to meet his request to feel himself and the reality around him more. His reaction to the experience of himself standing in a more aligned posture, activating muscle systems that are chronically flaccid, is to become flushed with energy, overwhelmed by even the small effect of these quiet movements.

He withdraws and becomes silent. The therapist asks him what he is feeling or thinking. He says he is considering ending the therapy because he is making no progress. Nothing is changing. He also says that when he stands and feels the floor under him he wants to feel like a "cock" with the aggression and brashness of a rooster. Instead he feels tremendous tightness in his shoulders and neck.

The therapist tells me of the struggle to know what to do at this moment; both with the patient and how to deal with the therapist's own feelings, which include some anger at the patient. The anger feels to the therapist a result of the patient's unwillingness to take the therapist's care and offers of help. We talk for a while about whether it is the therapist's job to 'get' the patient to take what is offered. We talk about the difficulty of caring for someone and wanting them to feel better, get stronger, and facing the limitation that the therapist cannot make those things happen. I suggest to the therapist that the anger felt by the therapist might be made up of two elements. One is a projective identification, the patient has evoked in the therapist his anger at not being enough for his parents (this fits with data we already have about him), and that what he offered them as a child did not make them feel better. Second is the therapist's anger at not being received and appreciated. We talk about how the first vector of anger can be useful as a way to share with the patient the enactment of this relationship process. The second vector belongs in the therapist's therapy – she has similar feelings of resentment and anger at not being sufficiently cared about and taken care of by those in her early environment who should have done so.

In the session the therapist adroitly responds to the patient's needs in a very effective way. In response to his complaints about discomfort after the active interventions, the therapist explained to him that he has been holding himself in these rigid somatic patterns for a very long time and that disrupting the patterns or challenging them results in discomfort. It is hard for him to feel the changes as natural. He responded to this by saying he was not ready to face the feelings that arose from the movements and postural changes. He reported a strong feeling of nausea that was more than he could work with.

He did relate the nausea to his feelings about his mother. He talked about a woman he has had as a friend for a decade who "also suffered with her family". She has a baby and from speaking with her he realized that "... those first two years of listening to their mother's language, connected with physical closeness to your mother, this is called mother tongue. You don't get this attachment you don't have a sense of identity." He said this made him aware of what he lacked.

His therapist and I talked at some length about what the therapist's job is. Where we left things, for now, is that the therapist's job is to create a space in

which this patient can feel himself as deeply and fully as he can and wants to. In that space the patient can form a relationship with himself and the therapist that includes maximal freedom for self-expression, the possibility of encountering himself as he is now, and stretching to be in new ways, to develop new forms. The therapist accompanies him in this, and organizes the space along the lines of very specific principles.

This paper discusses some of the principles presented in the previous case example. These central, basic principles are necessary to organize the psychotherapeutic space. This paper is also about the challenges posed by the requirement to establish an environment based on these principles. This construction demands a great deal from therapists. At the end of the paper I will propose that facing these challenges and the work to meet them offers a model for psychotherapy and also for relationships more broadly.

The Holding Environment

Containment, holding, and receptivity in modern psychotherapy practice are concepts that describe basic functions of the therapeutic process. These terms are often used impressionistically, with a spaciousness that allows for inclusion of various significant elements. But sometimes there is not enough clarity or specificity to assure that the users mean the same things by their use of the terms. This is particularly significant because, as will be suggested in this paper, these terms refer to essential elements in the construction of the psychotherapeutic environment. Included in that construction are characteristics of the space, both material and conceptual; and characteristics of the therapeutic relationship, including therapist characteristics. Since the method for understanding psychotherapy process in Bioenergetic Analysis includes the examination of energetic forces at work within and between people, and also treats psychic and interpersonal phenomena as events observable in somatic processes and structures, it provides a very useful lens for focusing on the concrete meanings of these concepts and their operation in the psychotherapeutic setting.

One way to organize the group of concepts and functions represented by the terms containment, and holding, and receptivity, is to place them under the rubric of what is meant by a holding environment. The concept of a holding environment is a concept developed by Winnicott (1958) to describe the relationship between mother and infant, the qualities of which can be repeated in later life relationships. If the original holding environment was deficient emotionally and psychically it will be repeated in the psychotherapeutic relationship. If the therapist facilitates the development of a healthier and more constructive environment than in the original parental-child relationship the possibility for healing is engendered.

The conceptual framework represented by the idea of a holding environment has penetrated the consciousness of psychotherapists of many orientations (see Mitchell and Black, (1995), for an elucidation of this idea and its prevalence in the field). To some extent it has found a reception in the public at large, along with a general idea of the significance and importance of attachment processes in the formation of people's personality, starting perhaps in contemporary times with the work of Benjamin Spock, MD (1946) whose book on baby development and earlier relationships are among the most widely read books in the world.

Attachment forms a matrix in which the person is embedded, and which nurtures – or impedes – the development and emergence of her or his personality. This perspective on formative processes, the somatopsychic aspect of which is profoundly elucidated by Stanley Keleman (1985), and the particular role of early relationships, is the product of many influences and many theorists. Nowadays it has become conventional wisdom among psychodynamically oriented psychotherapists that it is the therapeutic relationship between each therapist and patient, which is the primary healing agent of the psychotherapeutic process. What this means exactly is somewhat unclear. There is a general consensus on certain elements that ought to be present in the therapeutic environment, emanating from the therapeutic relationship, but not so much clarity and specificity on what those are, or why they work. This paper is an attempt to organize some of those characteristics of the psychotherapeutic relationship that operate in the holding environment, and enable it to function as a medium for healing and for growth. I will also illuminate what some of the challenges are if the ideas currently espoused about the nature and function of the relationship are correct.

A Basic Matrix

A student in a class of creative arts therapists I taught made a comment that opened a way to a deeper understanding of the psychotherapeutic relationship than I had before, or that I had seen or heard previously. She said that she thought that psychotherapy was an evolutionary development brought about in response to the particular kind of healing possible in the environment created by this practice. Her comment stimulated me to begin thinking about what it is that makes the psychotherapy environment unique. And how that uniqueness might be part of its function, and, now I see, integral to its success.

The psychotherapy relationship is not just a better version of other, especially parental, relationships. **In the relationship between patient and psychotherapist the patient is always, and forever, at the center of the process. In no other relationship is the focus on one partner so absolute. It would not be healthy**

were it so. In all other human relationships it is essential that the relationship be explicitly mutual. Giving and taking are reciprocal functions. Interdependency requires the needs of both (or more) parties in the relationship to be considered and for needs to be met in appropriate ways.

The psychotherapy relationship is a human invention, similar to a hyperbaric chamber. That is a device in which a person is placed that creates conditions of oxygen saturation and air pressure that do not exist naturally on earth. These conditions facilitate healing from certain medical conditions – the bends, severe burns – that are not easily healed otherwise. Similarly, **psychotherapy is not a better version of relationships that have come before. Or even an ideal version of relationships, a sort of paragon. It is a unique kind of relationship that we have created for the purpose of healing damage caused in other relationships. The central principle of that uniqueness is that the patient's welfare, autonomy, self-determination, and the patient's centrality in the relationship are always prioritized.**

It is not a natural part of relationships to be so exclusively at the center of the relationship for so long a time (as it is in psychotherapy) without any demand that the needs and feelings of the partner in the relationship (the therapist) be considered in the patient's decisions about what to do in the matrix of the attachment. One thing we learn from early infant research is the critical importance of the mutuality that informs healthy early relationships, even in earliest infancy (Bowlby 1969). There is no time when the infant and parent are not a pair. No time when the dance does not include both partners. To dance effectively, creatively, passionately, happily, and constructively, both partners have to be aware of each other, of each other's needs, limitations, what needs gratifying and what is gratified. This part of the dance is explicitly not required in psychotherapy.

The relationship that is co-created by patient and therapist specifically permits the patient to occupy the center of the relationship in whatever way, and for as long as is necessary, that the healing requires. And it specifically enjoins the therapist from impinging on that centrality in any way not absolutely necessary for the maintenance of the relationship (fee, scheduling, and the like), and certainly not to provide for the gratification of the therapist's needs to be loved, adored, admired, followed, served, deferred to, or otherwise to take the center.

This is the abstention that the therapist agrees to in order to create this unique environment that we have come to call in shorthand "the holding environment". Once this specialized environment is constituted the therapeutic actions of psychotherapy can begin to take place. Many of these actions get subsumed under the general rubric of the holding environment. But they are specific dynamic actions each with their own structure and energetic impact. Just as, for example, love and respect are not the same emotional-energetic forces, so each of the elements in the therapeutic holding environment are not the same. Bioenergetic Analysis with its focus on energetic processes, and its refined approach to understanding

somatopsychic processes gives us tools to examine in finer detail the nature and operation of these therapeutic elements and their actions.

Embodiment

It seems necessary here to ask what psychotherapy is for. The earliest emphasis in modern forms of psychotherapy was on liberation from repression and the freeing of personal autonomy, part of the political changes in Western civilization that began in the Enlightenment. More recently, there is a focus much more on anxiety and the reduction of suffering and on the possibilities for positive feeling.

One way to synthesize these two positions is in the concept of embodiment. Embodiment is another of those conceptual and experiential understandings that we have difficulty defining with specificity, although we kind of know, implicitly, what we mean. In modern bioenergetics embodiment refers to the capacity for deeply felt experience and strong expression of emotion. In this context **embodiment refers to somatopsychic structure and capacity in an individual that holds that deep experience and powerful expression and the holding allows for continuous integration and refinement of the experience.** Somatic oriented free-association, the following of one's process in a profoundly attentive way, without judgment, accepting of whatever arises, is made possible by the psychotherapeutic space.

From the moment of embodiment self-possession is possible, choice is possible, options for amelioration of suffering, if any exist, can be chosen. In this perspective one thing psychotherapy does is facilitate a person's capacity to be in reality. To be in reality means to be able to feel things and experience things as deeply as possible, to broaden awareness and understanding of ourselves and the environment, and to use as much of the information available to us as we can tolerate knowing and immersing ourselves in.

With this general view of what psychotherapy is for we can examine the ways that a holding environment creates and sustains a space in which this project can be undertaken. The next part of this paper involves an analysis of the elements that constitute a holding environment. It is not my idea that this exhausts the analysis. Rather this is the beginning of an investigation using the tools of bioenergetic analysis and is designed to illuminate the elements both structural and procedural that make the holding environment the therapeutic envelope, and why it works as it does. I hope others will add to our understanding of it.

So far my analysis has led me to divide the functional elements of a holding environment into three general categories that I label containment, holding, and receptivity. Each of these functions has both structural and procedural dimensions. That is, there are aspects of each that are built into a successful holding environment, and there are dynamic parts that are behavioral, executed by the therapist.

I. Containment

Containment refers to all the elements of the therapeutic space that contribute to its therapeutic effect. This use of the term has nothing to do with modulation, or suppression, or restriction, or regulation of affect. It has to do with the constituent elements in concrete material terms, in ethical and professional terms, and in characteristics of the therapist, of the therapeutic environment. **From a bioenergetic perspective the therapist's space is an extension of her or his body. It is designed to contain, meaning to cradle, and to sustain, strong and deep emotional experiences of self.** Some of the elements of a successful psychotherapeutic container are common to all psychotherapeutic modalities.

Ia. Common Elements

The common elements include structural elements of private and secure physical space. They also include the ethical and professional elements such as confidentiality, and a covenantal relationship, a bond based on faith and trust that the therapist will maintain the centrality of the patient, in which the interests of the patient take priority. And there are certain characteristics of the therapist – a non-judgmental attitude, and an ability to respect and appreciate the patient as an autonomous person, that are requisite for the containing function to operate properly. In bioenergetic analysis these characteristics extend to a physical space that allows for expressions that can be loud and unconventional by the standards of psychodynamic psychotherapy, and include emotionally evocative physical interventions that require the therapist to have mastered a discipline of direct physical contact and a tolerance for the ensuing emotional expression.

A clinical example of what I mean by this idea of containment comes from my own psychotherapy. Here is a moment from my psychotherapy with Michael Eigen, a therapy of many years duration now. One day, many years ago, I was on the bed he used as an analytic couch at that time, and I was in the throes of certain kind of unbearable tension in my neck. It is a maddening, demonic force in my body. It overtook me, and still does. I said to Mike: **"I wish you could hold my head so I could scream." He said: "I wish I could too." This was an immensely important moment for me. He was not denying the validity of that way of working. He was saying, to my ears anyway, honestly what his limitations are. That I could accept.** Those limitations of his have meant that I have had to do this, for me lifesaving, work of strong, loud, emotionally intense expression, on my own, or occasionally with others who work in this modality. Learning that has reinforced my conviction about the importance of the characteristics of the containing environment for strong expressive work, and how that environment can be internalized by patients.

Mike has personal experience with bioenergetic work, and the forceful emotional expression does not seem to throw him. But once, when I began on my own to make too loud or intense an aggressive sound, I'm not sure the exact nature of the stimulus, he asked me to tone it down because he had heard complaints. From other residents, I assume. So I have had to monitor and modulate my expression. I am clear that he can receive the force of my emotional expression, but I cannot express myself as fully as I can. Luckily for me, by the time I came to him, I was experienced at working with explicit strongly expressed emotion. My first extended therapy was with Vivian Guze, a bioenergetic therapist who saved my life, and the work with her taught me how to stay present for myself in the throes of intense experience despite the possibility of decompensation. And, even more important, I had a life partner whose capacity for strongly felt and expressed emotion exceeded mine and who could therefore provide a holding environment greater than any of the others in my life.

In fact, when I left my therapy sessions with Mike – who, despite his familiarity with bioenergetic work, and comfort with it, was not working in that modality – I would always need to make time for expression of the rage that was mobilized in me. I have been doing this kind of work on myself for years. Screaming, punching, kicking were the ways that I could exit, however temporarily the deadness engendered at the core of my being by early childhood mistreatment. I could not complete an episode of work without it. I had to be able to fight with those who so harmed me, and I had to express my own feelings of hate and sadism. This was the only way to return to some relationship with reality and to be in the present even in the limited way that may be possible for me.

Ib. Containment and Intimacy

A containing environment, which is the first constituent of a holding environment, is created when a therapist creates a physical, ethically guided space, and enters it prepared to embody the characteristics required for therapeutic action. The therapist uses the tool of empathy to register what the patient is experiencing internally, including that which is out of the patient's awareness. Starting from this position, the therapist attempts to effect a moment of meeting with the patient. This means receiving the patient as she or he actually is as a person and taking her or him in. This is a much harder task than it appears. **It is not tolerance, or compassion. It is intimacy, a knowing the other as the other actually is.** This is the first constituent of the holding environment, and already the task is very demanding for many of us. From this standpoint it is inconceivable to see the other person (patient) as someone who needs correcting, or fixing, or adjusting. To know the other person in this way is to know how they came to be who they are, and how much that history is who they are.

This turns out to be quite a difficult skill to develop and to deploy in a sustained way. I will take the risk to say that much of the criticism of psychotherapy, its slowness, its aimlessness, and the like comes from the fact that therapists are not engaged in this process of embodied containment with our patients. Some of us are too afraid – of the feelings in us and/or in the other; some of us are too narcissistically invested in having an impact; some of us allow the press for our own need gratification to take us out of the posture needed for containment. Whatever the reason, **the feeling of aimless, or pointless wandering comes from that lack of presence, not from a fundamental deficiency in the work.** The pressure then to produce a method that does more, and faster, is a response to a limitation in the way the therapist behaves and feels, and is not a problem exclusively in the method being used.

Containment is that set of functions which structures the therapeutic environment to make it possible for the patient to reveal and experience that which must be revealed and experienced, thus making intimacy possible. This revelation takes many forms. Here is one compelling description of that revelation from Michael Eigen's The Annihilated Self, published in 2006:

> "Emboldened by their contact and driven by need, this person comes in one day without makeup and shows herself as she is. Chilling, bloodcurdling, necessary. She shows her ravaged self to the one person who can take it. No, incorrect. Marlene [the therapist] may not be able to take it. She shows herself whether or not Marlene can take it. That is closer. To risk in therapy what no one can take." (p. 25)

Eigen goes on to say something that I think relates to the specific and unique function that psychotherapy performs for human beings, that is specific to it, and not only better versions of what relationships should be. He says:

> "The human race has not evolved the capacity to take what it does to itself, the pain people inflict on each other. In therapy one risks what is too much for another, too much for oneself. One risks what no one can take or may ever be able to take. That enters the room and is shared, whether or not anyone can take it." (p. 25–26)

Containment provides the environment in which that which must be felt and revealed will occur. The therapist prepares the space and most importantly, prepares her or himself for an encounter with what is most real and most painful, and most disturbing, and most frightening for the patient. In bioenergetic analysis creating the containing environment includes creating a physical space in which emotional expression can take place at the most intense, most overt and most evocative level possible for that person. In the context of Mike Eigen's article the affect is in

response to damage, harm and destructiveness. But the same preparation applies to love, pleasure, even ecstasy.

The therapeutic environment is unique in its focus on the patient and the patient's process. It is the patient's experience that takes precedence. This is not to the exclusion of the therapist or her or his experience. It is a matter of prioritization and of the nature of the space. No judgment is offered as the therapist endeavors to receive and experience both what the patient can and cannot tolerate experiencing.

This is the containment that we mean as bioenergetic therapists. There is no suppressive element in it. On the contrary, the space is made safe for as big or as small an expression as the patient and therapist can tolerate. It is part of the therapist's skill to open the space and invite expression that is within the range of tolerance for the patient, so that the experience can be integrated and metabolized. Since what is dealt with is so often chronic relational trauma and the long-lasting effects it leaves behind, the movement of revelation and expression followed by integration is both continuous and slow moving. This is the true nature of catharsis – a powerful emotional experience that results in a new integration of awareness and experience, and so requires a space for contained deeply felt and deeply expressed emotion.

II. Holding

In her book *Holding and Psychoanalysis: A Relational Perspective* (2014) Joyce Slochower describes the holding function in psychoanalytic psychotherapy. In a very elaborated exposition she describes holding as one dimension of the psychotherapy process common across many modalities. She uses holding to denote a condition in which the therapist minimizes the impingement of her subjectivity, her 'otherness' from the patient. Doing so creates the possibility for establishment of a temporary "*illusion of analytic attunement* [italics in original]" (p. 21). This state permits the patient to feel safe and secure in the therapeutic relationship without being confronted with the therapist's separate and unique self and the perspectives on reality, which that (the therapist's self) introduces into the therapeutic field.

Slochower contrasts this condition of soothing attunement that offers reparative possibilities for traumatic experiences of annihilation, abandonment, disregard, and denigration, with interpretative functions. Interpretations are one form of encounter between patient and therapist that require the patient to come face to face with the therapist's subjectivity, his difference and separateness as a unique person. In Slochower's view, holding represents those functions performed by the therapist when the patient cannot respond to the reality of the therapist's otherness without too great a disruption in the holding environment, which would threaten to derail the therapy. Depending on the patient's underlying personality

organization the holding phase of the treatment might be short, in response to temporary regression in the patient needing a more soothing adaptation by the therapist. Or it can last for years as the patient strives to build enough ego and self-structure to tolerate the reality of the therapist's personhood, thereby building the capacity to bring other dimensions of reality into the therapeutic encounter.

IIa. A Bioenergetic View Of Holding

I take a different view from Joyce Slochower. I use holding to represent all the operations that offer therapeutic contact between the therapist and the patient. These are functions the therapist offers the patient.

Starting with early psychoanalytic concepts of the therapeutic space, holding, in this sense of the term, is a critical element of what makes the space therapeutic. Some of the holding characteristics have been taken now as fundamental to this therapeutic possibility, and are nearly axiomatic in the expectation of creation of such a space. These include holding the patient in non-judgmental positive regard; suspending and holding at bay conventional expectations of social interactions; acceptance of the patient's self as valid and valued; validation of the person's experience as intrinsically valid and meaningful, are among the most significant. All of these represent holding energies, they are extensions of the therapist's energetic being and presence. The therapist holds the patient (the other) in her or his consciousness, as Bion (1959) suggests, without expectation or desire, in order to apprehend the person. When that specialized relationship between therapist and patient happens other elements of holding can occur. In bioenergetic psychotherapy, those other elements can also be directly physicalized, which adds another dimension to the psychotherapeutic process.

In bioenergetic psychotherapy the holding can refer to direct physical contact. Body-to-body contact can represent holding for the purpose of comfort, or holding for the purpose of restraint, or holding to reassure that the patient is not alone, or to support expression. Holding means, in almost all cases that a physical act, at least in its energetic form is taking place. When the therapist holds the patient in her or his consciousness, remembers the patient, her or his identity and suffering, there is a physical and energetic aspect to this event that we can identify and study. Holding, in this view will involve changes in both patient and therapist along every dimension of psychic and somatic process.

A concrete example of this is what takes place in the bodies of people organized as borderline or schizophrenic personality structures. Many such people have a location in the back, behind the heart, alongside the thoracic vertebrae that is experienced as a black hole. I know this phenomenon both personally and with patients of mine. The experience is that energy runs out of the body through that hole which cannot be stoppered. When I put a hand over that hole, some patients

report what I have experienced, that it is as if the hole operates in a realm of absolute zero, no warmth at all, and the hand delivers warmth for the first time ever, even though the touch has been made before. James Grotstein (1990) has written very movingly about this same phenomena from an intrapsychic perspective.

To illustrate this approach using the bioenergetic conceptual framework I will offer three clinical vignettes, the first taking off from this example of the black hole as an effect of early chronic relational trauma (Tuccillo 2012).

Vignette 1: Holding in presence of terror in a cold, dark place

Eleanor has been a patient of mine for many years. Over those years she has vouchsafed with me the version of her who was terrorized as a child. She was terrorized in a family that looked to those outside, and, amazingly, even to Eleanor on the inside like a happy wholesome family. But the abusive use of children to gratify profound deformations in the parents' narcissistic functions is evident, as is the ignored but regularly expressed hatred and vicious competitiveness with the children. Eleanor, who is very successful in her worldly life, has increasingly allowed me to bear witness to the abused child and hold her suffering in the foreground, even as she herself writhes in torment, accused of the wickedness of false accusations toward her parents.

An experienced patient, Eleanor guides herself into the inner reality of her childhood. Immediately I have to *hold* her conflicted and ambivalent feelings. She can validate the reality of her own experience now, but also wants to disown it simultaneously. She wants me to come and sit by her, but for the first time also expresses her ambivalence about that. An expression like this would be unthinkable in her family of origin. She had to be available at all times and in all ways for her parents in *their* need that she attend first and foremost to their psychic and emotional needs. To feel ambivalent is to be too autonomous. If she expressed the ambivalence, or any other autonomous self-representation they would punitively abandon her.

She decides to go ahead and ask me to sit by her as she lies face down on the bed and asks me to put my hand on her back just below her neck. A long conversation follows between us in which she asks me questions that I know from past work are based on her experience of her mother's (largely unconscious) hatred of her. Am I disgusted touching her? Is it painful to me? Do the sounds she makes cause me to have contempt for her? Am I repelled by her inadequacy and ignorance? No, I say to each of these questions. I have created a holding environment where my own struggles to deal with the feelings and states Eleanor lives through do not impinge on our relationship.

She says: "I am in a cold dark place. I can be here and there at the same time." This is actually the first time she can acknowledge this fact. Yes, I say, I know that what she is saying is so. As she cries out in pain and terror I am holding her in that

cold place, even though no one was there to hold her when she was first thrown into it. I am holding her by my presence and by my touch, holding her ambivalent feelings, and holding her terror of being left there. My touch is a crucial part of the *holding*. When it is time to stop we need to move to end it slowly so that she can substitute holding herself before she can return to the everyday world.

Vignette 2: An unexpected strength late in life

Jack is an older man, in his middle sixties who has engaged in a deep and life-altering psychotherapy in the five years or so he has been seeing me. Two persistent symptoms that have bedeviled him are profound anxiety and fear of criticism when he teaches or presents material (he is a very accomplished professional scientist and researcher), and an abiding irritability directed at his second wife who is – both by his report and by my direct contact since I did some couple sessions with them before beginning to work exclusively with him – a mature, caring person who treats him respectfully and well. In a session those two themes came together and the resulting associations illuminated an aspect of their origin in his relationship with his mother. The way the work went illustrates another aspect of holding in the holding environment.

Jack came in that day talking about obsessing about perfecting a poem he had written. This is not like him; he is not usually perfectionistic about his creative work, as he is about his professional presentations where his need to secure approval and his dread of criticism pervade the experience. It sounds to me like elements of his relationship with his mother are activated by his striving for self-expression, and I say so. He has to do things perfectly so that she (mother) will feel good about herself. He hopes she will then offer him praise or appreciation that he could turn into some positive self-regard. So, I say, he is very dependent on her for any positive self-regard he might be able to generate.

This reminds him of a recent visit to his mother in a nursing home. She is an irascible woman, often critical of him, and he is devoted, nevertheless, to her care, and she is very dependent on him. On this visit she is in the dining room when he arrives, eating. His wife who happened to be with him on this visit, advises him to wait until she finishes eating before approaching her, knowing, I suspect what will likely happen if he does not. Jack tells me that he "stupidly" ignored his wife's advice and went over to her anyway. At this his mother becomes "panicked in a way" he had never seen before. She stops eating, and it takes quite awhile for him to settle her down.

Our discussion of this event leads to his considering that he went over when he did with the unconscious intent of disrupting her. He considers this likely, but he can't feel it. He can't feel the rage he believes is there underneath a layer of sadness evoked by his mother's reaction to him. Jack is experienced at active, emotionally expressive work, and when he enters expressions of strong negativi-

ty it is clear how strong he is. Despite his age, and an appearance that looks on the surface somewhat collapsed, his chest sunken, his shoulders drooped forward, when he becomes charged another underlying somatopsychic reality emerges and can be seen.

I ask him if he wants to try to find the feelings he believes are there but cannot feel through movement, and he says yes. Often when Jack first starts to breathe deeply he experiences profound spasmodic gagging-like movements accompanied by loud, blasting sounds that carry feelings of rage and pain. That is what happens at first as he stands, bends his knees and increases breath. Knowing the effect on him of hitting with his fists I offer that approach. At first his two-fisted blows to the cushion on top of the bed as he swings both arms down are forceful but not yet infused with much emotion.

This is uncharacteristic of Jack. He usually finds his way to what he needs and wants to express in his negativity quite quickly and needs only my supportive presence to facilitate the expression. But this time I see that he needs more. So using my voice I encourage him to stay with the feeling and to amplify it, to use his own voice. When that is hard for him to do – to amplify his voice and intensify the rage and eventually, hatred, in it – I raise my voice, I make sound also. I see how my guttural angry sounding vocalizations support his extending his expression further. **I am holding him, with my presence and my voice and my intention, in the active expression of his indignation, his outrage, his rage and hatred at his mother's use of him.** Her use of him without subsequent appreciation is exploitation.

The realization that it is exploitation is stimulated by this event. That includes a dawning understanding for Jack that this was the chronic state of affairs between his mother and him. The expression of his rage is not an emptying out of a reservoir of feeling, not only a discharge of pent of emotion, it is also a moment in their relationship when his hurt, his disbelief, his rage at her for her treatment of him as a child can be organized into expression as fully and deeply as he and I can tolerate. Luckily for me he is not yet approaching my limit of tolerance for the experience and expression of these feelings. So I can continue to hold him as we work our way through the layers and formations of his relationship with his mother, started then, and that persist in his life today.

Vignette 3: A failure in holding accountable

I worked with Paul for a brief time many years ago. He was a man who rested on the edge of manipulative, self-aggrandizing behavior while failing to find success in life, at least during the time when he saw me. He was almost completely refractory to any of my interventions, many of which were challenges to characterological patterns. His defenses included rationalizations he employed to account for, or justify failures to do what was right, by acts of commission or omission.

There was a significant event in his early childhood that he did tell me about. He lived in a big city, in a neighborhood of modest one-family homes, many with small front yards that were often fenced-in. When he was a toddler he was unsupervised one day, wandered through the open gate in the fence at his house, and was hit by a car passing on the street. He was taken to the hospital, although not severely injured. He reported this story with anger that it happened, but not as evidence of a pattern of neglect or lack of care by his family. I thought it might represent that, but my efforts to call that possibility to his attention for consideration failed to arouse any interest in him.

One day he told me that he was planning to visit a prostitute. In keeping with what I have described above as the non-judgmental quality inherent in the containment provided by the psychotherapy environment, I took no position pro or con on this proposed action. But in taking this position without further consideration and nuance, I made a serious error. Paul was planning this action at a time when public awareness of the sexually-transmitted vector of AIDS was coming into the foreground of public view, and the significant risks of sexual activity with partners who had had themselves multiple partners was becoming known.

Some weeks after the announcement of his intention Paul came in, told me he had indeed been with a prostitute, and then told me that he was ending the psychotherapy with me. I should have warned him, he said, to use a condom, given the current state of knowledge about the risks attendant on his behavior. Taken aback, and certainly not sure he was wrong, I tried to investigate with him what he thought my failure might mean. But as before he was unavailable for further investigation. There was to be no greater connection to themes or patterns of his life. I had done wrong by him and he was going to go.

Afterwards, I began to delve into my failure, his experience of it, my experience of it, and what it might represent in a larger way than he related to it. What I came to understand was that I had acted like his family members in failing to hold him back from acting dangerously. Like his mother who left the gate open to the street, I had failed to hold him in my consciousness, hold his welfare as a priority, and act to create a restraint that would prevent harm to him. These are also elements of holding that take place in the holding environment when the containing functions of the environment have been put into place. **The enactment of this event with Paul created an opportunity for him to live out the experience of neglect to hold him in this way with me, and use that experience to open a way to his feelings about me, his family, and himself.** But he ended the enactment as the events had unfolded in his family, and my failure and his anger led to no new resolution.

Paul held me accountable for my failure to be alert to the danger to him, as well he could. But he did not hold himself accountable. Holding accountable – oneself or another – is a body state. It is a posture that accompanies the resolve necessary to hold one's ground and confront oneself or another with the consequences of

behavior. This will become a significant element of the holding environment in understanding the importance of receptivity in the therapeutic relationship.

IIb. The Strain of Holding

Joyce Slochower speaks movingly of the strain of holding in the psychotherapeutic relationship. Whether meant in the narrower sense she means it or the broader way I describe it, that strain is undeniably true. It is true even when the therapist is free to be more herself or himself because the patient is capable of responding healthily and constructively to the therapist's unique personhood. The strain of maintaining the patient's centrality, of maintaining constant awareness, even vigilance on the part of therapist of intention and feeling is tremendously demanding.

It is true because a great deal depends on the therapist's ability and commitment to do this. The patient puts his or her psychic and emotional, and sometimes physical, life in our hands. In other relationships a bond of mutuality and maturity will develop between the partners and the load of care, of attention, of decision-making will come to be shared. In the therapeutic relationship this is not required. In fact, the psychotherapy relationship has been created to heal the damage to that maturative capability in the patient, and healing possibilities are unknown until the work of healing is engaged.

The strain inevitably results in failures. These failures include failures of attunement, lack in understanding or experience, and even acting-out of countertransference feelings and attitudes that injure, or even harm the patient. It is to this dimension of what makes the psychotherapy relationship a healing process that we turn our attention now.

III. Receptivity

Introduction

In the continuing clinical research to understand the healing powers of the psychotherapeutic relationship the emerging perspective of relational psychoanalysis has offered a dramatic proposition. Building on a foundation that comes from feminist ideas about relationships and about psychotherapy, relational theorists consider all relationships to be intersubjective. This means that the partners uniquely construct each relationship. All members of the relationship have equal value and significance; dependency is a feature of the relationship flowing from each member and to each member. In this relationship matrix people know each other through direct, conscious communication. They also know each other through the interpenetration of unconscious self, sharing themselves with

each other and receiving each other through various psychic and emotional instruments: empathy, projection, identification, sympathy, are examples. To this bioenergetic therapists would add the transmission of energetic states of being and feeling which are received in various somatopsychic channels – body states, constellations of sensation and emotion that are studied for their complexity.

Receptivity to the other person at this level of openness and vulnerability allows for a knowing of the person that can be brought into the open. This knowing at so basic a level fulfills a developmental need that is in itself healing. It also permits the psychotherapist to continue to create holding moments that are responsive to the reparative, restitutive, boundary-making needs of the patient.

IIIa. Somatopsychic Challenges of Receptivity

This way of understanding psychotherapy process does raise significant questions. Joyce Slochower points to those challenges in an interview in a recent issue of the magazine, *New Therapist* (May/June 2016). She talks about the perceptiveness of some of her patients and the fact that they may pick up aspects of her reactions despite her attempts to keep them out of the interpersonal field (a process she calls bracketing). She goes on to say that for that bracketing process to be successful both therapist and patient must engage in it. The therapist tries to shield the patient from aspects of her that would disrupt the sense of resonance on which she or he relies. And the patient collaborates by removing awareness of those characteristics revealed by the therapist.

This resembles previously understood methods of protecting the primacy of the patient's welfare in a therapeutic space by restricting the impingement of the psychotherapist's needs, attitudes, or destructive impulses. The principles of neutrality, a non-judgmental attitude, abstinence from meeting the therapist's needs, are all elements of creating and preserving a benign space and a benign therapeutic presence. But from a bioenergetic standpoint once we introduce the idea of the interpenetration of energetic unconscious processes the already very difficult task of maintaining the benignness of the space becomes much more complicated. If the core of the therapist's identity is benign, if not benevolent, perhaps things are easier. But what if they are not?

IIIb. Psychopathy and the Function of Receptivity

This is a sharp term to introduce here, and it may seem to some readers as antithetical to an attitude of receptivity. It is not antithetical to the function called receptivity, which is the ability to see and feel the other. Psychopathy is a narcissistic deformation. It is a compensation for severe damage to a person's self-

esteem system. Depending on the level and extent of damage to the system the person so damaged cannot sustain positive self-regard or in the worst case cannot develop even the forerunners of self and other regard: admiration, appreciation, idealization. Where the therapist has no durable and flexible system of positive self-regard, one that can observe negative reflection on the self, the drive to restore approbation can deform the therapist's ability to sustain the environment I have described above. This can deform, if not vitiate, the containing environment in which holding operations can be conducted in the best interest of the patient.

In the modern understanding of relationships as applied to psychotherapy process, failures by the therapist are inevitable and necessary. These failures of attunement and of resonance, or even of loss of the centrality of the patient in the dyad are considered opportunities for the patient to find the long-buried history of similar, damaging failures in earlier life and feel them through. The failures also provide an opportunity for a different resolution to the interpersonal problem with a relationship partner (the psychotherapist) who prioritizes the patient's welfare and the maintenance and support of positive regard for all parties equally, even at the risk of confronting unattractive and unfavorable aspects of her or himself.

These are difficult conditions to maintain, however. Michael Eigen in his online book on psychopathy (2006) describes the prevalence of psychopathic compensations in human behavior. And in an article entitled the "Immoral Conscience" (1991) he talks about the way that omniscience, the drive to represent oneself as knowing everything, always, is a bane of healthy relating. Bernhard Brandschaft (2010) calls attention to this problem specifically for therapists. He warns therapists about the tendency to be so invested in favored theories and ideologies that the capacity to apprehend the patient as a unique person is compromised.

IIIc. Receptivity Gone Awry: Transgressions

How serious is the question of therapists' failures to maintain the most central element of the holding environment: maintaining the centrality of their patients' welfare and the preservation, recognition and receptivity for the unique subjectivity embodied by each patient? Articles by Muriel Dimen (2014) and Charles Levin (2014) point to answers. In her article Dimen talks about a "lapsus linguae" a slip of the tongue. Dimen reveals an episode in which her beloved therapist, to whom she feels much gratitude, slipped his tongue in her mouth in the only moment he physically embraced her in a long, and for her very helpful psychotherapy. The therapist never brought up the 'slip' and neither did she. Even writing about this long after his death she chose not to name him. Somehow she bypassed the transgression, even as she writes that his failure was greatly compounded by the additional failure of bringing up the lapse in boundary, which was the in-

troduction of the therapist's need and then its gratification at her expense. In a presentation she made based on this work she called on therapists to find a forum to talk with each other about such lapses in maintaining the holding environment (as I term it in this paper). Thinking about her exhortation I realized the great difficulty in doing so.

Levin expands the discussion of transgressions of the boundaries necessary for maintaining a proper holding environment to institutional training in psychotherapy. His article is in a volume devoted to themes of abandonment and betrayal in the analytic relationship. To my eye it is the most graphic and unapologetic of the articles that detail violations of dependency relationships. Many of the articles are on other subjects, the untimely death of one's analyst for example. But even among those relating inappropriate therapist behavior leading to betrayal of the therapeutic covenant and rupture of the relationship, his voice is singularly clarion in identifying both individual therapist rationalization and avoidance of blame, together with institutional collusion in covering up the transgressions and their significance. I am reminded of something that happened to me as a therapist, seeing someone – also a therapist – the child of a very well known psychotherapist, who depicted the parent in horrifying terms as an abusive self-centered person. It seemed credible to me. When I talked about it with my therapist his reaction was sufficiently watery that it felt like an apologia for the parent-therapist; enough so to disappoint me. I needed a full-throated denunciation of the parent. Why I needed that may provide a personal example of the question that bedevils me (no pun intended here, because the devil is a relevant part of this discussion) about the influence of the therapist in the energetic, interpersonal, psychic and emotional soup that constitutes the therapeutic relationship.

Where we are, where we go: The Challenge of Sustaining a Holding Environment

The Transgenerational Transmission of Abuse

My reality is an extreme. Extreme conditions have been used throughout human history to deepen understanding of more normative phenomena. The horrific brain injuries caused in wars past and present has led to more understanding of central nervous system functioning. Terrible burn injuries, and the damage caused by deep-sea diving has led to the development of technologies and techniques to react to and heal the damage. Similarly, the exposure of clinicians to the lifelong harm to soul, psyche and emotional life caused by chronic relational trauma informs everything we do with patients, including those patients whose suffering is less comprehensive, in whom damage to self is less severe, and whose capacity for recovery is greater, than that I know of for myself.

I have described much of the life experience and its effects that I am going to refer to here in more detail elsewhere (Baum, 1997, 2007, 2014). To make my point here I will say that I was destroyed psychically and emotionally by my mother and by the environment of people around her who were malevolent mad people who penetrated me body and mind. These people were driven by impulses, urges, and feelings that were un-neutralized and carried in adult bodies. My father, who ultimately saved me from all that (long after the damage was done), demanded unconsciously that I comply with his self-serving narrative of what happened by believing that he had saved me, that I had recovered, and that he had created me into an emotionally healthy child.

Facing what there is to Face

To so bend the truth of my own experience, under threat of loss of his approbation, and the threat that he would otherwise forget who I was and leave me, or return me to my mother, meant leaving all connection to inner truth and reality. This demand, plus the destruction already wrought on my inner being; plus a merged identity with my father that included his severe narcissistic deformations; plus the attacks leveled at me by both parents seeking an outlet for their vicious hatred for hypocrites and the sanctimonious self-righteous people who had harmed them, destroyed any capacity in me to develop the narcissistic functions and structures necessary for self-esteem. As Otto Kernberg (1975) delineated in his seminal studies of borderline and schizophrenic personality organizations, the problem for those of us living in that universe is not low self-esteem it is the absence of self-esteem.

Self-esteem is quite literally admiring and feeling good about oneself. Healthy self-esteem is built on the ability to encounter, integrate and metabolize negative aspects of oneself, act responsibly and appropriately in response to those discoveries and return to a positive relationship with oneself. When basic structures that undergird that functioning are destroyed then the craving for positive regard comes to dominate inner life, and the desperate search for anything that will quell the craving becomes the guiding star of behavior. There can be no moral center without the self-correcting mechanism of healthy self-esteem. Also, the craving for relief from self-loathing that accompanies the destruction of self-esteem systems warps all other considerations in decisions about behavior and relationship.

There are many descriptions of people organized this way in human history, in literature and drama. Coincidentally one very trenchant description came to me in an article in the New Yorker Magazine, by Jane Mayer (May 2016) profiling Tony Schwartz the man who acted as a ghostwriter for Donald Trump in the production of the book The Art of the Deal. Schwartz kept detailed notes for himself of his contacts with his subject. Asked about his understanding of the

man he says a number of significant things that are relevant to our understanding of the functioning of someone for whom the drive for positive regard is a central organizing principle of his personality.

Schwartz says about Trump: "Lying is second nature to him. More than anyone I have ever met Trump has the ability to convince himself that whatever he is saying at any given moment is true, or sort of true, or at least *ought* [italics in the original] to be true." (p. 23). This mechanism is part of the distorting effects of omniscience. Schwartz says also that Trump is driven entirely by a need for public attention to the point where it is all for "... recognition from outside, bigger, more, a whole series of things that go nowhere in particular." (p. 23) Ultimately, Schwartz sees Trump as driven by an "... insatiable hunger for 'money, praise, and celebrity.'" (p.24) Tony Schwartz concludes about Donald Trump that: "He's a living black hole." (p. 24). The damage that gives rise to this somatopsychic effect includes annihilation of self and identity, and I now see more clearly, also of narcissistic functions.

I recognize myself perfectly in Tony Schwartz's depiction of Donald Trump. Family, friends and acquaintances would find this unbelievable unless I have shared with them my knowledge of my interiority. I know it is true. A concrete example is in a comment made to me many years ago by my late wife, who loved me, and admired me and never wished me any harm. She told me that I could start a sentence going in one direction and end it going in the completely opposite direction. She was calling my attention to the fact that reality, facts, opinions, attitudes, everything is fungible in the service of securing the center and the possibility of obtaining narcissistic supplies – admiration, respect, adoration, idealization, idolization.

The Challenge to Therapists

We say that power is corrupting. This is partly because power is related to feeling good about oneself. Power is force, energy, and the capacity to do things or get things done. It is related to instrumentality (as described very well by Ron Robbins (1978) in his work on the limb character). It is related to being responsible for oneself. David Shapiro (1965) describes the connection of the disavowal of responsibility to the formation of psychopathic character defenses. It is very difficult to take responsibility for one's actions if it will lead to a devastating collapse of the shell of ego built on extracted narcissistic supplies that cannot be metabolized into somatopsychic structures that allow tissue to swell with pride, and glow with inspiration. In Narcissism and Power, Hans-Jürgen Wirth (2009) shows how this deformation of narcissistic functioning shows up in public life.

The corrupting effect comes from the use of power to supply self-interest at the expense of others. Greed certainly is a big element in this, envy also. So is

the desperation to garner positive regard. This type of positive regard goes as far as needing the centrality of the old-testament God, being at the center of every moment, and as the basic referent of a person's life.

Granted that most psychotherapists are not afflicted with this in the way I am. Many are likely more benign to begin with. They are likely to have metabolized and organized self and other representations that include the inevitable fallibility and moral confusion that affects all human beings. They may well, as clinicians, have learned to receive, accept and work with critical reactions of their patients about them, including those that have a correct percept of the therapist's narcissistic deformations, or limitations, or slips. I have had to create a self that could function as if I lived in the universe inhabited by those people. But as Dimen and Levin call to our attention, the problem of therapist transgression of boundaries to satisfy self-interest is common. Some theorists notably Harold Searles (1965) have made it a central principle of their work to sharpen their awareness of the destructive impulses, attitudes and feelings the therapist has toward the patient.

As I wrote in an article about the two-person identity (2014) I cobbled together whatever shards of soul survived the attacks on me, the projected idealism of my parents and their ego-ideal selves, and the souls lent to me by others – my late wife most of all, my children, my therapists, my friends, my patients, and I developed a consciously intended, purposeful self. As much as I able that self embodies the principles and values of goodness. The connection of pleasure and goodness is articulated now in the theory of Bioenergetic Analysis (Baum, et al. 2010). But the underlying self, as I know myself, built around a core of malevolence, revenge, and madness, cannot partake of that pleasure in goodness. Contempt and disdain and their corrosive effects are at the core of my body and identity and threaten all attachments.

I am acutely aware of the ways that self-interest seeps into relationship. Acutely so because of my knowledge of myself and because of both my father's and mother's mission in life to root it out in everyone, exposing hypocrisy and self-delusion. My father did this while sleeping with many of his women patients, espousing a theory proposed by Martin Shepherd in his book, The Love Treatment (1971), and then feeling scrupulous because he "didn't sleep with the fat ones". He told me this after I was already a fully qualified clinical psychologist! **In this case my need to be enfolded in his being, the only safe place I had ever known (as dangerous to my soul as it actually turned out to be), combined with his need for complete merger and identification with him. The result in me was best described in energetic terms as a swoon, a loss of self-possession and surrender to the sway and influence of another. This forced approval of his unconscionable behavior was both a result of and further augmented my general incapacity to register reality.**

Registering reality, in its most complex, nuanced and subtle ways is what is required if therapists are to conscientiously investigate transgressive behaviors, our

own or those of others. Here too a bioenergetic perspective helps to understand the dynamics of the investigative process, and the challenges it poses. I will use myself as the case study again. I know that many of my father's patients benefited from his ministrations, although not those he sexually abused. When I contemplate his sexual abuse of patients my consciousness is split. I can say categorically that I *know* that what he did was wrong. But the knowing is not uniform. In one of the splits in my being and in my body and in my psyche with which I am very familiar, I know cognitively and ethically that what he did yields to no rationalization. But my stomach and my guts do not follow this conviction. I feel the conviction wash out of my insides, even as I know on the other levels that I am right that he was wrong. I have worked on this phenomenon in me for a very long time. I understand the energetic process underlying this phenomenon, as part of the necessary transformation of self required of me to secure my adoring undying attachment to my father. I also know it is a manifestation of what was done to me articulated clearly when Mike Eigen said to me: "Your psychic heart and guts were torn out."

From the bioenergetic standpoint something has happened to my guts. We do not have the means to study cellular process at the level needed to understand this. But the ethical and moral function of gut reactions has been abrogated. It is a particular torment to know so certainly that what my father did was wrong – to his patients and to me, and to be bereft of the gut feelings and the intestinal fortitude to stand and denounce him and his behavior without being shaken by my dissolving insides.

This experience gives me insight into the difficulty we face when we strive to identify transgressive behavior when doing so threatens our relationship with ourselves, and with our positive regard. Or when it threatens our relationships with the important others in our lives who we want and need to admire, to identify with, and by whom we need to be positively regarded.

Some therapists I have told about his behavior have not, at first anyway, been able to generate a sufficiently outraged reaction to assist me in maintaining my own in the face of all the historical pressure to relinquish it. It cannot be only a rule-derived reaction. We therapists have to open ourselves to the impact that transgressions and violations have on our patients. This is delicate ground. The daily newspaper tells us how prevalent the rationalization of predation and exploitation is in the world we live in. On the micro-social level this behavior starts in families and the communities that surround them.

What to Do

If receptivity means being available to receive the toxic destructive elements of our patients, the concept seems straightforward enough. If we hypothesize that there

is a healing that takes place in an intersubjective relationship environment and that environment includes the mixing of unconscious material and of emotional energies of both the therapist and the patient, then my experience of myself tells me we are in delicate, and perhaps dangerous terrain. It behooves us therapists to develop methods to investigate our own psychopathy. Even if blessed with a fundamentally benign core self, our irreducible humanness assures the intrusion of destructive, self-interested feelings, and at least occasionally actions, into the holding environment.

The solution does not lie in a kind of neurotic, and ultimately self-righteous scrupulosity, it lies in assisted self-reflection. In developing this as a principle and methods for it, we can lead not only in our field but also in the world around us. **Sharpening, refining, delving into the ways that negativity, greed, envy, and narcissistic compensations create the ways therapists deform the holding environment becomes a method for preserving it**. Talking about it, among us and in the world is a mission to convey the hard-won knowledge that comes from the difficult work of psychotherapy for use in dependent relationships of all kinds.

Summary

The technical knowledge in bioenergetic analysis is the development of the set of skills necessary to know how to initiate, adjust and maintain the holding environment. The capacity to add the dimension of body-to-body contact between patient and therapist creates new dimensions of the holding environment. The purpose of that environment, in modern bioenergetic analysis, and in other expressive therapies is to allow for as near to absolute freedom of expression without risk of harm. **The aim of modern bioenergetic analysis is to create a holding environment that has the broadest dimension of durability that the therapist can manage. Included in that is the challenge to the therapist for the most direct, deepest encounter with her or himself that the therapist can sustain.**

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Traumatic Memories

A Neuroscience Perspective

Homayoun Shahri

Abstracts

English

In this paper, a detailed description of formation of memory based on neuroscience is given. Different types of memories are reviewed, and definitions of repressed memories and dissociated memories are introduced. Formation of dissociated memories, as well as mechanisms of repression of memory, based on recent fMRI studies and neuroscience research, are discussed. It is argued that traumatic memories frequently have dissociated aspects and repressed aspects. It is concluded and shown, based on recent research in neuroscience, that regardless of the nature of traumatic memories, a very important factor in treatment of trauma is the attuned therapist and the therapeutic relationship. Finally, two case studies are presented to highlight the arguments set forth in this paper.

Key words: Amygdala, Hippocampus, Prefrontal Cortex, Traumatic memories, Neuroscience, Therapeutic Relationship, Attunement

German

Dieser Beitrag liefert eine detaillierte, neurowissenschaftlich fundierte Darstellung von Gedächtnisbildung. Unterschiedliche Gedächtnisarten werden referiert, und es werden Definitionen von verdrängten und von dissoziierten Erinnerungen eingeführt. Die Ausbildung von dissoziierten Erinnerungen und Mechanismen der Verdrängung von Erinnerungen werden mit neueren fMRI-Studien und neurowissenschaftlicher Forschung belegt. Es wird gezeigt, dass traumatische Erinnerungen häufig dissoziierte und verdrängte Aspekte beinhalten. Auf der Grundlage aktueller neurowissenschaftlicher Forschung wird dargelegt, dass unabhängig von der Art der traumatischen Erinnerungen, ein einfühlsamer Ther-

apeut und die therapeutische Beziehung sehr wichtige Faktoren in der Trauma-Behandlung sind. Zum Schluss werden zwei Fallvignetten präsentiert, um die Darlegungen dieses Beitrags zu illustrieren.

Italian

In questo saggio viene descritto in modo dettagliato come si forma la memoria in base alle neuroscienze. Vengono rivisitati diversi tipi di memorie e vengono presentate le definizioni di ricordo rimosso e ricordo dissociato. Sono trattati la formazione dei ricordi dissociati e i meccanismi di repressione della memoria in base ai recenti studi fMRI e alla ricerca neuroscientifica. Si sostiene che i ricordi traumatici hanno frequentemente aspetti dissociati e aspetti repressi. Si conclude e dimostra, sulla base delle recenti ricerche neuroscientifiche, che, indipendentemente dalla natura dei ricordi traumatici, un fattore molto importante nel trattamento del trauma è la sintonizzazione del terapeuta e la relazione terapeutica. Infine, vengono presentati due casi clinici per evidenziare gli argomenti di cui al presente articolo.

Spanish

Este artículo ofrece una descripción detallada de la formación de la memoria basado en la neurociencia. Se repasan diferentes tipos de memorias y se introducen definiciones de recuerdos reprimidos y recuerdos disociados. Se plantea la formación de los recuerdos disociados y mecanismos de represión de la memoria basado en los recientes estudios de fMRI e investigación de la neurociencia. Así mismo se argumenta que los recuerdos traumáticos poseen con frecuencia aspectos disociados y reprimidos. Se concluye y se muestra en base a las investigaciones de la neurociencia, que independientemente de la naturaleza de los recuerdos traumáticos, un factor muy importante en el tratamiento del trauma es la sensibilidad del terapeuta y la relación terapéutica. Por último, se presentan dos casos con clientes para destacar los argumentos enunciados en este documento.

Portuguese

Este trabalho traz uma descrição detalhada da formação da memória, baseada na neurociência. Além disso, traz a revisão de diferentes tipos de memória, apresenta a definição de memórias reprimidas e dissociadas e discute sua formação e mecanismos, baseados em estudos recentes da fMRI e da neurociência. Demonstra, também, que memórias traumáticas têm, frequentemente, aspectos dissociados e reprimidos. Mostra, por fim, com base em pesquisas recentes da neurociência, que, apesar da natureza das memórias traumáticas, um importante fator no tratamento do trauma é a relação terapêutica – com um terapeuta sintonizado. Serão apresentados dois estudos de caso para demonstrar os argumentos aqui desenvolvidos.

Introduction

Trauma has a huge impact on all aspects of our society and civilization. However, the existence and reality of trauma is not considered to the extent that it should. The effects of trauma are rarely acknowledged and are often neglected. Trauma can alter the individual in his or her very core, and affects all aspects of life. Trauma changes the way an individual interacts with his or her environment, his or her flow of information, and flexibility of responses to their surroundings. Trauma may change the body of the individual, making it rigid at times or flaccid (collapsed) at other times, resulting in a loss of motility and limiting the individual's aliveness. It may also change the functioning of the internal organs. Trauma may change an individual's metabolism of energy, and exchange of energy with the environment. Traumatized individuals are prone to primitive self-protective responses when they perceive certain stimuli as a threat. Once sensory stimuli trigger past traumatic events, the emotional brain activates the old habitual protective responses resulting in an inability to self-regulate. At the core of understanding trauma and healing trauma, is the nature of traumatic memories and their activation. In this work, I shall look at traumatic memories in detail and bring together results from neuroscience and psychology.

Shock trauma is sudden, massive, and may be chronic. It affects individuals in their core, and may alter the functioning of the brain including the frontal cortex, limbic system, parietal lobe, insula cortex, and visual cortex, etc. (van der Kolk, 2014; LeDoux, 2002). This is in contrast to developmental trauma, which usually is chronic, happens during developmental stages, and is mostly due to non-optimality of caretakers responses to the developing child. Developmental trauma can and does affect brain functioning but generally not in the same way as shock trauma. Developmental trauma is also referred to as complex trauma (van der Kolk, n. d.).

Recently, healing of trauma, including PTSD, has found quite a lot of interest within the research community. This interest in studies of trauma, its causes, and healing is partially fueled by recognition of its existence, and to recent technological advances in neuroscience and brain imaging (notably fMRI), as well as a changing political climate. In the following section, I will discuss the nature of traumatic memories from the standpoint of classical psychology as well as recent advances in neuroscience.

Neuroscience of memory – a microscopic view

At the core of the brain are the neurons. There are about 100 billion neurons in our brain, and each neuron can have thousands of connections with other

neurons. Neurons communicate via their axons (transmitters) and dendrites (receivers). A neuron can have thousands of dendrites, thus receiving input from thousands of other neurons. Neurons however, usually have one axon, but axons can have many branches as shown in Figure 1.

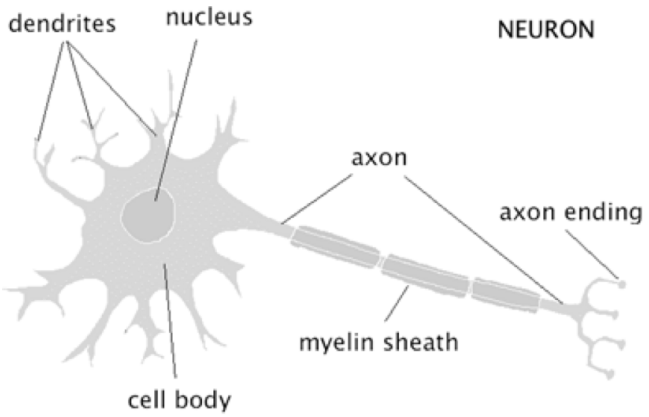

Figure 1. Structure of a neuron

The junction where an axon meets a dendrite is called a synapse. The neurons transmit information by their axon to other neurons through synaptic space. When an electrical signal reaches the end of the axon it releases neurotransmitters contained in Vesicles (see Figure 2). These neurotransmitters travel through the synaptic space and bind to dendrites of other neurons, resulting in electrochemical changes in the body of receiving neurons. There are two general types of neurotransmitters, these are inhibitory and excitatory neurotransmitters. Excitatory neurotransmitters stimulate the brain (increase the potential buildup in the receiving neuron), while the inhibitory neurons calm the brain (reduce the probability of potential buildup in the receiving neuron).

The main inhibitory and excitatory neurotransmitters in the brain are Gaba (Gamma-Amino Butyric Acid), and Glutamate respectively. There are also other neurotransmitters that play a significant role in brain information processing and memory, which I will discuss below. When the receptors on the receiving dendrites bond with the neurotransmitters, and electro-chemical change inside the neuronal cell takes place, this results in increase of the internal potential of the neuron from a resting voltage of –70 mV to possibly a voltage of +40mV. At this point the charge rapidly decreases to –90 mV, which results in release of neurotransmitters into the synaptic space of the receiving neuron through its axon. This event is called *action potential* and the rise and fall of potential is called a *spike*, which is shown in Figure 3, below.

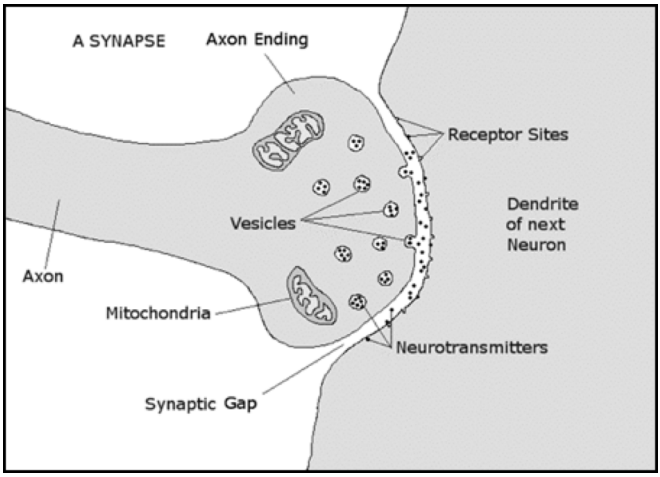

Figure 2. Structure of a Synapse

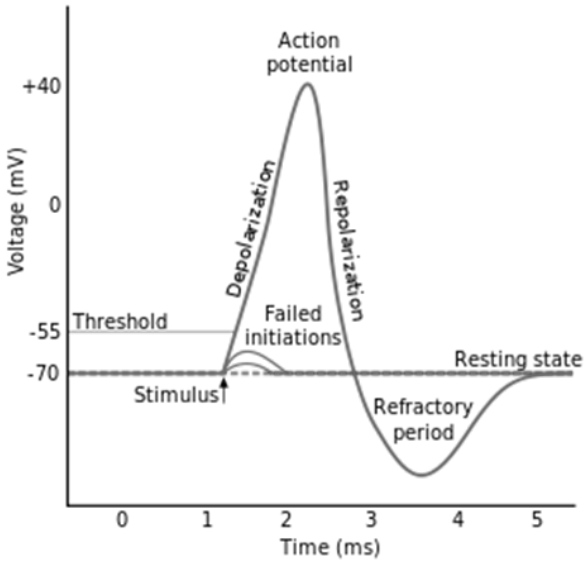

Figure 3. Formation of action potential (spike)

A neuron usually releases a sequence of spikes called a spike train, or a train of action potentials. Information is carried in the spike trains. In order to gain a deeper understanding of this process, please refer to Figure 4.

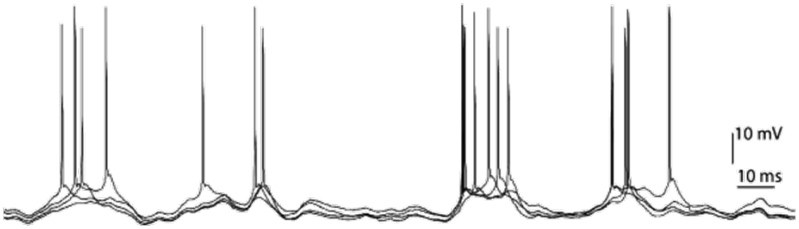

Figure 4. A spike (action potential) train

However, neurons do not function in isolation. The axon of one neuron may form synapses with dendrites of many other neurons. Of course many neurons may fire action potentials at the same time, thus the question is, what happens when many neurons are involved in generating action potentials. In other words, what is the mathematics of synapses? LeDoux (2002) indicates that the principles of synaptic mathematics are: **Exuberance** – that is more synapses are made than are preserved; **Use** – that is the synapses that are preserved are the ones that are active; and **Subtraction** – that the synaptic connections that are not used are destroyed. This clearly points to synaptic plasticity. That means the brain is constantly in the process of rewiring itself, thus forming new synapses, and destroying others.

Neural networks and memory are associative. Associative memory is defined as the ability to learn and remember the relationship between unrelated items. Let us now discuss the associativity in formation of memory in neural networks. In 1949, Donald Hebb suggested that if the axon of neuron A is close enough to the dendrite of neuron B to excite it and result in action potential, and if the process occurs repeatedly and consistently, then the connection between neurons A and B will be strengthened, and will result in higher likelihood that neuron B fires an action potential in response to neuron A. In other words, **neurons that fire together wire together**, and this is known as the Hebbian axiom, which also describes the essence of learning and memory (LeDoux, 2002). Much has been discovered about the underlying mechanism of Hebb's fire-and-wire theory which involve sodium, potassium and calcium ion channels and NMDA receptors, which are special glutamate receptors that pass calcium resulting in long term potentiation (LTP – long lasting increase in transmission, which results in a longer spike train), when both the presynaptic neuron (through its axon) and postsynaptic neuron (through its dendrites) are active at the same time. LeDoux (2002) writes:

> "Presynaptically released glutamate finds its way to both AMPA (a glutamate receptor involved in regular synaptic transmission) and NMDA receptors. Binding of glutamate to AMPA receptors is one of the major

> ways that a postsynaptic cell can be induced to fire an action potential, and is the means by which cells normally get fired up. In contrast, when presynaptically released glutamate reaches NMDA receptor on the postsynaptic cell, it has no effect initially because part of the receptor is blocked (by Magnesium – Mg). However, once glutamate has activated the post synaptic cell (caused it to fire an action potential) by binding to AMPA receptors, the block on the NMDA receptors is removed, and glutamate can open the receptor channel and allow calcium to enter the cell. LTP is the result." (p. 144)

This is the essential requirement for Hebbian neural plasticity. LeDoux (2002) describes NMDA receptors as "coincidence detectors", which detect the coactivity of both presynaptic and postsynaptic neurons, and more importantly according to LeDoux (2002) they detect which presynaptic neurons where active when the postsynaptic neuron fired an action potential. This is the essence of associativity of neural networks.

Hebb's Theory Applied to Formation of Memory Based on Associativity

LeDoux (2002) writes:

> "In order for two stimuli to be bound together in the mind, to become associated, the neural representations of the two events have to meet up in the brain. This means that there has to be some neuron (or a set of neurons) that receives information about both stimuli. Then and only then, can the stimuli be linked together and an association be formed between them." (p. 135)

Many neuroscientists as well as psychologists believe that memories are represented by associative neural networks which are structures in which various aspects of memory are represented separately and also linked together (LeDoux, 1996). In order for the memory to form the associative network, it has to have reached a certain degree of activation, which is dependent on the constituent components of memory, as well as the weight of each component. The weight of the components is dependent on the cues that were present during the learning process, and are also present during recall. These cues in many cases are emotions associated with the components of memory. Thus as a given component of memory is activated due to presence of a given cue, the activation of the full associative network is also facilitated. The cues in this case may be signals from brain and the body (emotions) that indicate that we may be in the **same emotional state as during the time of formation of memory** (LeDoux 1996). At this time it is also very

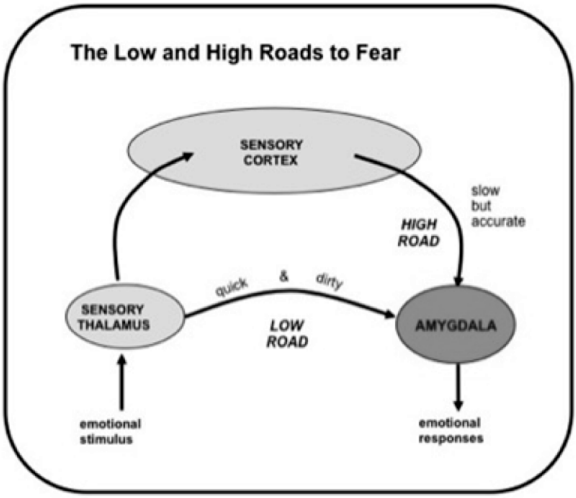

Figure 5. The low and high roads to Amygdala

important to emphasize that memories are a reconstruction of events at the time of recall, and thus **our emotional state can influence the way the recalled memory is remembered. And the converse is also true in that memories are recalled and remembered *best* when one is in the same situation or emotional state** (LeDoux, 1996). In particular, not all aspects of an experience are remembered in the same way, and emotions may affect the recall of certain aspects of memory more than others. In general, the memory of the more **emotionally significant aspects of an experience is remembered *better* than the more emotionally benign aspects of memory** (LeDoux, 1996).

With the above introduction to memory encoding and recall, let us now discuss what happens in the brain as the brain is exposed to a stimulus. All the sensory nerves (except for olfactory nerves) end up in the thalamus and are then relayed to various parts of the brain. The thalamus (which has two halves) can be thought of as brain's switchboard or information hub. After sensory input (from eyes, ears, touch, etc.) is received and processed by the thalamus, it is sent to various cortices and to a brain structure called the amygdala. The amygdala is an almond size structure (one on each side of the brain, deep within the limbic system), which is responsible for appraisal of stimuli and evaluation of emotional significance of the stimuli. Van der Kolk (2014) calls the amygdala the "smoke detector" of the brain. If the amygdala's evaluation of a stimulus is presence of danger, then it triggers the release of various (stress) hormones including adrenaline and cortisol, resulting in activation of the sympathetic nervous system, preparing for fight/flight or in certain situations the freeze response.

Once the amygdala deems that danger is past, the body should return to its baseline state. Sensory information reaches the amygdala through two paths, which LeDoux (2002) calls the high road and the low road. I already discussed the low road, which is formed by a direct connection from thalamus to amygdala, but the high road runs through the hippocampus and anterior cingulate to the prefrontal cortex, where sensory information is processed and then sent to the amygdala (see Figure 5). For example if we see a plastic snake, our immediate reaction may be fear resulting in a defensive movement, but then within about 500 milliseconds (mSec) we may realize that the snake is plastic and harmless. This example demonstrates the low road and high road. Signals traveling through the low road reach the amygdala in less than 30~50 mSec, but the same signals traveling through the prefrontal cortex reach the amygdala in somewhere between 400~500 mSec (Siegel, 2015).

Neuroscience of Memories – a Macroscopic View

Memory, in its most general sense, can be defined as what we consciously recall from past events. But memory is more than what we consciously recall from the past (Siegel, 1999). Siegel (1999) states, "memory is the way past events affect future functions", (p. 24). In particular if a certain neural pattern has been activated in the past (in response to external or internal stimuli) then the probability of activating a similar pattern in the future is enhanced. This is how we remember and learn from the past. "The increased probability of firing a similar pattern is how the [neural] network remembers" (Siegel, 1999, p. 24). He further writes, "Memory storage is the change in probability of activating a particular neural network pattern in the future" (Siegel, 1999, p. 25). Our memories therefore are associated with the way these neural networks bind together to form a broader activation pattern.

Memories can be categorized in two broad categories: implicit and explicit. Implicit (procedural) memory can exist early in development and can be present at birth. Implicit memory is not subject to recall whether of self or of time (timeless). Emotional, somatosensory, and perceptual memories can be encoded as implicit memories. Generally attention is not required for encoding of implicit memories. Recall of implicit memories is independent of the hippocampus and medial temporal lobes, and thus not under conscious control (Siegel, 1999). Encoding of explicit memories begins near the second year of life, and includes semantic (factual), and episodic (autobiographical) memories. Explicit memories require conscious awareness for encoding. Explicit memories involve a subjective sense of recall and are not timeless, that is there is the notion of time in encoding of explicit memories. The hippocampus, and the temporal lobes and cortices are involved in processing and encoding of explicit memories (Siegel, 1999).

Our brain generally does not encode and save every experience as explicit memory, or else we would be inundated with so much information, such that we would not be able to function. Siegel (1999) states: "It turns out that many studies of emotion and memory point to an inverted 'U' shaped-curve" (p. 47). It seems that the more emotionally intense an experience is, the higher the probability of its encoding and recall. The event is simply labeled as important (by the amygdalae). Likewise, less emotionally intense events have a lower probability of being encoded and saved (Siegel, 1999). It is also important to note that events that are filled with fear, terror or are just overwhelming may not be encoded by the hippocampus. Several factors such as amygdala discharge and various neuroendocrines including noradrenaline and corticosteroids may inhibit the functioning of the hippocampus, thus blocking the encoding of the event and later recall. However, these events may be stored in implicit memory as fragments, while explicit memory is impaired (Siegel, 1999). Interestingly, when implicit memory is reactivated, it is not associated with a sense of time, place, and sense of self in time, nor is there a sense that something is being recalled. Implicit memory stores emotional dynamics of events, and not their contents. **The brain can have implicit memory (mainly stored in the limbic system) from very early in an infant's life (even prenatally). But it is only after roughly the second year of life that the hippocampus is developed enough to encode explicit memory.**

It turns out that stress also mediates encoding and storing of explicit memory. Small amounts of stress generally do not have a significant effect on encoding events into memory. Moderate amounts of stress help to encode events into memory for later recall. However, **large amounts of stress impair memory encoding and recall (Siegel, 1999).**

Studies have shown that secretion of various neuroendocrines are involved in mediating the process of memory encoding and recall in response to stress. This process is normally transient and may last from seconds to minutes. Recent studies indicate that the HPA (Hypothalamus-Pituitary-Adrenal) axis is involved in inhibiting the functioning of the hippocampus. However, if the stress becomes chronic then it affects the **size and functioning of the hippocampus, which mediates encoding of explicit memory. Chronic elevated levels of the stress hormone cortisol result in atrophy of the hippocampus.** Excessive levels of epinephrine and norepinephrine (catecholamines) in response to acute activation of the autonomic nervous system (ANS) also affect encoding of memory resulting in impaired memories (Siegel, 1999). Joseph LeDoux (2002) argues that because of its connection with the hippocampus and other regions related to explicit memory system, **the amygdala strengthens learned memories in the presence of emotional arousal.** LeDoux (2002) further argues that as long as the degree of emotional arousal, during the memory formation is within a limit, the memory is enhanced. But if the emotional arousal goes above a limit, then formation

of memory may become faulty and result in impaired memory. **During a highly stressful event with high emotional arousal, the level of the stress hormone cortisol increases, resulting in interference with the functioning of hippocampus and formation of memory (LeDoux, 2002).**

Traumatic Memories: Repression and Dissociation

Let us now discuss traumatic memories in more detail based on the material presented above. I indicated that if one is exposed to a highly stressful stimulus (trauma), then through activation of the amygdala and secretion of stress hormones including cortisol, the normal functioning of the hippocampus may be affected and may result in formation of impaired memory of the trauma. These memories may then be **stored as isolated and dissociated fragments which can then become state dependent and get activated by sensory stimuli and emotions that are correlated with the original stressful event (trauma) (van der Kolk, 2015).** It is also possible that processing in the thalamus may break down and thus the sensory information may not reach the cortices for further processing and categorization **resulting in sights, sounds, smells, and touch being encoded as isolated fragments** (van der Kolk, 2015). **We can thus see that traumatic experience and exposure (highly stressful stimuli) may result in fragmented and dissociated memories.**

LeDoux (1996) writes: "The same amount of stress that can lead to amnesia for a trauma may amplify implicit or unconscious memories that are formed during the traumatic event" (p. 246). LeDoux (1996) further discusses that the failure to recall traumatic memories may be due to amygdala mediated shutdown of the hippocampus. In this situation due to the shutdown of the hippocampus, no conscious memory might have been formed and therefore no recall can take place.

Traumatic memories may also be **repressed**. In fact certain aspects of traumatic memories may be repressed and other aspects dissociated. In this work however, I refer to repressed memories as those that are **repressed from the conscious mind due to their unpleasant nature**. It is possible that memories that may have been fragmented can also go through repression. Brewin & Andrews (1998) suggest that somewhere between 20 and 60 percent of patients in therapy who were sexually abused as children, went through periods in their lives with no recollection of their sexual abuse, and this amnesia often lasted several years. Erderlyi (2006) writes:

> "Repression, conceived of as a class of consciousness-lowering processes, is divided into two sub-classes, inhibitory and elaborative processes. Inhibitory repression involves cognitive avoidance of some target material

> and leads to loss of accessible memory. Some of the lost memory may, however, express itself indirectly and may be partially recovered with subsequent retrieval effort. Elaborative repression distorts the original memory through a variety of transformations and false additions [fills in the gaps]" (p. 499).

Erderlyi (2006) paraphrases Freud and argues that repression originates from a highly developed ego and thus involves intention. Erderlyi (2006) also cites studies that have identified neuronal circuitries that are involved in intentional retrieval – inhibition and forgetting. These circuits involve areas within prefrontal cortices. It has also been shown using fMRI studies that prefrontal regions play an important role in suppression of emotional memories (Depue, Curran, & Banich, 2007). Depue, Banich, & Curran (2006) show that the memory representation of emotional events are encoded stronger that non-emotional events.

Anderson and Green (2001) designed an experiment called Think/No-Think in order to investigate suppression of unwanted memories. The experiment is divided in three phases. In the first phase (training) participants are presented with cue-target word pairs, and were asked to memorize the word pairs, so that when they are presented the cue they can recall the target. In the second phase (experimental), participants were asked to suppress thinking about corresponding targets when presented with certain cues (no-think condition), while they were asked to think about corresponding targets when certain cues were presented (think condition). And in the final phase of the experiment memory recall of corresponding targets for each cue was assessed. Using the experiment designed by Anderson & Green (2001), Depue, Banich, & Curran (2006) further found that in *Think/NO-Think* experiments designed to achieve suppression, the recall of emotional memory was seen to be greater that non-emotional memory in the *Think* experiment, and the reduction of recall for emotional memory was smaller in the *No-Think* experiment.

Thus emotional memories would go through stronger encoding. It is therefore more difficult to suppress intruding thoughts related to highly stressful events, as is the case in those who suffer from PTSD. Erdelyi (2006) asks the question **whether emotionality enhances or degrades memory, and the answer that is given is yes and yes**. The author explains, "There is widespread consensus that emotionality enhances memory for central elements of stimuli but degrades memory for peripheral items" (p. 503). It is important to note that memory in general is a heterogeneous construction and what applies to one aspect of memory may not apply to other aspects (Erdelyi, 2006). Thus, it is possible for certain aspects of memory to be fragmented and dissociated due to the level of stress associated with the stimuli, while less important and peripheral aspects may be repressed by conscious memory and forgotten.

Howell Compares Repression and Dissociation

On the subject of repressed vs. dissociated memories, Howell (2005) compares and contrasts repression and dissociation:

1. Repression is both motivated and defensive. In contrast, dissociation does not have to be motivated or psychologically defensive. For example, dissociation can arise automatically in the moment of trauma, or non-defensively in response to hypnosis.
2. Repression refers to formulated experience, and dissociation generally refers to unformulated experience.
3. Repression usually refers to a piece of information that was accessible at one time but not at another, whereas dissociation usually refers to divisions of experience in which the parts are side by side, contrasting, and may be concurrent in time. Dissociation refers to states and systems of states, which are often mutually exclusive.
4. Dissociated memories are especially context-dependent. (p. 198)

In repression unacceptable psychic content is pushed down into the unconscious, while in dissociation the split-off and dissociated content is not out of sight permanently or continuously but can reappear at any time due to external or internal stimuli. Freud was hypothesizing that repressed material is converted in alternatives such as dreams, slips, and symptoms, etc., while Erdelyi (2006) and van der Kolk (1994) argue that alternative modes of remembering are not conversions, but are spared memories. Erdelyi writes, "By this view, repression knocks out declarative (conscious) memories, but other memory systems (e. g., procedural ones, as in symptoms) are not similarly affected and continue to reflect remembering" (Erdelyi, 2006, p. 507).

Freud versus Janet on Trauma Memories as Repressed or Dissociated

There have been disagreements between researchers as to whether traumatic memories are repressed or dissociated in nature. This debate and discussion is not new and originates from the historical disagreement between Freud and Janet. Freud believed that memories of trauma, and he was specifically referring to hysterics, are repressed, while Janet was of the belief that traumatic memories are dissociated. Of course both Freud and Janet were writing about hysterical phenomenon, and it is particularly the hysterical phenomenon that may share aspects of both repression as well as dissociation. Freud (1952c) believed that the major motivation for repression is avoidance of pain. He also indicates that the essence of repression is to keep something painful out of consciousness. While Janet thought that intense emotions can cause dissociation of memories from

consciousness. These dissociated memories are then stored as visceral sensations, or as visual images (flashbacks) (van der Kolk, 1994).

Afferent Neurons, Memory and fMRI

In shock trauma, the signals from afferent neurons (sensory neurons) may not fully reach the cortex to be processed, neither can the hippocampus categorize, organize, and encode the memories. Therefore these memories may not be recalled as a complete whole, but only are recalled as fragments and tend to be associated with sensory inputs, and certain body states, which may include sounds, imagery, touch, and certain body positions, etc. (Siegal, 1999). What happens, as I indicated earlier, is that signals from afferents (sensory nerves) take about 30~50 milliseconds to reach the limbic system (and the amygdala), but the same signals take much longer, that is of the order of 500 milliseconds to reach the frontal cortex to be processed. This is an evolutionary advantageous process, as in the face of an attack by a predator, our ancestors needed to act immediately, or else they would have been killed. In the face of massive trauma, the neuropathways from the limbic system to the cortex are blocked. The memories retained in the limbic system are timeless and can be activated at any time due to certain stimuli, and the patient's perception is that the memory fragments correspond to "now", due to the timelessness of such memories. Furthermore, memories are stored in different functional parts of brain, and are organized later by the hippocampus and processed by the prefrontal cortex (PFC). Recent fMRI techniques have shown that there is an inverse correlation between activation of the amygdala and the right prefrontal cortex.

Recent studies in neuroimaging have also indicated that the dorsalateral and ventralateral prefrontal cortices (DLPFC, and VLPFC), as well as the anterior cingulate cortex (that is connected to the prefrontal cortex – PFC) and pre-supplementary motor cortex, are all involved in repression of painful memories. In contrast, activities in the hippocampus, a region of the brain crucial to encoding of explicit memory were reduced (Anderson, et al. 2004). This result was also shown in a separate study conducted at the University of Colorado, Boulder (2007) by Depue and Curran, which measured brain activities in subjects who were trained to repress painful memories, and memories of negative images. Depue, Banich, & Curran (2006) have found that the suppression of unwanted memories occurs along two pathways, and write:

> "The first pathway involves cognitive control by the right inferior frontal gyrus (rIFG – part of the lateral frontal lobe) over sensory components of memory representation ... This finding is consistent with computational models that posit that activation and inhibition of the thalamus is a critical

> means of gating (blocking) working memory information. A second pathway involves cognitive control by the right middle frontal gyrus (rFMG – part of the lateral frontal lobe above rIFG) over memory processes and emotional components of memory representation via modulation of hippocampus and amygdala." (p. 218)

Limbic System, Implicit Memory and Elaborative Repression

It is however, important to note that emotional aspects of the traumatic memories are stored as implicit memories in the limbic system. There is thus a splitting off or dissociation of contents of the painful experiences from the emotional aspects and dynamics of the experiences. The painful contents are repressed while the emotional dynamics are retained as implicit memories. As Shore (1994) indicated this splitting process is inter-hemispheric as well.

It is also important to mention that the recall of (degraded) past memories recovers some parts of these memories but may further **augment these memories for meaning (elaborative repression), in an effort to reduce the uncertainty, and increase predictability in order to reduce arousal (Erdelyi, 2006). In dissociation however, this same process may not occur, as these memories are highly state dependent and typically are not amenable to augmentation the way repressed memories may be. This is partially due to the nature of the dissociated memories that overwhelm various neuronal circuits and block the normal processing of these memories.** Ledoux (1996) writes:

> "... if the hippocampus was completely shut down by the stress to the point where it had no capacity to form a memory during the event, then it will be impossible through any means to dredge up a conscious memory of the event. If no such memory was formed, then no such memory can be retrieved or recovered. On the other hand, if the hippocampus was only partially affected by the trauma, it may have participated in the formation of a weak and fragmented memory. In such a situation, it may be possible to mentally reconstruct aspects of the experience. Such memories will by necessity involve "filling in the blanks", and the accuracy of the memory will be a function of how much filling in was done and how critical the filled-in parts were to the essence of the memory" (p. 244).

Gluing Dissociated Memories

However, it may still be possible to "glue" the dissociated memories together to make some sense of them, and to reduce arousal. However, for this gluing of dis-

sociated memories to be possible, clients must be able to tolerate high arousal and not be overwhelmed, while the narrative is being reconstructed. We, as bioenergetic therapists are fully aware that the presence of an empathic, supportive, and attuned therapist is a crucial stem in this process. This form of client-therapist connection allows clients to make left hemisphere centric sense of their right hemisphere representations, resulting in the capacity to regulate strong emotional states (Siegel, 1999). The presence of an empathically attuned therapist may keep the clients arousal within a tolerable level, causing the integration of traumatic memories.

In summary, it is clear that empathic attunement and limbic resonance in the therapeutic relationship is a necessary requirement for treatment of trauma whether traumatic memories are repressed or dissociated. The therapist must be emotionally attuned to his patients and let them regulate their strong affects within the therapeutic relationship. This means that the therapist must also be able to contain those same affects (Hilton, 2007). Traumatic experiences and memories cause us to split from our integrated and spontaneous selves. And it is the presence of an empathically attuned therapist that can give us the possibility of recovery and integration. We can then become free, and not be haunted by nor enslaved by traumatic memories (Hilton, 2007).

Case of Elizabeth

Elizabeth (name changed for confidentiality) was an attractive woman in her thirties. She came to see me due to severe anxiety. She was highly educated and was pursuing post-graduate studies in science. Her body was rigid with some oral characteristics. Elizabeth did not describe herself as an anxious person but said that over the last few weeks, before coming to see me, she had been very anxious and concerned about her health. Specifically, she feared that she had cervical cancer. She had seen her physician who had observed an anomaly in her blood test and wanted her to come back for more tests. My first recommendation to her was to see her gynecologist, which she did and it turned out that her anxiety was baseless. However, her anxiety continued as she was not satisfied with the test results. She continued to believe that she had a serious disease related to her sexual organs. After a number of sessions working with her on her anxiety and getting her family history, I felt that the therapeutic connection and relationship was established. I was nearly of the same age as this client's father, and a strong positive father transference had also established. The first few sessions were mostly conducted around taking a history, having the client breathe deeply and ground. I also explored with her if she felt her pelvis. Her answer was "no"! In fact she felt that part of her body somehow was not clean and she essentially had dissociated from her vagina and pelvic area.

From the very first session, I noticed that Elizabeth, when listening to me, turned her head slightly to the right and looked at me from the corner of her eyes, as if she did not trust me. Also her right arm was essentially immobile while she sat on the couch, but her left arm was fairly animated. Her legs were very close together and her right arm, while immobile gave the impression that she was covering her vagina. When I felt that a strong therapeutic relationship was established, I decided to go a little deeper, and brought my observations to her attention. I asked her to see what happens if she perturbed those movements and positions of her limbs, as well as listening to me while she was directly looking at me. She immediately recognized that she did not fully trust me yet, but did not know why, as there was no reason in her mind not to trust me. However, when she put her arms to her side, she immediately felt very anxious, especially as she relaxed her legs.

She then shared with me a story that she had not shared with anyone. She mentioned that shortly after she started working with me she became aware of sexual abuse by an older cousin that occurred when she was 5 or 6 years old. She felt those memories were dreamlike and she was not sure if they had actually happened. This cousin was a favorite of hers and she looked up to him with great respect and admiration.

As she told this story, Elizabeth became anxious. I asked her what sensations she had in her body, and she said that her legs felt really cold. I asked what her body wanted to do. She replied she wanted to stand up. I asked her to follow her instinct and do so and keep her knees slightly bent. Her legs started vibrating. She started crying and expressed that she was very scared. She did not want to share her memories that had just come up. I mentioned to Elizabeth that of course it was okay not to share the memories, but it would be great if she felt safe enough to stay with them. She reported that she felt safe and could stay with the memories that had just surfaced. I asked if she had been alone with the perpetrator. She replied "yes", and that the two of them were alone in her cousin's house. I asked her if she was aware whether she was in a room and where the door was. She mentioned that she was aware and I asked if she could **run toward the door, open it and run out**. In her imagination she did that, and found herself in an alley outside the house but alone which was scary for her, as he could follow her and catch her. I asked her if there was a store around. She replied "yes" there was a small grocery store around and I asked her to **run there and stay as she was safe there**.

Her fears then subsided but her body was shaking and discharging trauma. I had read in one of Peter Levine's (2003) articles that he had intervened in a similar way for a man who was attacked by wild dogs. My intervention was influenced by what I had read in Levine's work. The session was coming to an end and we had gone over by some time. Since she was my last client that day, I stayed with her until Elizabeth's nervous system calmed down.

The following session mostly revolved around processing what had happened in the previous session. Elizabeth still did not feel she could share what actually had happened, and I again normalized her feeling, in that it was not necessary to share if she did not want to. In the next session, I asked Elizabeth if she wanted to do more work with her trauma, and she replied "yes". Again, I asked her to feel her body, her legs in particular and her right arm (which was immobile), while she became aware of the memories. Her legs started vibrating very quickly and she spontaneously stood up and her vibration got stronger. This time her right, previously immobile forearm, started to rotate around the elbow. The rotation got a bit more intense, and while this was going on I noticed that her weight tilted to the right and the left side of her right foot was slightly lifted off the ground.

It gave the impression that someone was twisting her arm behind her back. I shared my observation with her. She then started sobbing and was very fearful. She did not share the memory that had come up, but I asked her if her right arm was twisted behind her back while the abuse was going on. She mentioned that it was the case, but this time she was much more fearful and scared. She was shaking and sobbing.

Elizabeth was becoming dysregulated and I could not intervene the way I did two sessions prior. This time I asked to her to hold on to my forearm (for more support) so that **we could run together** and that I would be with her as she runs for safety away from the house and the perpetrator. We "ran" together to the same grocery store that she imagined before. This time I told her that **I would stay with her for as long as necessary until her parents came back and until she felt safe**. Her nervous system calmed down after several minutes followed by more shaking and sobbing.

The work with Elizabeth is continuing and she is progressing well. She has been working with me for about 8 months. In one session two months ago, she mentioned that one of her colleagues was inappropriate with her, especially when she visited him in his office and that she froze and could not move or say, "NO". We worked on setting boundaries and saying "NO". I asked Elizabeth what it was that she could do if the colleague could not hear "NO", and did not respect her wishes. She very **quickly and spontaneously said: "Of course I can run away".** Elizabeth has been empowered since that session, is dating someone now, is discovering herself and her sexuality again, and the memories of the trauma have lost their grip on her.

This case demonstrated dissociation as well as the repression of traumatic memories. Elizabeth did not remember the abuse and then only as a dreamlike memory which she was not sure was real. We started from her body, her sensations and feelings to recover and integrate the fragments. But as I discussed earlier, recalled memories are the highly worked over version of the original encoded memories and go through transformation. Hence, we augmented her memories by empowering her and enabling her to run away, which included completing the

actions that were blocked at the time of the trauma. The newly formed memories, although containing the original painful aspects, now were augmented by the empowering memories as well. My hope is that over time these newly formed memories will become her default memories. In other words, we were able to **glue the fragmented and dissociated memories of the abuse with new memories that empowered Elizabeth, reduced her arousal and lowered the activation of her amygdala.** This approach is further confirmed in a recent study by Díaz-Mataix, Ruiz Martinez, Schafe, LeDoux, & Doyère (2013) who showed that it might be possible to **trigger synaptic plasticity and reconsolidation of aversive memory** in the lateral amygdala (LA) **by introducing new information at the time of recall and reactivation**.

Case of John

John (name changed due to confidentiality) was a man in his late forties. He came to see me because he had just changed jobs and found himself in a very anxious place. His anxieties were on the verge of becoming panic attacks. He said he would wake up in the middle of the night sweating and was very anxious in the morning once he woke up. He was also showing signs of mild depression. This was not the first time that John had faced anxiety and depression. It seemed like any time he was in a situation in which the stakes were high (as in possibly not performing well and losing his job), he ended up with anxiety and eventually depression. He described how he experienced the same symptoms (even stronger than now) 10 years ago when his business had to file for bankruptcy and he had to be hospitalized for several days. John was an educated man who was very rigid and very obstinate. His jaw was very tense, such that he could hardly open his mouth. His lower back was also very tense and contracted. When I pointed these out to him, he agreed. He mentioned that as a result of the tightness in his jaw, he had destroyed many of his teeth and had muscle spasms in his lower back frequently! I asked John for his memories of his childhood and what he remembered. I usually ask this question right after I hear the presenting issue.

The idea behind this is that due to the **associative nature of memory**, there is a strong likelihood that childhood memories and experiences that are responsible for present day behaviors and conflicts get activated, and the client can describe them as they are closer to conscious recall. John mentioned that he was the youngest in a family of 6 siblings. He shared that his father, for as long as he remembered, was severely depressed, was not working, stayed at home essentially most of the time, and passed away when John was 10 years old. His mother, on the other hand was working two jobs to make ends meet. She essentially was a single mom and the only breadwinner, although as John's older siblings became old enough to work, they helped as well. John remembered that his family had to

move many times, as the family could not afford the rent, would fall behind and get evicted.

John never felt secure and was anxious as a child. He remembered the worried look on his mother's face, not knowing what he should do and getting more anxious and scared. John is the most educated in his family and when he was 16 he left his household and started to work, went to school, and eventually became successful. He also brought his mother to live with his family when he married his wife, and essentially took care of her until she died. It took many sessions for John to realize the connection between his earlier experiences in life and his present day symptoms. We moved very slowly and I mixed analysis and interpretation with bodywork (grounding and breathing), while we were building a strong therapeutic relationship.

On one occasion John called me half an hour before his session to cancel. I was somewhat upset and told him, perhaps in a harsher tone than my usual, that he should have let me know at least a day in advance. He missed the following session as well. When he eventually came back, I felt that what had happened between us had to be processed. John mentioned that he expected me to ask why he was canceling and felt that I did not care for him as much as he thought I did, otherwise I would have asked him *why* he was not able to make it to his session. I said to him I was sorry for letting him down. He replied that he was very depressed, was feeling really down and that was why he could not make it to his session and had to cancel. That session was mostly spent on processing what had happened which turned out to be crucial, as the positive transference had turned into strong a negative transference. I also expressed how sorry I was that he was stricken by severe depression and anxiety on the day that he canceled his session. We were able to mend the rupture, and rebuild a very strong therapeutic relationship.

John was showing signs of improvement and feeling less anxious albeit at a slow pace. In one session, several months ago, John said that he was taking a couple weeks off, would travel and would like to spend time with his children and other close relatives. I was very encouraging of this plan, as in general John did not have strong connections with his family or friends. When he came back, much of the work we had done had solidified and he was and continued to feel much better, with his anxiety mostly gone. The **new neural pathways that were being laid out in our connection and work were finally activated and had become the default pathways, in the Hebbian sense**. The new pathways had taken hold and his new experience of being seen for who he was nonjudgmentally with empathy, understanding, and affection were the crucial catalysts for his change. John had never experienced this and it was this kind of connection that created the facilitating and holding environment for him to be able to tolerate the affects related to his earlier experiences and to integrate them. Much work still needs to be done, as his body still manifests strong holding. This case presented a situation in which there was **dissociation between the narrative (story), and the affects**

related to earlier developmental trauma. The affects were repressed but the explicit memories of the experience were retained. However, John was repeating and recapitulating the earlier traumas, despite the dissociation and repression.

Conclusion

In this paper, a detailed description of formation of memory based on neuroscience was given. Different types of memories were reviewed, while definitions of repressed memories and dissociated memories were introduced. Formation of dissociated memories as well as mechanisms of repression of memory based on recent fMRI studies and neuroscience research, were discussed. It was argued that traumatic memories frequently have dissociated aspects and repressed aspects. It was concluded, and shown, based on recent research in neuroscience that regardless of the nature of traumatic memories, a very important factor in the treatment of trauma was the presence of an attuned therapist in the therapeutic relationship. Finally, two case studies were presented to highlight the arguments set forth in this paper.

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From Body Structure to Bodies in Resonance

Evolution of the Therapeutic Relationship in Bioenergetic Analysis

Fina Pla

Abstracts

English

This article takes the reader on a journey with two different parts. In the first one, contributions on the transference/countertransference theme provided by bioenergetic authors are presented giving an overview of the richness and creativity of each author. In the second part, a reflection about the impact of Attachment Theory, Relational Psychoanalysis and Neuroscience in the therapeutic relationship in Bioenergetic Analysis is provided. The impact of new concepts is exposed and the rethinking of old ones is revised. The result is a new, enriched view of the therapeutic relationship and its transferential/countertransferential processes where the therapeutic process becomes an interrelational somatosensory process within the therapeutic dyad. Some short clinical vignettes are provided.

Key words: therapeutic relationship, transferential/countertransferential processes, somatic attunement, empathy, intersubjectivity, relational matrix, self-regulation

German

Dieser Beitrag nimmt seine Leser/innen auf eine Reise mit zwei unterschiedlichen Etappen mit. In der ersten werden Beiträge von bioenergetischen Autor/innen zum Thema Übertragung/Gegenübertragung geliefert, die einen Überblick über die Differenziertheit und Kreativität der einzelnen Autor/innen bieten. In der zweiten wird der Einfluss der Bindungstheorie, der psychoanalytischen Objektbeziehungstheorie und der Neurowissenschaften auf die Konzeption der therapeutischen Beziehung in der Bioenergetischen Analyse dargestellt. Als Ergebnis resultiert daraus eine angereicherte Sicht auf die therapeutische Beziehung

und ihre Übertragungs- und Gegenübertragungsprozesse, wobei der therapeutische Prozess zu einem interrelationalen, somatosensorischen Geschehen innerhalb der therapeutischen Dyade wird. Es werden einige kurze klinische Vignetten geliefert.

Italian

Questo articolo conduce il lettore in un viaggio composto di due parti differenti. Nella prima sono presentati dei contributi sul tema del transfert/controtransfert forniti da autori bioenergetici, fornendo una panoramica della ricchezza e della creatività di ogni autore. Nella seconda parte, è proposta una riflessione sull'impatto della teoria dell'attaccamento, della psicoanalisi relazionale e delle neuroscienze sulla relazione terapeutica in Analisi Bioenergetica. È esposto l'impatto dei nuovi concetti e il ripensamento di quelli vecchi. Il risultato è un nuovo punto di vista, arricchito, della relazione terapeutica e dei suoi processi di transfert/controtransfert in cui il processo terapeutico diventa un processo somatosensoriale inter-relazionale all'interno della diade terapeutica. Vengono presentate alcune brevi vignette cliniche.

Spanish

Este artículo lleva al lector a un viaje con dos partes distintas. En la primera, se hace un recorrido por las aportaciones de autores bioenergéticos al tema de la transferencia/contratransferencia dando una visión de conjunto de la riqueza y creatividad de cada autor. En la segunda parte se aporta una reflexión sobre el impacto de la Teoría del Apego, El Psicoanálisis Relacional y la Neurociencia en la relación terapéutica y en el Análisis Bioenergético. Se expone el impacto de nuevos conceptos y se revisa la reformulación de los antiguos. El resultado es una visión enriquecida y nueva de la relación terapéutica y de sus procesos transferenciales/contratransferenciales donde el proceso terapéutico se convierte en un proceso somatosensitivo e interrelacional dentro de la díada terapéutica. Se muestran algunas viñetas clínicas.

Portuguese

Este artigo conduz o leitor a uma jornada em duas partes. Na primeira, traz contribuições sobre o tema da transferência/contratransferência, trazidas por autores bioenergéticos, dando uma visão geral da riqueza e criatividade de cada autor. Na segunda, traz uma reflexão sobre o impacto da Teoria do Apego, da Psicanálise Relacional e da Neurociência. Mostra o impacto de novos conceitos e traz uma revisão do modo de pensar os antigos. O resultado é uma visão nova, enriquecida, da relação terapêutica e seus processos transferenciais/contratran-

ferenciais, onde o processo terapêutico se torna um processo inter-relacional e somatosensório dentro da dupla terapêutica. Traz também, algumas vignettes de casos clínicos.

1 Introduction

> "I needed someone who worked with the body and recognized it as the energetic core of self-expression and source of the true self but, more than that, I needed a person who wanted to connect to me, not just a body, not just a problem, not just a character, not just an energetic system, but me, with all my weaknesses and needs." (Hilton 36, 2000)

Purpose

My purpose with this article is to provide a journey through the contributions on the theme of the therapeutic relationship through one of its most important manifestations, the transferential/countertansferential dynamics, from thirteen different bioenergetic authors, from the first published articles to the most recent ones. I've chosen the articles I could get access to and I apologize if I have missed any. I've tried to grasp the main ideas of each author considering the limitations of space allowed. We can see the richness of contributions, from more analytical views to more somatic and some more personal ones. The second part of the article revises the contributions of bioenergetic authors on the theme of the therapeutic relationship and its transferential processes, incorporating concepts from a new paradigm and revising our understanding of traditional bioenergetic concepts under this light. I present concepts through the lens of our bioenergetic authors, in order to provide evidence of how Bioenergetic Analysis theory and practice have been impacted by them.

Evolution

Bioenergetic Analysis has evolved from its beginnings until now without losing its ground and core beliefs. Throughout the years, the concepts of therapeutic relationship, transference and countertransference have evolved from a classical Freudian analytic view, to a Reichian and Lowenian body focused one, to one

enriched by the contributions from Attachment Theory, Relational Psychoanalysis and Neurosciences where the emphasis has been displaced by intersubjectivity and mutual somatic attunement. Some courageous bioenergetic analysts have opened the way to incorporate these new concepts without losing our roots. I would like to provide an account of this evolutionary process in Bioenergetic Analysis, how the vision we have about the therapeutic relationship and its transferential and countertransferential processes has evolved from the earlier "Body Structure to Bodies in Resonance", a term I have taken from Michel Brien's article which synthesizes this long and rich evolutionary path.

History before Bioenergetics

In Classical Psychoanalysis the relationship is based on the patient's transference to the therapist. Through transference, the patient feels impulses and feelings, has fantasies and defenses that have to do with his/her primary figures. The therapist, from his anonymous, neutral place seeks to amplify transferential reactions to access unconscious material. In Object Relations Theory (Kohut), relationships are considered the most fundamental aspect in life. The relationship with the primary caretaker is internalized and structures the self. The patient internalizes the therapist as a good object and the therapist becomes a healthier model for the patient's inner world.

The Relational Theory (Aron, Mitchell) aspires to integrate the previous ones. Compared to Classical Psychoanalysis where the patient is seen as someone dysfunctional who transfers to the therapist, Relational Theory is based on a dyadic system, two people co-participating and change happens when the two members solve the conflicts in their therapeutic interrelationship. The classical analytic position of neutrality and abstinence changes to one of mutuality, spontaneity and authenticity where the patient learns to have healthier relationships through the relationship with his/her therapist.

The concept of transference originated with Freud and according to him, what was relived in the transference was the relationship with the patient's parental figures. Freud's theory about drives and the unconscious was dominant in psychoanalysis and has had an impact on other therapeutic approaches. Reich expanded Freud's ideas and introduced character analysis and the work with the body. Lowen followed Reich and continued basically with the same idea, that the neurotic behavior of the patient showed itself through his/her body armor and in the relationship with the therapist. Transference has been seen for a long time as the patient's parental contents projected onto the therapist. To Lowen, working with transference meant working mainly with the repressed emotions and their counterpart in body blocks, and transference was seen as the main impediment in the therapeutic process.

2 Contributions of Transference/ Countertransference by bioenergetic analysts in chronological order

With the new research about trauma processes and earlier disturbances, bioenergetic analysis has had to evolve towards more efficient ways to work with the type of early traumatized patients that we find now in the therapy room. As we go through the different authors, we will encounter the richness and diversity of contributions and we will see how the transferential processes in the therapeutic relationship have been evolving since their origins, body structure, to the present, bodies in resonance. I will present these contributions, some of which are focused more on the theoretical analytic concepts, others on somatopsychic processes and others are more experiential. I have followed a chronological sequence so we can see how the different authors address the theme.

Stanley Keleman: Bonding (1986)

Stanley Keleman (he belonged to the IIBA and was a CBT) wrote *Bonding*, where he talks extensively about transference and countertransference as somatic phenomena and develops the concepts of bonding, somatic resonance and pulsation.

Transference includes the muscular response patterns by which the client bonds to the therapist and countertransference includes the therapist's somatic responses, the ways he accepts or rejects the client's emotional and somatic states. Transference and countertransference are viewed as poles of a relational continuum and the term bonding is used to refer to this continuum. He describes different levels in somatic transference following the developmental patterns from fetal life to adulthood: umbilical, mouth, breast, genital and body to body contact. Which developmental level the client functions at, determines the nature of the transference.

Transferential processes define a relationship as an attempt to establish a somatic-emotional bond of communication. In this relationship the therapist needs to know how he/she bonds somatically. Pulsating is the basis of bonding and involves a continuous circulation and Keleman's goal is to re-establish the pulsatory continuum:

> "This is a process of pulsation in which waves of somatic emotional expansion and contraction, projection and introjection organize fields of cellular activity into patterns of complex behavior."(102)

Therapeutic bonding is a continuously shifting process that involves a complex organization and structures a relationship with many levels of experience. In

this process, transference and countertransference are organized by the somatic emotional attitudes of the client and the responses from the therapist. As the client projects into the therapist and evokes responses, a resonating process is established.

The therapeutic task will be to help a client create a container, deprogram past responses and form a pulsatory movement. What is central is the emotional response from the therapist for if he is not aware of his neural, emotional, and muscular responses, he tends to project them on the patient. Transference involves distortions of this pulsatory continuum and the key to solve it is to disorganize the initial structure. A client has structured his past experience and he needs help to de-structure it, to form new muscular-emotional patterns. Keleman writes, "To restructure obsolete bonds is what somatic therapy is all about" (104).

Virginia Wink Hilton: Working with Sexual Transference (1987)

Virginia Wink Hilton has had the courage to address the issue of sexual transference, not an easy subject. In fact it is one of the few bioenergetic articles I found on this specific type of transference. She stresses the importance for the therapist to be aware of his/her own sexual issues and to work them through in therapy and supervision. Here we can see how the therapeutic relationship was considered in the 1980's:

> "The nature of the patient-therapist relationship is that it is an intense, intimate dyad where the therapist is perceived as being in control and having the power. The patient is in a dependent position. There is no mutuality in that the therapist reveals comparatively little of himself."(216)

The fact that the patient projects onto the therapist the aspects of the longed for object, is seen by Virginia as, "the most powerful tool for healing and for righting the wrong" and at the same time, "it can also be the source of the greatest destruction" as she says, "it is difficult not to misuse that power in an attempt to repair one's own oedipal damage, as the therapist can seduce or reject in accordance to what he experienced as a child". (216)

There is the danger for the therapist of acting out and blaming the patient. One important statement from her is that transference only ends when it is worked through. She outlines our responsibility as therapists: "Our responsibility as therapists and trainers is first and foremost to understand our own unresolved issues and how these may manifest themselves in countertransference". (219)

There are two basic premises when working with sexual transference: one is the setting of clear boundaries and the second is acknowledging and affirming the sexuality of the patient. A child needs to hear from his parents: 1-you are a sexual

person, 2-you are attractive, 3- your sexual feelings are good. As the child needs the parents to see and acknowledge his/her sexuality without getting involved in it, exactly the same is required from the therapist who must be connected to his/her own sexuality.

> "When the patient through the therapy process is experiencing his or her sexual energy with that joyful, expansive feeling that accompanies it, we need to have the courage to be fully connected to our own sexual energy, to stay fully present and completely separate, wanting or needing nothing from the patient". (223)

Len Carlino: The Therapist's Use of Self (1993)

Len Carlino prefers the term "the therapist's use of self" rather than countertransference. Psychoanalytic thought distinguishes between a real relationship (interactions between patient and therapist that lack of unconscious projections and are based on accurate perceptions) and the transference-countertransference relationship which includes a repetition of the past that distorts reality. As it is difficult to make a clear distinction between the conscious and unconscious material of the therapist and since the distinction between a real relationship and a transference one is relative, the best option for the therapist is to actively use the countertransference: "The patient stimulates his disavowed affect in us in a hope we can tolerate the affect and respond to it." (89)

The patient learns to contain and integrate his affect as the therapist beams it back to him/her. This re-learning experience must involve an emotional response from the therapist and the "emotional reality" between patient and therapist is, "the only reality". (89)

Commitment is the most essential attribute for the therapist, "an unyielding commitment, a commitment to the truth to maintain the integrity of the relationship and the process and to being aware of how the transference molds the countertransference and vice versa." (90)

Strong countertransference that cannot be recognized and dealt in the treatment will be acted out. The acting out can take many forms: keeping a non-therapeutic distance from the client, refusing to merge with him out of fear of being out of control, or obtaining some direct gratification from the patient. He proposes some guidelines for the therapist's use of self:

1. The therapist must be aware of his own strengths and weaknesses (his character structure).
2. Any intervention should be for the patient's cure and not for the therapist's self-cure.
3. The use of self should be seen on a continuum in the therapeutic relationship.

4. The therapist needs to be grounded in his body and able contain a strong affective charge and able to express it.
5. The therapist needs to handle his/her feelings more constructively than did the patients' parents.
6. The most effective way to apply the use of self relies on the therapist being honest, direct and nonjudgmental.
7. The therapist needs to have stable boundaries for patients who do not have them and permeable boundaries when allowing for regressive experiences.
8. The therapist needs to be able to share the patient's early affects rather than observing them. The therapist must be open to experiencing uncomfortable feelings such as confusion, anxiety, craziness, despair, anger and sexual excitement.

He concludes that the more a therapist is grounded in his/her self-awareness and self-possession, the greater will be his/her ability for constructive use of self in the therapeutic relationship.

Jean Marc Guillerme: Contre-Transfert Corporel chez Freud, chez Reich, … Aujourd'hui (1994)

What does the body of the analyst tell the analyst himself? Jean Marc Guillerme comments how Searles needed to develop a "detective" task to make sense of his countertransferential reactions. He takes us into his own body countertransference exposing a clinical case and referring to countertransferential body reactions in Freud and Reich:

The client, a man with a persistent complaint, in a workshop makes a dismissing comment about Guillerme's work as superficial, and Guillerme's reaction is somehow inadequate and he has diarrhea and feels worn out and affected later on. The patient does not attend his next therapy session and the therapist suffers a terrible lumbar pain and needs days to recover his digestion and lumbar tension and to integrate the meaning of what had happened: he had felt publicly diminished by his client's remark on his clinical capability, in his work as a bioenergetic analyst and as a person.

Lowen's feedback to Guillerme was that he was touched by fear of his own violence when he found out that his narcissistic need to be a super-therapist for his patient, (an impossible unconscious demand from the patient) had failed. Reich calls this unconscious demand a "Midas' finger", as if everything the analyst touches magically heals. The analyst becomes then the magical healer and his interpretations are magic presents for his patients, but these are muddy waters, as it leads to a false evaluation of patients and "to feel hostility towards the patient who does not succeed to giving his analyst the narcissistic satisfaction to have healed him." (129).

Guillerme goes through the vicissitudes of countertransference, its body signals, the therapist's wishes projected onto the client, the narcissistic ambition and its failures, and the difficulty of coming apart, which are all essential elements to understand what is played out somatically in the relationship.

At the same time he reflects on the physical symptoms Freud and Reich suffered because of painful break ups and separations. Freud had his first heart attack after his rupture with Breuer and the second after Abraham's death, while his fainting related to a comment made by Jung. Reich developed tuberculosis after Freud coldly received his theory about orgasm and after his conflicts with his wife. He was rejected by Freud who did not agree to analyze him and was very hurt by his conflict with Freud, possibly resonating with his conflict with his father.

Guillerme provides a definition of body countertransference departing from Freud's definition of countertransference as an affect that comes to the analyst due to the patient's impact on the analyst's unconscious feelings. This view follows Lowen's comments about analysts not having confronted enough their own body structure and not having changed enough on a body level. Guillerme defines countertransference as, "a sudden body agitation, unpredictable, incomprehensible at first sight, before, during or after the session. This agitation gets manifested through a body symptom, a specific tension or dream material. In any case, it is related to the patient's body or to a patient's affect". (132)

Body countertransference is lived by the therapist, he says, as a kind of trauma that requires long self-analysis "detective" work and an emotional energetic discharge from the therapist, as well as tolerance and patience to not act out towards the patient and concludes saying: "Maybe our countertransferential body reactions are like hieroglyphs that we, alone, cannot decipher".

Bob Hilton: Countertransference: An Energetic and Characterological Perspective (1997)

Bob Hilton quotes Alice Miller on the two kinds of countertransference:

1. Subjective countertransference where the therapist gets from the patient the narcissistic supplies he was denied by his parents.
2. Objective countertransference, where the therapist, having worked his narcissistic needs, feels in his body the patient's experiences and with this somatic knowledge is able to build a bridge for empathic contact and move to a resolution of the transference relationship.

1. In subjective countertransference he distinguishes between the primal self, the contracted self and the adaptive self. The primal self is the basic psyche/soma self-expression in the world. When it meets negativity its energy contracts

and forms the contracted self that inhibits the life force of the primal self. The wish to die is invested in the contracted self and the survival needs develop an adaptive self.

The contracted self and the adaptive self find expression in the negative self, that gets expressed through negativity and the characterological self maintains equilibrium between those aspects. It is the form one has created to survive the prison in which one lives. When the primal self is recognized, a real self can take the place of the characterological self. Hilton goes through the different possibilities when these different selves from patient and therapist meet. He exposes how the patient can sense the narcissistic wounds in the therapist and how they can both collide when the patient does not reward the narcissistic needs of the therapist and how the therapist can withdraw according to his/her character structure, and how he can manipulate the patient in the same way he had to do it to survive.

It is important for the therapist to break this cycle, have supervision and personal therapy and build the foundations of the real self. He needs to acknowledge the failures of his characterological self, grieve his original loss and face the patient who needs to grieve the same loss and with this new awareness the patient can be heard in a new way and he gains a real person to help him grieve his loss.

2. The objective countertransference refers to the therapist's ability to be an open channel with his client. He is able to experience the feelings generated in him by the patient and allow them to be present. He has to stay grounded in his own reality and can be experienced as a genuine model for the patient. The therapist then "is able to use his body as a resonating instrument upon which the "music" of the patient is played. This resonance is what the patient did not have from her own family and now becomes the foundation for healing the narcissistic wound ... the therapist is now able to trust his intuitive response and is less likely to fall into the narcissistic trap led by himself and the client."(262)

Through transference and countertransference the therapeutic relationship fosters a mutual healing process where therapist and client both get healed:

> "The countertransference process, through which the therapist must move for his own healing is the same transference process for the patient. The patient-child is in a constant process of healing the therapist parent so that he himself must be healed." (263)

Vita Heinrich: Physical Phenomena of Countertransference. Therapists as a Resonance Body (1999)

Vita Heinrich introduces the concept of bodily resonance and shows us her creative way to work with intuition as a central body tool, using it to feel her body

and her client's body resonances. Transference and countertransference manifest as psychosomatic phenomena:

> "I must get involved with my intuition, the examination of everything, instead of analytic dismemberment, my bodily sensations and pictures are as resonance towards the physical reality of the client". (20)

In the therapist-patient interaction, the unconscious and repressed traits of the patient and the split off parts have a direct effect on the therapist. She positions herself in the energy field of the client (20 cmts distance) "eyes shut and instead of feeling selective tactile muscles I let myself be touched without touching". Positioning herself in the four positions (both sides, front and back) she explains:

> "I let my body respond to the physical reality of the client: body sensations emerge: cold, relaxed, hunger, tired and as time progresses more complex feelings emerge (shame, fear, rage, sadness),coupled with physical signs: breathing rhythm, and muscular posture pattern. These feelings show something of the true self of the patient who communicates non verbally from body to body". (21)

To Heinrich, resonance can manifest through metaphors, images, body sensations, or feelings. They are bodily messages the client sends us. There is an energetic exchange from body to body that she finds is quicker than a verbal exchange, and an important source of communication. Being aware of our countertransference feelings will help us connect with the patient's feelings.

Ben Shapiro: Will Iceberg Sink Titanic? Avoiding Collisions and Collusions instigated by the Dark Side of Client and Therapist: A Bioenergetic Approach (2000)

Ben Shapiro introduces us into the transference-countertransference issue with a metaphoric story. The iceberg and the Titanic represent client and therapist who can collide and collude. He takes us into what he calls the "dark side" of the therapist and client, that is, transference and countertransference's negative aspects.

The client stands on the iceberg calling out to be rescued from his stuck state, the top of the iceberg is the false self of the client and behind, there is his character structure. From the bridge, the therapist wants to help. He distinguishes the bright side of therapy and the dark side, the defensive aspects of the client: resistance, negative transference, acting out, represented by the underneath ice that threatens to sink the grandiosity of the therapist. There is also the dark side of

the therapist, his subconscious fears, and his tendency to suppress them. And he shows us a way to avoid the dark side collision:

Symbolically the therapist uses a zodiac to approach the iceberg, to see where the ice is dangerous and can make a humorous approach that helps, so the client can show his devils and they can be worked through. Then the client can join the therapist in the zodiac and both have scuba diving to address the most difficult aspects of the dark side. The dark side, being those feelings and impulses blocked by the character structure. Shapiro uses the metaphor of devil as the personification of our dark side.

Leslie Case: When Trust becomes Distrust and other Perils of Countertransference (2000)

Leslie Case shares with us her very personal and intimate experiences and reflections on transference and countertransference on her long personal therapy journey, including her experiences with many therapists. She says " it took twenty six years of therapy with six bioenergetic therapists to be in this body" (67).

Throughout her journey she learned quite a lot about transference and countertransference challenges and what therapist and client feared:

> "The mutual resistance to exploring the interactions prevented me from facing my deeper pains. I was afraid- of weakness and failure, inadequacy and insignificance. They were afraid too-of their own shortcomings. Each of us, protecting ourselves from the past, each of us, making our lives more predictable". (72)

From her challenging and deep experience she reflects about the possible dangers that can interfere in the therapeutic relationship, which, summarized, would be:

a) not being understood, b) not being supported, c) being blamed, d) therapist trying too hard, e) being denied, f) therapist being too close or too distant, g) receiving double messages, h) being overpowered by therapist.

Describing her journey, using poetic imagery, I find her article a very courageous act where she shares with us her inner feelings, the darkness and the light, the connection and the broken bridges, the joy and the impotence, the attunement and the betrayal, Case shares all the intricacies of a therapeutic relationship as she delves into the depths of her soul and body. And she finishes with these words:

> "The journey I just described took me on a very bumpy road. At times it was a very dangerous one. Filled with blind alleys and detours, dead ends and cloverleaves. The countertransference with my therapists created many of these obstacles, adding to the ones structured in my body. But, fortu-

> nately, the truth and beauty of bioenergetic analysis was stronger than all our characters."(80)

Michel Brien: Corps en Rèsonance (2001)

Michel Brien develops the theme of the therapist-patient body resonance, how the therapist can sense what happens in the patient's body. The body continually emits messages in the therapeutic process. It is as if the therapist's body can sense the patient's internal experience that he tries to grasp but it is not yet accessible to the patient's awareness. The therapist's body becomes an essential therapeutic tool we need to decipher, an essential part in the message that needs to be understood, a therapeutic revealing tool as important as words and listening which allows us to explore territories where words are not allowed:

> "Could we think of the symptom in the therapist's body as revealing the client's dynamics? If we pay attention to it, the body speaks, continuously emits messages. It is as if the therapist's body evokes the inner experience of the client that is not yet available. The body manifestations in the therapeutic context belong to a non- verbal message that must be understood. The body is a major part in this discourse that must be understood and it becomes the therapeutic tool exactly as do the words and the listening". (2)

He quotes three authors who have made contributions to the issue of the client's resonance in the therapist's body. From Reich, he says that we keep the principle of functional identity, from Lowen we take energy circulation and from Keleman the bonds between the family environment of the client and the somatic organization that comes from it. This is the path he refers to as going from body structure to bodies in resonance. He exposes an interesting concept by Keleman: the client's body as the therapist's environment. The environment client is dysregulated and needs help:

> "In therapy, the environment the therapist is exposed to is the body of the client with its history, its expression, its way of contact. It is in resonance with the body of the client that the body of the therapist develops an answer." (4) He uses a beautiful musical metaphor: "the melody that resonates in the therapist's body is the music played within the client's body. As with the music, the client emits a wave, carrying an emotion that affects the therapist's body". (5)

He quotes Sandler and his concept of "floating resonance", and sees a similarity between listening to the body and the psychoanalytic floating attention listening

to words. Wallin, the attachment theorist who says "we are the tools of our trade" sees the therapist as a basic tool for therapeutic change, while Brien sees **the therapist's body as this basic tool**. Energy circulation in the therapist's body shows the therapeutic process in action in the client's body. A tension in the therapist would signal a defense in the client. So tension is an indicator of conflict and inversely, energetic circulation shows life in movement.

Another beautiful metaphor he uses is the body as the ground where words get grounded. He stresses the need for the therapist to take care of himself so that the client can resonate with a healthy therapist's body. Then, he says, we can be the land where the client can plant his seeds and recollect them later. And he ends with another musical metaphor to explain the healing interrelated process going on: "The body of the therapist offers a variety of resonances so that the patient can compose his piece and take the melody that is created in the therapeutic alliance."(9)

For him, bioenergetic analysis offers the key access to the therapeutic use of the resonant body.

Louise Frechette: Countertransference, How to Use it Energetically? (2004)

Louise Frechette quotes Searles viewing transference and countertransference as "attempts to cure, repair and make others whole" and countertransference as "a place for mutual growth". (1)

There are two functions in therapeutic treatment, the primary function is to provide for the patient's analytic resolution through insight and a second function would be the resolution of the analyst's psychopathology only if it serves to further the primary function. In her teaching material she talks about some authors (Irvine, Stern) who distinguish two types of countertransference:

1. Countertransference that results from the analyst's unsolved issues.
2. Countertransference as a response to the patient's transference.

Complimentary transference "occurs when the analyst unconsciously identifies with the internal objects of the patient and experiences them as his own internal objects, activating the unresolved conflicts in the analyst" (2)

She develops the concept of projective identification and defines it as an unconscious interaction, independent of the analyst's conflicts. It is the reaction of the therapist to the intensity and quality of the patient's projective identification:

> "When the therapist experiences an unfamiliar sensation, emotion, thought, something that feels "out of character", that feels like a "false note", which is hardly ever felt with other clients, chances are the therapist is struggling

> with a piece that belongs to the client but he/she cannot own for the moment." (4)
>
> " Through the defense mechanism of projective identification the client puts that sensation, that feeling, that thought, into the therapist for him/her to "hold" until the client is ready to take it back and integrate it on a conscious level ... it is a piece that belongs to the patient but she cannot own for the moment". (4)

But if the therapist experiences feelings known to her/him, or sensations typical of his/her somatic organization that are experienced with other clients, then it means the patient has triggered something in the therapist's character structure. Examples of the therapist's own issues at work might be problems related to boundaries (schedule, fees, time frame).

Bob Lewis: Projective Identification Revisited, Listening with the Limbic System (2004)

Bob Lewis revisits the concept of projective identification under the light of neuroscience contributions. He looks at the clinical implications of Schore's psychoneurobiological model of projective identification. To Schore it is a process used throughout the life span involving the non-verbal, spontaneous emotional communications within a dyad. Schore describes both healthy and disturbed patterns of emotional regulation in the early dyad as "conversations between limbic systems" and, Lewis adds that "When the dyadic conversations involve significant dysregulation and misattunement, a defensive use of projective identification is imprinted into the maturing limbic system".

The therapist's body needs to be available for the client's dysregulated states like the empathic mother who matches her infant's internal states: "it is the clinician's body which is the primary instrument for psychobiological attunement."(4). Lewis defines projective identification processes as somatosensory processes: "Since feelings and emotions are psychobiological phenomena and the self is bodily-based, projective identification represents not linguistic but rather mind-body communications" (4)

What can be done to not cut your empathic connection to your pain and to your patient's pain and avoid shifting out of the right (feeling) brain state into a left (thinking) brain state? The key, Lewis says, is to hold onto this visceral state until images (visual, tactile, olfactory, etc.) come to us, though auditory and tactile material may occur without images.

To Lewis, body communications that are conveyed through posture, gesture, movement, are not often recognized in the therapeutic context. He specifically talks about the patient's hands and how they can express the patient's inner state.

We can decipher the patient's body messages with our right orbitofrontal cortex and what the patient communicates through projective identification is decoded by the therapist's right brain: "it is only the analyst's unconscious mind that can receive the message". He views the therapist as a holding container for the patient's dysregulated inner states:

> "When I sit with my patient and direct his attention to his tone of voice ... my way of being present with him is holding his unconscious, somatosensory or otherwise un-integrated material ..." (11).

He finishes by saying that there are some things that cannot be explained very well, and projective identification is one of them.

Violaine De Clerk: Body, Relationship and Transference (1993, rev. 2007)

The classical analytic relationship includes two aspects: the development of an analytic relationship and the resolution of transference and there is a third dimension in bioenergetic analysis which is the body: "body work is seen as the axis around which the other two dimensions of the process are articulated ..." (180)

Traditionally, bioenergetic analysis had two dimensions, verbal analytical work and body processes. There were two relational phenomena occurring in a therapy: a "real" relationship and a transference relationship and the transference-countertransference relationship was considered the whole therapeutic relationship.

Violaine De Clerk writes that Van Lysebeth proposes three relational phenomena that develop in therapy and places the relationship between therapist and patient as a major therapeutic agent:

1. the transference relationship, based on the patient's inner world, independent of the therapist. It stimulates a countertransference that is part of the process.
2. the relationship, in the common sense of the word, when the therapist colludes with the patient. It is determined by the blind spots of the analyst that must be worked through in therapy and supervision.
3. the analytic relationship, due to the transformation of the two previous ones and due to the analyst's attitude and interpretation. This one leads to a relationship that is real and promotes growth, where analyst and patient form an intersubjective bond. The three phenomena are present throughout the therapeutic process.

The analytic relationship would be at the core of bioenergetic analysis. In it, the analyst assumes parental functions, contains emotionally and is available for the

patient. From this perspective, there are three dimensions in bioenergetic analysis: relational work, body work and transference analysis which are mutually interrelated. Each of these dimensions produces therapeutic changes and each one affects the other two.

The development of an analytic relationship is at the core of the therapeutic process. The analyst repairs the impasses due to a deficit of self-development as a result of early traumatic attachments that can be healed through a relational experience and engages in building a relationship which is reciprocal. Body work in the transference and in the analytic relationship can precede, be simultaneous to, follow the transference analysis or be a help to it.

1. Body work and the transference relationship
    a. Body work precedes transference analysis: "Only the emotionally connected insights produce release and therapeutic change" (192).
    b. Body work as an auxiliary of transference analysis makes it more accessible as the physical interventions of the therapist can bring about transference reactions. The therapist acts as the transferential object.
    c. Transference analysis precedes bodywork.
    d. Bodywork and transference analysis are simultaneous. It happens when the characterological muscular tensions embody transferential emotion.

    She concludes that, "the body interventions that serve the transference analysis are body equivalents of transference interpretation. It is the analytic dimension of body work."(197).
2. Body work and the analytic relationship

The analytic relationship proceeds when the bodily self is developed but strongly disturbed: "the feelings and perceptions emerge from a "subject" but can be rigidified in relational impasses, determined by early relational experiences" (199).

For De Clerk, body work that unifies emotional experience develops the analytic relationship. When the therapist engages in an exchange, this contributes to developing the analytic relationship. The therapist makes repairs and creates bonds: "The bioenergetic therapist allows the interaction between patient and therapist to co-create a vibration, which represents for the patient a major corrective emotional experience engaging his whole organization and releasing his vital force" (200).

She ends up with some reflections about the "right presence" of the therapist in the bioenergetic setting: "the bioenergetic therapist engages actively in partnering in a relational experience, which allows an emotional exchange while maintaining an analytic position." (202).

Guy Tonella: Attachment, Transference and Countertransference (2008)

Guy Tonella distinguishes between two possibilities regarding transference:

a. working with sexual conflicts (character analysis), based on a body-mind analytical process where you work with muscular tensions, defensive psychic patterns, and the relational patterns as transference.
b. working with deficit and developmental trauma that requires an intersubjective system where the work is more nonverbal. The therapist is the safe base for the patient and there is a regulating system in action. In this case "the therapist is no longer somebody who knows, does a body lecture and interprets, but he is somebody who experiences, regulates, feeds-back and contributes in a co-creative way to give a sense about what happens." (5).He quotes Fonagy who has contributed to develop this intersubjective dimension with his conviction that "when the patient experiences that he is felt and thought of by the therapist, he begins to feel and think by himself" (5)

Tonella distinguishes between the traditional concept of transference and attachment transference:

> "What we call usually transference can be present through body postures, emotional expressions in the face, in the eyes, subtle tremors or spastic micro-movements, superficial breathing, thoughts, images, dreams and fantasies. The therapist is unconsciously considered, through projections, as the real parent of the patient. Working on transference means to help the patient to make conscious these projections and to release or transform the body and mind mechanisms that produce that "repetition". (5)

But he distinguishes another aspect of transference, the attachment transference, when the client considers the therapist as the parent he did not have. In this kind of transference the patient doesn't consider the therapist as a parent who rejects his sexuality, but as a parent who can answer his primary needs. The patient does not hope to release inhibition but he hopes to meet the real person of the therapist.

In the attachment transference, the patient needs to internalize the secure, empathic parent he never had. The patient will interact with the therapist according to his unconscious attachment pattern, he will adapt, get frozen, feel threatened ... etc. These attitudes, Tonella says, belong to the bodily self, they are shown, acted, but maybe there are no words for them. "The patient uses his limbic memory without knowing", says Tonella. This is a specific attachment transference, which " is not located in the linguistic memory, in thoughts with representations and words; it is located in the bodily self and in the forms of interactions with others" (6).

He sees some tasks the therapist has in this mode of transference:

- to explore the patient's attachment pattern which can show insecurity, fear of being ignored or not understood, dysregulated inner states, etc.
- to help the patient discover the origin of his attachment patterns sensing and feeling it through his limbic resonance. He will help the patient "to feel that state and no longer be that state".
- to help the patient understand how this attachment pattern impacts his love and sexual relationships. Sexual problems, Tonella says, can be consequences of insecure preverbal attachment.

Posing the question of what countertransference is, Tonella answers that "countertransference is an insecure attachment pattern reaction of the therapist in response to the insecure attachment pattern of the patient" (6). Depending on the therapist's own attachment pattern, sensory-emotional expressions from the patient will be allowed or dismissed.

3 Redefining Therapeutic Relationship, Transference and Countertransference: Contributions from Relational Psychoanalysis, Attachment Theory and Neuroscience through the lens of bioenergetic authors

3a New View of the Therapeutic Relationship and Countertransference from Relational Psychoanalysis

Historically the therapeutic relationship has been seen as being asymmetrical. The therapist is supposed to know and interpret and the patient doesn't know about unconscious parts of himself that need to be disclosed. Countertransference has been seen as a hindrance to the therapeutic process due to unresolved conflicts within the therapist. But the concept has evolved in the therapeutic field and in bioenergetic analysis too. From relational psychoanalytic approaches, it is perceived in a radically different way, as an essential tool for the therapist. Transference and countertransference are viewed as an interactive matrix and aim to use the therapist's countertransferential responses constructively. Therapist and client contribute with their subjectivities to the therapeutic alliance and the therapist is not interpreting anymore but participating and co-creating. Transference and countertransference manifest in body dimensions that enter for the first time in therapeutic approaches, which are not bodily based, mainly due to the contributions from these new theories. Relational analysts talk now of "embodied countertransference", recognizing the importance of body processes.

Relationality and Intersubjectivity have had a profound effect on the therapeutic encounter. The intersubjective experience of patient and therapist takes a prominent role as both therapist and client contribute with their subjectivities to build the therapeutic alliance. The shift involves moving the therapist's position from interpreting or administering treatment to one of participation. These analysts talk about the "intersubjective body" referring to the complex and unconscious interactions within the dyad.

One interesting contribution is from The Boston Change Process Group, a group of relational analysts and researchers (Stern, Tronick, Lyons-Ruth, and others) whose thought is affected by Martin Buber's philosophy. Buber's central idea is that all genuine healing implies an authentic encounter with the Other. Their definition of the therapeutic relationship is that there exists a relationship between patient and therapist that is real, authentic, and it is defined by Lyons-Ruth as:

> "The intersubjective field formed by the intersection of the patient's and therapist's implicit relational knowledge. This field extends beyond transference and countertransference and it includes the authentic personal implication and perceptions about the ways to be with each other ". (2007)

Another concept coined by this group is the "implicit relational knowledge" and it refers to the unconscious processes stored in implicit memory, which are revealed by unconscious material present in the relationship.

The Analytic Third, Intersubjectivity and the Relational Field

"The analytic third" is a concept developed by Ogden and Benjamin, both relational analysts. In their view, there are two subjectivities in the therapeutic space and there is a bonding space between them. This intersubjective space is what Ogden and Benjamin call "the intersubjective analytic third", a kind of third subjectivity, which results from the interaction between the other two. The relationship between these two subjectivities, together with the bonding space between them, constitute a relational field or intersubjective system. In this system, there is a continuous reciprocating interaction between therapist and client. It is an ongoing psychic, emotional and somatic interchange, which is mainly unconscious. The analytic third would hold all the ideas, beliefs and fantasies created jointly and shared by patient and analyst.

For many relational theoreticians the concept of "mutual interaction" substitutes the traditional concepts of transference and countertransference in clinical practice, because transference and countertransference belong more to model one (Stark) focusing in the intrapsychic, that does not take into account the weaving of subjectivities. Some scholars propose to even abandon the concept of transference (Rodriguez Sutil) and others (Lachman) to radically redefine it.

Aron, a relational analyst quoted by Sassenfeld, points out the limitations of the transference concept, as the therapist not only reacts but also initiates interactions with the patient. For him the term countertransference minimizes the impact of the therapist on the patient. Diverse relational theoreticians criticize and abandon the analytic concept of projective identification for different reasons (Aron, Mitchel, Stolorow, Brandchaft and Atwood). Sassenfeld, a relational analyst, shows us this change of perspective:

> "The classical model operates in only one direction, the analyst impacting the patient and not vice versa. The relational approach stresses a mutual influence in two directions that brings a mutual transformation, if the patient changes it is because the intersubjective system has been transformed and so the therapist has to change too. Aron says that there exists a relatively asymmetric mutuality, there is an impact on each other, though this influence is not equal nor are there shared roles, functions or responsibilities." (58)

Sassenfeld introduces the concept of new "emergent patterns" that appear as a result of the interaction between therapist and patient, new patterns that did not exist before. "In this non-linear complex of dynamic systems, reciprocal interaction between the components can generate emergent patterns, forms and structures that are generated through the interaction"(58).

In this evolved relational psychoanalytic model, transference and countertransference are seen in quite a different way, as an interactional process, as Jody Davis, a psychoanalyst, shows us:

> "We now recognize the transference-countertransference process as intrinsically and irreducibly interactive ... transferences are not distortions, but competing, oftentimes conflicting, organizing schemas or interpersonal fantasies laying at the foundation of each participant's unique striving toward self-integration ... transferences are not necessarily displacements of the past."(185)

Psychoanalytic theory, Angela Klopstech points out, has undergone a deep transformation from the Freudian drive model to the first relationship models (attachment theory, object relations theory, self- psychology) that aimed to provide some corrective experience, to the later relational models more based on the Buber (I-You) approach, focused on reciprocal interaction. The relational paradigm, conveyed by the Boston Change Process Group and other analysts, place the relationship as the crucial element for transformation and develop the idea that our sense of self is continuously transformed by our intersubjective relational experiences. Somatosensory experiences take a relevant place and they talk about a body memory, called the implicit memory, which is unconscious. The contents stored

in this implicit memory form the "implicit relational knowledge" (a term coined by the Boston Change Process Group), that can only be transformed through present experience.

Another key concept they use is the concept of intersubjectivity coming from phenomenological philosophy. Mind, body and environment are closely connected and interrelated and Descartes's mind and body split is not acceptable anymore. From this approach, we do not have a patient in treatment anymore but two subjectivities interacting. As Jody Davies exposes:

> "There are two participants coming together, attempting to create an optimal space in which to experience and process multiple aspects of who they both were, are, and might yet hope to become. We seek ways of reaching and touching each other, of nurturing, exciting, soothing, arousing, and ultimately healing the places that hurt. Within this intersubjective space, the analyst, too, wants to be reached, known and recognized." (188)

3b The Impact of Relationality and Intersubjectivity in Bioenergetic Analysis

Stern, a member of the Boston Process Change Group, stresses the importance of relationship as the core element in change processes:

> "Most of us have been dragged kicking and screaming to the realization that what really works in psychotherapy is the relationship between therapist and client. We are all devastated by this reality because we spent years and a lot of money learning a particular technique or theory and it is very disheartening to realize that what we learned is only the vehicle or springboard to create a relationship; which is where the work happens."(Stern quoted by Resneck, 2012)

In the 1980s–90s, the global psychotherapeutic field was strongly impacted by new discourses and findings coming from these new theories and some brave bioenergetic analysts start to explore, reflect and incorporate these new concepts that profoundly affect the vision and dynamics of the therapeutic relationship and the concepts of transference and countertransference. I intend to reflect on the evolution of the therapeutic relationship through the contributions of some bioenergetic authors who, without losing their connection to Lowen's basic principles, have felt the need to connect with present mainstream psychotherapeutic approaches and have included some of these contributions to our bioenergetic theory and practice enriching it, finding new nuances and at the same time aiming to place bioenergetic analysis among mainstream therapeutic approaches. Res-

neck-Sannes (2005) gives us a historical perspective and views three chronological paradigms present in Bioenergetics:

- The first one, developed by Pierrakos and Lowen, viewed the person from the outside and can be stated as: "open the armor and you will be free".
- A second paradigm with Keleman, Boadella, Boyersen, and Levine can be stated as: "not only is the outside structure important but the flow of energy into the body".
- A third paradigm with Carlino, Finlay, Lewis and Hilton, and, I would add Campbell, introduces the neurobiological and attachment research. In this third paradigm the therapist is no longer a neutral observer reading the body. In recent years there is a shift towards a more relationship-oriented approach, for example the one and a half/two person model of Martha Stark, which will be explained below.

I would add, from more recent years, a fourth wave of bioenergetic analysts: Resneck-Sannes, Klopstech, Schroeter, Tonella, Scott Baum, Heinrich-Clauer, Clauer, Koemeda and possibly some others, with contributions from attachment theory, relational psychoanalysis, neurosciences, polyvagal theory etc. who revise bioenergetic concepts under the light of the latest research and open a new view and understanding of bioenergetic concepts. With that comes a new view of the therapeutic relationship, and of transference and countertransference being seen as a dyadic somatic and relational interaction.

Angela Klopstech quotes Stark on this evolution:

> "Psychoanalysis has come a long way since Freud emphasized sex and aggression. The spotlight is no longer on drives or on the patient's relationships, and no longer focuses on the relation between structures within the psyche, but contemporary psychoanalysis focuses more on the intersubjective relationship between the patient and her therapist"(44).

It is not an easy process, for us, bioenergetic analysts, to be open to new concepts while we find a way to keep our roots. Klopstech addresses the struggle to integrate new knowledge without losing our essence:

> "Bioenergetic analysis from its inception retained quite a strong theoretical orientation by using the drive model of classical Freudian analysis and the Reichian model of character analysis as its foundation. But it has not adequately integrated the newer analytic theories that focus on the self or object relations or intersubjectivity. Attempts have been made by various authors ... but these have not reached a critical mass yet to provide a coherent change ... in the struggle to integrate psychoanalytic concepts, we, in bioenergetic analysis, risk losing our deeper connection to the energetic

> and bodily aspects of our endeavors and becoming a school of psychotherapy with some body techniques thrown in. (46, 2012)

This evolution has brought a discussion within the therapeutic field about two models of therapeutic relationship, the "one person psychology" model, centered on the internal dynamics of the patient and the "two person psychology" model, centered in the relational aspects. Klopstech introduces us to Stark's three models:

- One Person Model views the individual in intrapsychic terms as a closed system with internal drives and defenses. The therapist is an observer where the patient's transference is projected. Countertransference is viewed as interfering with the therapist's neutrality and must be eliminated. The curative factor comes from interpretation. (classical Freudian analysis)
- One and a Half Person Model (self- psychology and object relations approach) views the patient needing an empathic therapist to validate him. The healing factor is the corrective emotional experience the therapist provides.
- The Two Person Model (contemporary interactive and relational schools) is based in a mutual relationship where the therapist is an active participant. Transference is a dyadic process and countertransference is a response to the patient. The healing factor is an authentic relationship. She remarks it is advisable that therapists be able to cope with the three models depending on the situation.

To Klopstech, Bioenergetics starts from a one person model (therapist works on the emotional blocks and connects them to client's childhood) and shifts towards a more relationship oriented approach, from one person to one and a half (the patient manifests his posture, the therapist is the empathic giver) and two person approaches (the therapeutic relationship as a central tool to heal the patient). In this last case, two authentic subjects are engaging in a relationship in the here and now. Models 1 and 2 are familiar to bioenergetic therapists, model 3 is a major challenge and we will tend to choose the model which is our home base, based on our character, Klopstech remarks.

Some quotes from Bob Hilton illustrate this relational shift in bioenergetic analysis:

> "Our contractions are the result of relational wounds. They can only be "fixed" in relationship and no amount of "self-help" or "I'll do-it-myself" will resolve or release them." Hilton (198, 1984)

> "The energetic dynamics of the body and its holding patterns were seen as an outer manifestation of an inner process. To effect change in the form and motility of the body was to alter the rigidity of the client's inner psychic conflicts ... it was assumed that healing occurred by release of tension

> and did not involve a relationship with the person facilitating the release." Hilton (32, 2000)

According to Hilton, the classical bioenergetic approach was not enough, what was needed was a true and real relationship between patient and therapist, two bodies dancing a mutual dance. In this relational model, what heals and produces therapeutic change is the relational dynamics within the dyad. He writes,

> "I needed someone who was committed to our relationship, someone who could weather the storms of my rage and disappointment, someone who never once thought that whatever happened in the therapy could not be worked out; someone who was committed regardless of the outcome. I needed someone who would fight for us" Hilton (37, 2000).

Relationality and Intersubjectivity have had a deep impact in bioenergetic analysis. The present vision now is one of two bodies, two minds, and two energetic systems interrelating and affecting each other. On one hand it can be more challenging for the analyst, as he can feel more exposed or less protected, on the other hand, the gains are considerable as the therapist can feel freer to be who he/she is and able to engage in a relationship that is real, where he/she does not have to be the ideal therapist but a real human being.

3c Contributions from Neuroscience to the Psychotherapeutic Field

Neuroscience research has deeply impacted the understanding of the therapeutic process, independently of the approach. These theories provide a map of brain's plasticity and how brain circuitry can be transformed by our emotions, beliefs and relationships. They confirm how the brain, the body and the nervous system get structured through their relationship with the environment. They have validated attachment theory and have developed a psychoneurobiological theory of emotional development in childhood.

It is an emotional revolution in psychotherapy, which had been behaviorally oriented in the sixties, cognitivist in the eighties/nineties and now emotion and somatosensory processes take a central place. The brain and emotional connections are exhaustively studied as well as the different functions of each brain hemisphere. Both Schore and Siegel incorporate attachment principles to brain functioning and their research validates that it is through emotional communication that attachment experiences organize the brain. The "I and Thou" are now substituted by "We". These new theories incorporate the body in the processes of change, something we bioenergetic analysts have known and practiced for

a long time. Some bioenergetic analysts have introduced neuroscience concepts into their writings and in their practices. I thank these authors for their contributions and for keeping us connected to the mainstream psychotherapeutic world and for allowing us to acknowledge contemporary paradigms and not be isolated from them. I was interested to see how these new concepts have impacted and are present in the writings of our bioenergetic analysts and my purpose is to take you through those contributions, which have enriched bioenergetic analysis with concepts coming from these theories.

Klopstech (2008) advocates for the need to "rethink what we do bioenergetically in neuroscience terms". Concepts such as arousal, self- regulation, mirror neurons, window of tolerance, somatic attunement, and others, are developed and incorporated, all affecting the understanding of the therapeutic process. Other concepts such as transference, grounding, catharsis, energetic charge and others are revised broadening our understanding of them.

Daniel Siegel's Concepts

Dan Siegel and Allan Schore's contributions to a new understanding of the therapeutic relationship's dynamics are remarkable. Siegel, a resident psychiatrist discontented with conventional psychiatric treatments, went to listen to a talk given by Mary Main, the attachment researcher, and was deeply impacted by it. This encounter awoke in him an immense curiosity to know how attachment affected human neurobiology and how this could contribute to neural integration. In his approach, Interpersonal Neurobiology, he develops his view of how relationships shape our brain, how our brain can be changed and how this directly impacts the therapeutic relationship. In this neurobiological system, emotion becomes the central element, and it is through the communication of emotion that attachment experiences organize the brain in the baby and it is through shared emotions and experience between patient and therapist that new neural pathways are structured. As a result, both therapist and patient can be transformed.

He develops a new concept of the mind, a mind that is both embodied and relational. The mind is seen as a complex concept that integrates interpersonal processes, body processes and the functioning of the brain. The process named, "mind" is localized in our bodies and in our relationships. In his theory, an embodied mind is a mind that deals not only with what happens in our head, but what happens in our whole body. And the mind is relational, because we live within our relationships and our connections with people shape our mental and emotional processes. It is a mind that emerges from the encounter with other minds.

Interestingly, he talks about energy. There is a flow of energy and how energy flows through our lives shapes our mental and emotional experiences. Information is a flow of energy structured in a pattern and the mind is the emotional embodied process that regulates this flow of energy and information. To him, our separate

bodies become connected as energy flows from you (a smile) to me (I receive it). Closeness would be a kind of resonance between two interactive systems. The brain is a social process and emotions are its fundamental language. Integration among the different parts is a key concept in his theory as from integration emerges coherence and harmony and when integration is impaired chaos and rigidity ensue.

According to Siegel, the specific clinical approach used becomes less important than the attunement of the therapist. Attunement becomes a key word as the unconscious, intuitive, emotional interaction becomes more important than the verbal interaction, and reparative enactments of early experiences co-constructed by therapist and client are fundamental to healing. In this approach, the therapist needs to access the right (emotional) brain to fully experience the client's feelings and his own feelings. The therapist must keep a right brain-to-right brain connection to create an empathic attunement but also a left-brain-to left-brain one to make sense of the felt experience. Wallin, a relational psychoanalyst, talks of "binocular vision" needed from the therapist, who engages in contingent communication with the patient and at the same time must be in contact with his own inner states to establish new pathways in the patient's brain and increase his/her capacity for self-regulation. For us who work with the body, this is all good news. We can somatically attune to our patients through our somatic and emotional clues and decipher their somatosensory clues and respond to them. Siegel coined the concept "window of tolerance", as different for each patient, that refers to the intensity of emotion and charge a patient can hold without being dysregulated.

Allan Schore's Concepts

To Schore, a neuropsychoanalyst, the therapeutic connection happens through a "relational unconscious", where both unconscious (therapist and patient's) communicate. To be empathic does not only mean the patient feels better, it means to create a neural activating state. He was the first to connect right (emotion) brain to right brain connections, seen in infant dyads as well as therapist and patient dyads. Schore places emotion in a central place and talks about an "emotional revolution" in the psychotherapeutic field. Clearly Bioenergetic Analysis has included emotional work since its very beginnings but we know it was not the case for most therapeutic approaches. Schore's relevant contribution is the integration he makes of biological and psychological models developing a theory of emotional development and self-regulation in childhood that can be applied to psychotherapy. His research in emotional regulation has had a profound impact on the understanding of the therapeutic relationship. Schore's contributions have influenced many different fields such as affective neuroscience and trauma theory. His research has dealt with the effects of early trauma on brain development and, as I have said, he has provided us with a deep understanding of the neurobiology of attachment, which has had a deep impact on the therapeutic field.

From this new perspective, there is a reunification of body and mind, the mind as a complex system that integrates the body. We do not "get out of the head" anymore but integrate it with the body:

> "Now is the time to focus on the body that lives in the mind ... no longer are we a mind versus a body, but the mind and the body are one functioning as an intricately related system transferring information regarding somatic states and processing verbal and cognitive events." (Resneck-Sannes, 2005)

Bob Lewis wrote of his important work on cephalic shock, "In classical Bioenergetics the head/brain/mind were seen as blocking our deeper, more vital experience and the therapy was structured to get one out of the head and into the body. In 1976 I initiated a paradigm shift in bioenergetics, a shift that included the head and mind/brain as co-equal in importance. (Lewis, 2012)

Angela Klopstech shows that Schore's research highlights the role of emotion in change processes and the key role of relationships to shape neural processes and self-regulation capacities. To Schore, there is a therapeutic connection that happens through a "relational unconscious", that is, all the processes going from right brain to right brain. With his research in self-regulatory emotional states, he sheds light on these implicit relational processes:

> "The therapeutic relationship can alter the patient's internal structural brain system that consciously and non- consciously processes and regulates external and internal information and thereby, not only reduces the patient's negative symptoms but expands his or her adapting capacities". (Schore quoted by Klopstech, 2005)

To us, bioenergetic therapists, it confirms what we intuitively knew, that there exists a somatic resonance that develops from the right brain hemisphere interaction between therapist and patient that is mainly unconscious. Schore applies his research on infant-caretaker right brain to right brain communication to the therapeutic process. We know now that emotional and body communication is a right brain to right brain process and this leads us to understand that much of the healing in the therapy process is unconscious. Resneck-Sannes (2002) exposes Schore's contributions and also reflects on the crucial impact these findings have in the understanding of the therapeutic relationship.

> "Early attachment experiences are encoded in the right brain, they remain there unsymbolized and are available through communicating with the body in relationship ... Mother and baby co-construct a relationship and

> the mind develops in this relational matrix and the structure can be damaged without appropriate empathic resonance from the mother. To Schore it is the self-regulation process between mother and child the clue to attachment". (Resneck-Sannes, 111)

Schore's self-regulation theory outlines the importance of the non-verbal experiences between patient and therapist and the capacity of the therapeutic relationship to regulate affects. Exactly as it happens between mother and baby, the therapist, through the relationship, helps to regulate the patient's dysregulated emotional states.

> "The empirical research on the caretaker-infant interaction challenges the notion of a therapist who is separate from the client and who can from body readings provide necessary therapeutic interventions by reading frozen function. We are in a relational matrix at birth and therapy is about the mutual effect of client and therapist on each other's bodies." (Resneck-Sannes, 112)

The research about the important role of emotions in therapeutic change has been significant and has produced a whole revolution in the psychotherapy field though this aspect has always been quite known to us as bioenergetic analysts. We have always known the power of emotional expression and regulation for change processes. Yet, emotion currently takes a central role in therapeutic change as never before in the history of psychotherapy. Now there is scientific evidence for the close connection between emotional arousal and depth of experience and how both are linked to the therapy outcome. The role of catharsis is revisited and redefined and the impact of intense affective experience is validated: "therapeutic change results from bringing the full capacities of the cortical brain to intense affective experiences." (Resneck-Sannes, 39, 2005)

> "Deep authentic affective experience and its regulation through coordinated emotional interchanges between patient and therapist are viewed as key transformational agents" (Fosha quoted by Klopstech, 120)

Klopstech takes on Schore's concept of "dual hemisphere regulation". Regulation is seen as an interactional process. She finds this process relevant for the non-verbal body-to-body communication between therapist and patient which is the essence of our way of working. He distinguishes between an interactive person-to-person and a non-interactive intra-person mode and emphasizes that good therapy involves use of both modes:

> "Schore's regulation theory suggests that implicit mechanisms lie at the core of major change processes. "Implicit mechanisms" means the "limbic

> attunement" between patient and therapist and the body and emotional interactions that happen unconsciously."(ibid.121)

The concepts of arousal level and charge are redefined in Bioenergetics under the light of these new contributions. We know now that some arousal level is needed for neural restructuring in the limbic brain to occur. Greenberg, a relational analyst, believes that intensity, expression and reflection are major agents of change. Siegel defines a "window of tolerance" as the optimal frame for arousal to process emotional material. This window of tolerance can vary from person to person but therapists should find what falls into the window of tolerance for each patient. A patient feels dysregulated if what he feels or experiences goes beyond his/her window of tolerance.

Klopstech writes that neuroscience proves, that how much charge a patient can hold depends not only on his/her character structure but on how one relates to this patient in this precise context. We bioenergetic analysts have advantage in the field of regulation within the therapeutic window with our knowledge of body reading and character structure. We know how to create low and high arousal and how to work with it, she says. From this perspective, grounding a patient would mean bringing the patient into his/her window of tolerance. Klopstech advocates having the neuroscience and relational frames present." She says, "Having this multiplicity of frames has made me a more effective therapist." (ibid.122)

3d The role of empathy and somatic attunement in the therapeutic relationship

This new understanding from neuroscience redefines key aspects in the therapeutic relationship. Now we know that relational processes are at the core of healing. Empathy and attunement become core concepts, like knowing the importance what we feel when we relate to our patients and how their emotional states impact our body and vice versa. Resneck-Sannes states that in classical body interventions, empathy, attunement and congruence are missing and it has been proven that they are crucial. She outlines the importance of empathy and attunement in therapeutic processes and the emotional regulatory task of the therapist:

> "An empathic therapist is neither under-stimulating (too removed, neutral, not there), nor over-stimulating (not modulating the material to prevent the client from flooding, dissociating or splitting off)." (Resneck-Sannes, 48, 2005)

> "Research has been showing for years that clients report that neither insight nor body interventions heal by themselves. I am not saying that our somatic interventions should be discarded. Quite the contrary, they must occur

> in the context of an attuned, empathic relationship. This means that the therapist must no longer be separate from the client, but now must enter the room as a human being. (Ibid. 49)

What really matters now is the therapist's ability to engage in a real, empathic and attuned relationship with his/her client and there is a significant change of roles as we have already seen. The relationship is seen as a shared regulatory process of mutual growth where each element is affected and transformed by the other. The focus of what healing is has deeply changed.

> "The healing that occurs is primarily by the adept therapist being able to read the somatosensory cues from his client and providing the correct somatosensory communication in return". The therapist's right hemisphere decodes emotional stimuli and responds empathically and this allows the psychobiologically attuned clinician to act as interactive regulator of the patient's dysregulated internal states. The therapist is not only reading the overt behavior and its external forms but, like a "good enough mother" is adept at reading the client's internal state. He/she uses his own somatosensory process to be aware of the state of the client and aids him in processing these states."(Ibid, 115)

Clauer reflects on empathy as an energetic-emotional resonance process:

> "Feelings and posture patterns can also be conveyed in the psychotherapeutic treatment situation via the physical resonance processes of empathy, the embodied countertransference. I understand empathy in terms of sensitivity towards and feeling into the other person as a process of physical co-vibration or a coming into resonance with the non-conscious reality and the feelings of another person." (Clauer, 84)

Mirror Neurons

Lewis takes Lyons-Ruth's term "implicit relational knowing", to describe what goes on in the empathic process, a process which happens out of awareness. Concepts such as "mirror neuron pathways" help us to understand the phenomena of empathy and body resonance as key elements in somatic transference and countertransference processes. The mirror neurons system allows us to read the mind of others through nonverbal clues. We perceive an emotional state in another person and the same emotion gets activated in us. They are taken into consideration by bioenergetic authors.

> "Mirror neurons are necessary for our attunement but they may not be sufficient. They may help us to see into the mirrors (eyes) of our client's

> souls but we still have to be able to tolerate what we see in their mirror. What these neurons support is our "implicit relational knowing" ... they help us to listen to what comes to us intuitively in fleeting images, body sensations or sentences. I called this "listening with the limbic system ... I learned to quiet my mind and listen to my hands. They quite often knew where and how I should be touching my patient before I did."(Lewis, 2012, 121)

> "Mirror neurons recreate the experience of others within ourselves, allowing us to put on the shoes of another person and thus experience empathy. They are located in the premotor cortex and are connected to the limbic system, the brain's emotional region. When my mirror neurons fire in reaction to my patient it triggers empathic emotions or limbic resonance in me". (Klopstech, 2008, 131)

Lewis (2005) on empathy, implicit and explicit memory

Lewis sees the therapist's body as a crucial instrument for change. To him, we are empathic when we respond to the patient's needs and when we receive the projective identifications of our clients. Lewis talks about implicit and explicit modes of knowing which take different neural pathways. We know that implicit memory is the emotional and procedural memory out of awareness and explicit memory is conscious organized information.

He proposes a dyadic, non-linear systems view of therapy, where each member of the dyad is seen as both simultaneously regulating itself and the interaction. He quotes Fogel, "In a systems model, all behavior is simultaneously unfolding in the individual while at the same time each is modifying and being modified by the changing behavior of the partner". (Lewis, 11)

To Lewis the therapist's body is an essential tool, "we ourselves are the unique instruments that attune to the other's psyche and soma". He quotes Schore, "The attuned, intuitive therapist, from the first point of contact, is learning the moment-to moment rhythmic structures of the patient and is relatively flexibly and fluidly modifying his/her own behavior to fit that structure". (Ibid, 17)

The important evidence from neurological research, Lewis states, is that traumatic experiences from the first years can be accessed implicitly on a body level. He stresses in many of his writings that we must not forget we are wounded healers and how from this basic wound we have limitations and strengths in our empathic contact with our patients.

As somatic therapists we are trained to be aware of our internal body processes, we are aware of our muscular tensions and our somatic signals show what's happening in our own and our client's bodies. In a therapeutic process there will be moments of attunement, moments of impasse, moments of disconnectedness

and ruptures, but the important fact is the reparation. If we can repair the broken bridges, through empathy and attunement, the process will go on. Schore uses the concept of disruption and repair, which is extremely important in psychotherapy but also in all relationships.

> "Breaks in attachment activate the therapist's limbic system which produces a somatosensory resonance throughout his or her body. Somatically trained therapists are taught to focus on the information from their own bodies and to use the data to examine the relational qualities of engagement and disengagement occurring in therapy. (Resneck-Sannes, 116)

T. Warnecke, a body therapist, provides us with a description of the complex process of somatic transferential processes, phenomena that ranges in a continuum from empathy and attunement to intersubjective processes, re-enactments and transference issues at the other end of the continuum:

> "Two people meet and two sensory motor systems and two autonomic nervous systems begin to respond, relate and interact. Somatic transference is facilitated by limbic resonance and by our sensory motor system ability to feel movements, postures and affect states observed in others. Mirror neurons form part of an action resonant system that evokes neural motor representations by movement observation (Pineda). Mirroring is a prereflective, intuitive and spontaneous process. Kinesthetic and limbic resonance enables us to co-experience and asses the intentions of others and form the basis for inter-personal phenomena such as empathy, resonance, bodily synchronicity and transference." (Warnecke, 234)

4 Implications for Psychotherapy

The patient's and the therapist's somatosensory emotional experiences meet and get affected in this intersubjective field. The body of the therapist becomes a central tool that resonates with the patient's internal states. Resneck-Sannes explains this change in Bioenergetics:

> "The focus is shifted from the client as a pathological character to the mutual influence of client and therapist on each other's states of physiological arousal, desire for contact and intimacy and mutual regulation. It confirms our experience that instead of being a neutral observer who can read frozen function, two bodies are in the room together who by touch, mutual gaze, and words, set up a resonance. Implications of infant research state that our attention must be directed to our internal somatic states ... the therapist at-

> tends his own somatic experience and uses this information to understand what is happening interpersonally."(Resneck-Sannes, 116)

Bob Hilton talks extensively about this shift from the initial idea that the body heals itself if tension is released and emotion facilitated by physical movement is expressed, to the idea that without excluding the initial one, the relational dynamics between therapist and client are crucial aspects for the healing process:

> "The therapist and client eventually create an I-Thou relationship wherein each is taught and renewed as a whole person by the other. The therapist in this process is constantly attempting to integrate the interpersonal self-needs of the client along with his own limitations to meet those needs. As the therapist accompanies the client on his journey back to the origins of his interactional failures, the therapist must know and understand her own relational failures and the solutions she sought for them. This dynamic interplay and all that is implied in it becomes the healing process for both therapist and client."(Hilton, 42, 2000)

This creates a significant shift in the therapist's role when what really matters is his/her capacity to attune to the body/emotional movements in the client and his/her capacity to be empathic and respond to them. Resneck-Sannes expresses this shift:

> "Attachment theory showed that what mattered most was the therapist's capacity for emotional attunement – the ability to hear, see, and sense the client's verbal and nonverbal cues in a way that the clients felt genuinely seen and understood. Attunement or "contingent communication" as Siegel names it is a highly complex interpersonal dance between two systems" (Resneck-Sannes, 45)

Somatic attunement, necessary for infant attachment and for any therapy process becomes a key concept. The healing role of the relationship in psychotherapy takes central stage and much of it is an unconscious process. The therapeutic connection happens, through Schore's "relational unconscious". From this new perspective, the therapist's role is evolving deeply.

> "The therapist needs to be attuned so that the material is within the "therapeutic window. We then become the mirroring, empathic, attuned other that will begin to live inside our clients body/mind and support them in being vulnerable, needy, scared, angry". (Ibid, 48) Somatic attunement becomes crucial to process emotional material. "Our knowledge of breath, of grounding, of ways to form somatic and energetic boundaries and our

> knowledge of affect containment enables us to be sensitive to flooding ... body interventions are necessary but not sufficient for healing, they must occur in the context of an attuned, empathic relationship."(Ibid, 48)

5 A new view of the body: the Relational Body

Klopstech (2009) provides us with an interesting historical overview on the issue of the body in therapy. From Freud privileging language over body to Reich developing a model of body/mind interaction that was expanded by Lowen, how do the new paradigms affect the view we had of the body?

The body finally comes to the stage in the psychotherapy field due to the central role emotion takes in the new paradigm, the body as a depository of emotions. The relational-neurobiological paradigm has affected too the view we had of the body in bioenergetic analysis, it is no longer a body which has to be analyzed but two related bodies in a co-created dance where two subjectivities meet and impact each other.

> "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 in the therapeutic dyad".(Klopstech, 19)

The concept of the relational body takes space. Intersubjectivity is not only about two minds, but about two bodies. Siegel and Schore highlight the role of emotion and because of this, the emotion-expressing body takes a prominent place. It is not a single body anymore but a body in relationship. Klopstech's clearly expresses the shift in our perception of the body:

> "The body in modern psychotherapy needs to include the objective physical body with its emotional and energetic dynamics, with its history and character structure but it also needs to be viewed side-by-side with the subjective and 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). The complexity of multiple bodies is awesome and we need to select which is our comfort zone" (ibid 20)

Despite the body taking more space in the therapeutic field, Resneck-Sannes provides a useful reflection about the limitations of neuroscience research as neuroscience has worked a lot with face-to face and eye-to eye contact, but there is

little mention of holding and touch. Instead, the emphasis is placed on mind-to mind interactions and little importance is given to what happens below the head. An important contribution in the bioenergetic field is Vincentia Schroeter's recent article (2016) where she explores bioenergetic techniques from a neuroscience point of view with the entire body working with the nervous system.

> "While the emphasis has been to mobilize the organism away from defensive, destructive processes and toward emotionally healthy processes, it is polyvagal theory that sheds light on the inner workings of the nervous system in a way that helps us understand more deeply the mechanisms of defense and healthy emotional communication on a body level." (Schroeter, 12).

Margit Koemeda-Lutz (2012) synthetizes well the complexity of our present moment, complex, exciting and challenging at the same time:

> "Integrating brain mind and body means to perceive our clients and interact with them on several different levels, most of them beyond our conscience. There are biochemical, cellular, behavioral and psychological changes in each of the participating organisms involved. None of these levels is more essential than any of the others. Processes on each of these levels influence each other, bottom-up and top-down and evolve parallel in time. Most perceptions are processed unconsciously and our nervous system initiates or triggers many psychic and somatic reactions without our awareness."(64)

6 Clinical Vignettes

These brief vignettes show some of these new concepts in action taken from different therapy sessions.

1. Vignette

L. comes in excited and ecstatic at the prospect of visiting her new boyfriend who lives in another city. Her face and body look really alive. I feel a sensation of warmth and a feeling of joy coming to my chest (empathic attunement) as this relationship is the outcome of a deep process to heal a wound by an abusive father. She feels happy after having endured a long gloomy period. We both share in her aliveness and I try to help her to ground it having her feel her feet and legs and feel the breath in her chest going down to her pelvis and we breathe together and share this moment of bliss. In the next session, after the meeting with her new

boyfriend went well, she comes in anguished and afraid. She feels her emotions are too intense, she is quite afraid to let her heart be opened and get hurt. The result is anxiety and fear of not being able to hold all this intensity without feeling lost. I sense her anguish in my chest and I intuitively feel that working with breathing and contact will help her ground and contain this dysregulated state to move to a more regulated inner place. We have built a good therapeutic alliance and I try to touch her with my words and I propose to her that we have physical contact with her feet on mine while she breathes. She agrees and little by little her breathing gets deeper and calmed and she regains a place of inner self-possession she had lost. She leaves feeling more relaxed and understanding what caused her to feel dysregulated. I feel relief and relaxation in my back.

2. Vignette

N. stays hieratic (immobile) in his face and body and keeps his immobile eyes fixated on me. When he talks, his cheeks and mouth are almost frozen, and his eyes are tight, hieratic and fixed. Often, at the beginning of the session, I have an awkward sensation, a tension in my chest and a feeling of being invaded by his penetrating look that often dysregulates me. His voice is monotonous, flat, with no emotional quality in it. I do not find him an easy client and I often feel tension in my back as I do not feel completely safe. Somehow, I have to keep on guard. My somatic countertransference gets easily activated. I can go from feeling empathy to feeling really irritated as many times, physical movements are mechanical and useless. There are times I have the fantasy of shaking him as he leads me to visit a place of impotence inside myself. This correlates with the same impotence he feels toward making any movement in his life towards a different direction and toward an embodied movement in the therapy session. He feels a permanent dissatisfaction in his life, in his job, in his relationship and, obviously, in his therapy with me. He is unable to make any movement in his life towards a more satisfactory position and sometimes, I feel countertransferentially trapped in his immobility. Creating a mutual bond is not an easy task but quite a challenging process where we move in an often disharmonic dance of coming a little closer, (he is less tense and more open), followed by a disruption (he withdraws from the contact) that leads us apart. I feel him distant and I haven't found yet how to create a bridge to his steel-armored chest. He rarely feels or expresses an emotion and often goes back to the fortress in his head. Nevertheless, we both try to go on with all this complexity. Sometimes I can feel a little closer, I breathe and relax a little, other times I am unable to contact him, to find even a little fissure to approach his fortress. I use my somatic attunement, an empathic attitude towards this shocked little boy who saw his father threatening his mother with a rifle, and with my eyes, a soft and calm voice and body posture, I try to send him

the message that he is in a safe place and I am not going to damage him while we try to go on.

These vignettes are small examples of how embodied processes of transference and countertransference interact, how bridges can be built, how they can get broken or damaged, and the most important part, how we, as therapists, use our somatic and empathic attunement in our attempts to repair those broken bridges.

7 Conclusion

We have made a long journey and the process continues. The bioenergetic view of the therapeutic relationship and its transference/countertransference processes has been transformed and expanded by the impact of these new concepts and theories without losing what defines us. We cannot see the patient anymore as only an energetic system whose blocks must be released. We know physical blocks are the manifestation of repressed emotions and we find it is crucial working with them, but it is the way we deal with them that has changed. From this new perspective, we do not see the patient as an isolated energetic system but we see patient and therapist engaged in a somatosensory intersubjective system mutually affecting each other and getting both affected and transformed by it. The role of the therapist is to help the patient regulate his/her inner states through the relationship and also be regulated by it. For patients with early pre-verbal issues, focusing on somatosensory cues can be extremely helpful and sometimes, the only possible way. We can now consider our bioenergetic tools and understanding validated by research. We know now how our work in an embodied relationship can change a person's neural circuits, his/her perceptions, emotions and position in the world. We have known for a long time how emotions can be contained and regulated through physical contact in a therapeutic relationship, now we have scientific research that validates our understanding.

Transference and countertransference involve all those somatopsychic interactions that we already know but within an intersubjective field that happens in the here and now of a real relationship. We need to learn more about how we as bioenergetic analysts can use our own body and emotions as therapeutic tools to resonate with our client's bodies and emotions. As Bob Lewis says, we need to recognize more these subtle body messages that many times go unrecognized. We have come a long way and it is not finished yet, from the single body to the relational body, from body structure to bodies in resonance. I have taken you on a journey that now reaches its end, from the contributions of bioenergetic analysts to the theme of the therapeutic relationship and its transferential/countertransferential processes, to the contributions from the new theories and their impact on Bioenergetic Analysis. I hope you have found it useful.

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The Borderline Client, Shame and Somatic Counter-Transference

Ingrid Cryns

Abstracts

English

This paper is about understanding possible source causes of Borderline Personality Disorder (BPD) and how it differs from Bipolar Disorder (BP), Narcissistic Personality Disorder (NPD), Post Traumatic Stress Disorder (PTSD) and Attention Deficient/Hyperactivity Disorder (ADHD). The distinctions can be hard to grasp, are often overlapping, co-occurring at times and/or possibly mis-diagnosed. An overview is offered that compares the similarities and differences between these conditions. The core affect of shame is explained in how it may be experienced somatically in a Borderline client and the relationship of shame to distinct negative feelings of disgust, abandonment, and rejection are discussed. When working with difficult emotional states, some ideas are presented to work as a body oriented (Bioenergetic) psychotherapist to support a more integrated healing and recovery program for a BPD client. Some suggestions of diet, supplements and natural remedies are also included. Finally, recommendations are presented regarding how a psychotherapist can track and understand their own somatic counter-transference issues in order to work more effectively with a BPD client.

Key words: Borderline, Shame, Trauma, Somatic Counter-transference, Negative Feeling Affects

German

Dieser Beitrag bemüht sich um ein Verständnis möglicher ätiologischer Faktoren für die Entstehung von Borderline-Persönlichkeitsstörungen (BPS) und wie sich diese von Bipolaren Störungen, Narzisstischen Persönlichkeitsstörungen, der Posttraumatischen Belastungsstörung (PTBS) und der Aufmerksamkeits-Defiz-

it/Hyperaktivitätsstörung (ADHS) unterscheiden. Die Unterscheidungen sind zum Teil schwer fassbar, die Störungsbilder überlappend; manchmal treten sie als komorbide Störungen auf und/oder werden fehldiagnostiziert. Es wird eine Übersicht zum Vergleich von Ähnlichkeiten und Unterschieden zwischen diesen Störungsbildern gegeben. Der Kernaffekt der Scham wird als somatisches Erleben bei einer Borderline-Patientin beschrieben, und es wird der Zusammenhang zwischen Scham und den klar unterscheidbaren negativen Gefühlen des Ekels, der Verlassenheit und der Ablehnung diskutiert. Für die Arbeit mit schwierigen emotionalen Zuständen werden einige Vorschläge gemacht, wie man als körperorientierte (bioenergetische) Psychotherapeutin ein integratives Heilungs- und Genesungsprogramm für eine Patientin mit BPS unterstützen kann. Schließlich werden Empfehlungen formuliert, wie ein Psychotherapeut eigene somatische Gegenübertragungsthemen kontinuierlich beobachten und verstehen kann, um effektiver mit BPS-Klient/innen zu arbeiten

Italian

Questo articolo cerca di comprendere le possibili cause alla base del disturbo borderline di personalità e come questo si differenzia dal disturbo bipolare, dal disturbo di personalità narcisistico, dal disturbo post traumatico da stress (PTSD) e da quello di deficit di attenzione/iperattività. Le distinzioni possono essere difficili da afferrare, ci sono spesso sovrapposizioni, comorbilità, e/o a volte, errori nella diagnosi. Viene offerta una panoramica che confronta le somiglianze e le differenze tra queste condizioni. L'affetto centrale della vergogna viene spiegato per come sperimentato a livello corporeo da un cliente borderline e viene approfondito il rapporto della vergogna per distinguere i sentimenti negativi di disgusto, abbandono e rifiuto. Vengono presentate alcune idee, utili quando si lavora con stati emotivi difficili, per lavorare come psicoterapeuti corporei (bioenergetici) e sostenere un programma di recupero di guarigione integrato per un cliente BPD. Infine, vengono presentate delle raccomandazioni che aiutino lo psicoterapeuta a monitorare e comprendere i propri problemi corporei di controtransfert, al fine di lavorare in modo più efficace con un cliente BPD.

Spanish

Este ensayo consiste en entender las fuentes posibles de las causas del Trastorno de la Personalidad Borderline (TPB) y cómo se diferencia del Trastorno Narcisista de la Personalidad (TNP), del Trastorno Bipolar (TB), del Trastorno de la Deficiencia de la Atención e Hiperactividad (TDAH), y del Trastorno de Estrés Postraumático (TEP). La distinción puede ser difícil de captar porque a menudo se sobreponen, concurren y a veces, o posiblemente se mal diagnostican. Se ofrece un resumen que compara las similitudes y diferencias entre estas condiciones. El

sentimiento base de la vergüenza se explica desde el punto de vista de la experiencia somática de un cliente con trastorno de personalidad Borderline y se plantea la relación de la vergüenza para diferenciar sentimientos negativos de asco, abandono y rechazo. En la intervención con estados emocionales difíciles, se presentan algunas ideas para trabajar como un terapeuta de orientación somática (Bioenergética) y así mismo apoyar la curación integral y un programa de recuperación para un cliente TPB. Por último, se presentan recomendaciones acerca de cómo un psicoterapeuta puede seguir y entender sus propios problemas de contratransferencia somática para trabajar más eficazmente con un cliente TPB.

Portuguese

Este artigo é sobre o entendimento de possíveis causas da fonte da Desordem de Personalidade Borderline (BPD) e de como ela difere da Desordem Bipolar (BP), da Desordem da Personalidade Narcisista (NPD), da Desordem do Estresse Pós-Traumático (PTSD) e da Desordem da Deficiência de Atenção/Hiperatividade (ADHD).

Essas diferenças podem ser difíceis de compreender e frequentemente se sobrepõem, ocorrendo às vezes simultaneamente e/ou sendo mal diagnosticadas. Mostra-se, também, uma visão geral que compara semelhanças e diferenças entre essas condições. Focaliza-se o afeto central da vergonha como experienciado somaticamente no cliente Borderline e discute-se a relação da vergonha com diferentes sentimentos negativos como nojo, abandono e rejeição. Ao trabalhar com estados emocionais difíceis, algumas ideias são apresentadas para ajudar o psicoterapeuta de orientação corporal (Bioenergética) a dar suporte a um programa de tratamento e recuperação integrado para o cliente BPD. Finalmente, apresenta-se algumas recomendações sobre como um psicoterapeuta pode descobrir e entender suas próprias questões de contratransferência somática, no sentido de trabalhar mais efetivamente com um cliente BPD.

Introduction

For many individuals that are diagnosed Borderline Personality Disorder (BPD), the core root has been theorized as insecure early attachment with a primary caregiver, which this paper briefly explores. Early attachment disruption for BPD clients may be affected by disorganized patterns or paradoxical triangulations of early family interactions. One example is in the absence or confusion of the essential interactive role of the father (or secondary caregiver) in the Primary Triangle relationship between mother, father and child[1].

1 Clauer, J. (2012) Neurobiology and Developmental Aspects of Grounding., *Bioenergetic Analysis, Clin. J. of IIBA*, V21:38–40

BPD may also develop outside of insecure early attachment bonding. There is some evidence of a more 'sensitive' genotype that may be inherited[2] [3] (Linehan, 1993, Stepp, 2011). This sensitivity may also be linked to traumatic environmental influences such as, "*sexual and physical abuse, parental divorce or illness or parental psychopathology*"[4] (Distal, 2009). Experiencing trauma through war, accidents, or peer bullying for some individuals may also cause decreased ability to respond well to environmental stresses and thus become a pre-disposition to higher risk for developing BPD symptoms. Adolescents that have had childhood bullying or difficulties with peer relationships have been found to have an increased risk factor for developing BPD[5] [6] (Kaess, 2014, Woke, 2012). This risk may be exacerbated by the brain development that occurs during this period.

There is more recent research that indicates there may be brain abnormalities in the pre-frontal cortex (PFC) and the amygdala in BPD individuals that explains their difficulty with negative emotions, heightened impulsivity and the struggle to modulate their emotions in healthy ways for themselves[7] (Weill Cornell Medical Center, 2007). This creates a central core issue of a non-cohesive self-image where there can be an incongruent continuum of feelings of shame, disgust, abandonment, and/or rejection of their sense of self.

A brief note about the DSM diagnosis labels: The DSM was originally created as a way to accurately prescribe pharmacology support to help patients manage presenting symptoms so as to not suffer. It also provides a base with which to discuss with other clinicians issues of common understandings. However, diagnostic labels can also be very limiting in terms of accurately describing the complex characteristics of a distressed or suffering individual. For the purposes of this paper, the intent of its use is to be able to describe some of the larger issues that individuals may have. The focus is to differentiate more clearly what is characterized mostly as BPD and the difficulties in distinguishing the BPD way of relating to

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2 Linehan M. (1993) Cognitive Behavior Therapy of Borderline Personality Disorder. New York: Guilford

3 Stepp, S. D. (2011) Children of Mothers with Borderline Personality Disorder: Identifying Parenting Behaviors as Potential Targets for Intervention. *Personal Disord*. Jan; 3(1): 76–91

4 Distal, M, et all (2009) Familial Resemblance of Borderline Personality Disorder Features: Genetic or Cultural Transmission? New York: Guilford

5 Kaess, M, et al (2014) Borderline Personality Disorder in Adolescence. *Pediatrics, Official Journal of the American Academy of Pediatrics*, V134(4)

6 Weill Cornell Medical Center (2007) *Brain Abnormalities Underlying Key Element Of Borderline Personality Disorder Identified*, Science Daily. www.sciencedaily.com/releases/2007/12/071221094757.htm

7 Ibid

the world. It is important to note that all individuals can be understood along a dimensional continuum of severity of ego functioning, with a great variety of strengths and weaknesses.

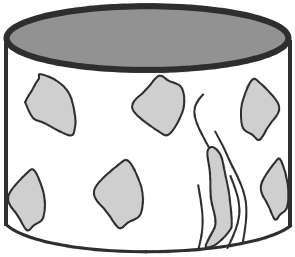
The recovery prognosis of BPD can be very promising if understood in terms of how to work with the inter-connectedness of the body and mind, how to regain the capacity for biological self-regulation, how to reform the relational attachments, and how to cooperate with other people. It is important to also note that this is long-term therapy that requires a commitment as well as the ability to be able to follow through with treatment suggestions.

It is the right brain, non-verbal processing that creates the ability to connect the physical and emotional experiences with the mind's conscious awareness[8] (Resneck-Sannes, 2002). The brain can continuously change through teaching new body connections and sensory awareness, as well as new methods of how to bring the body back into regulation from disconnected, confused, incoherent or chaotic states (due to emotional, unconscious, and/or dissociated triggers).

A body-based form of psychotherapy, such as Bioenergetic Analysis, is uniquely placed to work with re-establishing a secure, relational attachment (with the therapist) though the non-verbal, somatic information system and integrate it into a new consciousness of safe, consistent connection with self, with others, as well as ways of how to cooperate with others. Long term therapy with a body oriented psychotherapist, familiar with how to work with the subtle hiding, splitting off or dissociated aspects of BPD, can help to reform the neural network pathways and neurobiology within a BPD client.

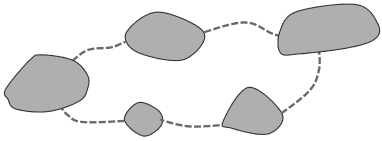
BPD Concepts & Diagnostic Criteria

Imagine that your core sense of self feels like it is a cylinder of Swiss cheese, with the holes, rips or tears as the missing, fragmented pieces of their solid sense of self.



8 Resneck-Sannes, H. (2002) Psychobiology of Affects: Implications for a Somatic Psychotherapy. Clin. J. of IIBA, V13:111–122

Or that your sense of self is like a series of separate islands of consciousness that switches or leaps from one island to another, missing a solid connection or bridges holding them all together. This is what the internal organization of a client with Borderline Personality Disorder is like. It is a complex and often difficult disorder to fully comprehend.



BPD is essentially about emotional affect dysregulation and how that ultimately creates an unstable and non-cohesive sense of self. The core structural essential disturbances that are commonly suggested for BPD are[9]:

1. A pervasive pattern of disturbed or unstable interpersonal relationships
2. Affective or emotional dysregulation, and
3. Behavioural impulsivity or dys-control by early adulthood

What is very significant in BPD clients is an extreme fear of abandonment. This fear is an unconscious driving impulse that contains rejection along with extreme shame and disgust about their sense of self. These clients often have poor interpersonal relationships and behaviour impulsivity caused by constant intense triggers (perceived or real) and the consequent emotional dysregulation in response. Other preferable names have been suggested for BPD, such as '*Emotional Dysregulation Disorder'* or *'Emotional Regulation Disorder'* [10] *(Gunderson 2005), which* may be preferable when speaking with clients and their families.

The following is a Basic Checklist of BPD symptoms (A minimum of 5 out of 9 Symptoms according to the DSM-IV-TR[11] is required and some points from DSM-5[12] are also integrated with extra descriptions).

1. **An intense fear of abandonment or being left alone**. [Separation insecurity: Fears of rejection by – and/or separation from – significant others, associated with fears of excessive dependency and complete

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9 Gunderson, J. G., Hoffman, P. D. (2005) *Understanding and Treating Borderline Personality Disorder*. American Psychiatric Publishing, Inc. p. 7

10 Ibid 10

11 Ibid 6

12 Sarkis, S. (2011) *Borderline Personality Disorder: Big Changes in the DSM-5*. www.psychologytoday.com/blog/here-there-and-everywhere/201112/borderline-personality-disorder-big-changes-in-the-dsm-5

loss of autonomy. (This can be real or imagined, sometimes seen as a high need to do everything together, or desperate efforts to hold onto the other person, or acting out rejection of others before they get rejected themselves)]

2. **A pattern or history of unstable and intense, conflictual relationships** [Impairments in interpersonal functioning through empathy (compromised ability to recognize the feelings and needs of others with interpersonal hypersensitivity {i.e., prone to feel slighted or insulted}; perceptions of others selectively biased toward negative attributes or vulnerabilities) and/or intimacy {mistrust, neediness, and anxious preoccupation with real or imagined abandonment, close relationships often viewed in between extreme swings (seeing others as all good) or devaluation (all bad) and alternating between over involvement and withdrawal.]
3. **An identity disturbance, or low sense of self worth** [A persistently unstable or unclear sense of their self-image, impairment in self functioning, often associated with excessive self criticism, poor self-direction: instability in goals, aspirations, values or career plans]
4. **Impulsive, Disinhibition and/or self-destructive or sabotaging behaviours** [Acting on the spur of the moment in response to immediate stimuli or acting without a plan or consideration of consequences, denial of reality of personal danger, as seen in at least two areas such as reckless driving, out-of-control spending, substance abuse, sex, or binge eating, etc.]
5. **Recurrent self-harming behaviours** [such as threats, gestures, self-cutting, burning, skin scratching, hair pulling or repeated suicidal impulses]
6. **Extreme emotional affect instability** [Unstable mood swings, easily aroused & reactivity out of proportion to events and circumstances with alternating states of intense negative feelings such as: episodic dysphoria (depression, sadness, misery, hopeless, pessimistic about the future, pervasive shame, feeling of inferior self-worth and difficulty to recover from these moods), irritability or anxiety (nervousness, tenseness, or panic, worry about past or future, apprehensive, threatened by uncertainty, fears of falling apart or losing control) lasting often from a few hours to (rarely) a few days]
7. **Chronic feelings of emptiness**
8. **Inappropriate, intense, explosive anger reactions** [Persistent or frequent anger in response to minor slights and insults and/or a difficulty controlling anger such as constant angry outbursts, recurrent physical fights, frequent displays of temper, etc.]
9. **Temporary states of losing a sense of reality or paranoid thoughts** [that can be triggered by stress, food or medications and causes severe dissociative symptoms (psychosis)]

According to the DSM-5, it is important to note that there are 3 further criteria traits to consider[13]:

"A. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
B. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
C. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma)."

Some BPD individuals may have an inability to hold separateness with the 'other' in their sense of self and their core fear of abandonment and/or rejection. In general, BPD individuals tend to have a poor sense of boundaries. This may be observed externally in leaving doors open, poorly organized closets, drawers or refrigerators; living with a lot of clutter, hoarding or difficulty letting go of personal possessions (attachment displacement); feeling threatened by differences or alternative points of view; a great difficulty saying 'No' to others; or a difficulty making sound decisions. Other BPD individuals may also have an inability to hold an inner sense of constancy with others that is reliable and trustworthy. Defined as a lack of 'object constancy'[14], when an 'other' is not physically present with them, they find it difficult to hold their image or sense of connection with them.

Reality for many BPD clients can feel like walking on sand that is constantly shifting. It never feels like their reality feels stable or solid. Typical phrases describing or generally felt by BPD clients can be any of the following:

"I hate you but I can't leave you."
or
"I hate you – don't leave me."[15]

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13 Ibid

14 Formica, M.J. (2008) *Understanding Constancy in Relationship*. Psychology Today. www.psychologytoday.com/blog/enlightened-living/200805/understanding-constancy-in-relationship.

15 Williams, K. (2016) *I Hate You, Don't Leave Me: Understanding the Borderline Personality*. www.psychcentral.com/lib/i-hate-you-dont-leave-me-understanding-the-borderline-personality/.

"I'm so good at the beginnings, but in the end I always seem to destroy everything, including myself."[16]

"Some say I'm too sensitive, but the truth is I just feel too much. Every word, every action and every energy goes straight to my heart."[17]

"It's like always walking on eggshells" (being in intimate relationship with a BPD)[18]

Distinguishing BPD vs. NPD, BP, PTSD & ADHD

The following is a description of the similarities and differences between Borderline Personality Disorder (BPD) verses Narcissistic Personality Disorder (NPD), Bipolar Disorder (BD), Post Traumatic Personality Disorder (PTSD) and Attention Deficit Hyperactivity Disorder (ADHD). These diagnoses are often confused and sometimes can be co-occurring depending where the client is on the complex continuum of severity, sensitivity and external environmental influences. Also, as trauma has a profound relationship to affect dysregulation in the body, it is extremely helpful to understand how PTSD has some similarity in terms of how to treat BPD.

Narcissistic Personality Disorder (NPD) vs. BPD

Borderline Personality Disorder (BPD) can have traits of Narcissistic Personality Disorder (NPD). If BPD is considered as originating in early attachment, they both derive from the pre-verbal period of the first two years of an infant's life. If not due to early attachment trauma, the traits may appear to be similar due to shock trauma. It can be difficult to determine BPD due to the often-overlapping aspects and the more common understanding of NPD. There also can be a co-occurrence with both disorders, in varying degrees.

According to Bioenergetic Character Structure, early developmental trauma of insecure attachment with NPD forms within the Oral stage of development, at an earlier stage than BPD, somewhere between 6 weeks and 1 year of age. BPD

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16 Van Gelder, K. (2010) The Buddha and the Borderline: My Recovery from Borderline Personality Disorder through Dialectical Behavior Therapy. New Harbinger Publications

17 *Borderline Personality Disorder Quotes.* www.healthyplace.com/insight/quotes/borderline-personality-disorder-quotes/

18 Mason, P., Kreger, R. (2010) *Stop Walking on Eggshells.* New Harbinger Publications

falls a bit later within 6–12 months of age. The Oral character is shaped primarily by the threat of abandonment. Neuroaffective development (the *biological* capacity for self-regulation) activates the core issues for all five Bioenergetic Character structures within the first 24–36 months of life[19]. This correlates with Schroeter's theory (Schroeter, 2009) that aspects of BPD can be found within all Bioenergetic character types.[20] See Table A below:

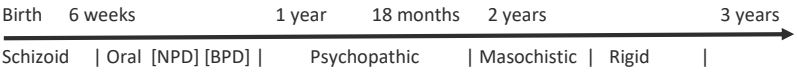

Table A: Bioenergetic Character Structure: Early Stages of Neuroaffective Development

Along with sharing common traits of shame, abandonment and rejection, NPD and BPD also share traits of conflictual relationships, low body feeling awareness, general anxiety, dissociation, and blaming. See list in Table 1 below:

Table 1 – BPD & NPD – Similar Traits

BPD & NPD – SIMILAR TRAITS
Conflictual relationships
Low body feeling awareness Anxiety
Dissociation triggers
Blaming/projection
Core fear of abandonment
Shame, rejection

However, there is a distinct difference in how they express their anger and handle conflict. A NPD person will often think that they do not need therapy. This is because it is difficult for them to actually feel their feelings in their body, due to missed cues from inadequate early bonding attachment with their primary caregivers. This causes core splitting off and dissociation within themselves. Blaming is a common characteristic where they will project the conflict that they create onto others. When their self-centred reality or what they want is denied, their

19 Bentzen, M. (2015) Shapes of Experience: Neuroscience, Developmental Psychology, and Somatic Character Formation. *The Handbook of Body Psychotherapy and Somatic Psychology,* North Atlantic Books

20 Schroeter, V. (2009) Borderline Character Structure Revisited. *Clin. J. of IIBA, V19:41*

anger often contains more critical and demeaning content. Refer to Table 2 below, regarding a list of differences between BPD & NPD.

Table 2 – BPD vs. NPD – Differences in Traits

Borderline Personality Disorder – DIFFERENCES vs.	**Narcissistic Personality Disorder – DIFFERENCES**
Anger can be explosive, easily triggered – over-reactive or over-responsive (rage) to others (shame response to not feel rejection or abandonment) Anger can be unconsciously resentful, setting up conflict reactions in relationship (looping pattern is trying to unsuccessfully individuate) Anger can turn inwards, imploding, self-harm behaviours (cutting, suicidal) Anger can become chronic or suppressed into depression, despair or hopelessness (due to inability to tolerate intensity of core abandonment pain, shame and/or rejection) Feelings can switch quickly, dissociated from the other extreme Sometimes does not feel need for therapy (there is a continuum range)	Anger is critical and often with demeaning content to self and others Great difficulty to feel own needs, their feelings with others, or for the feelings of others A difficulty to feel empathy or compassion for others (there is a continuum range of ability) Try to imitate feelings the best that they can (that they learn by observation), in order to get what they want from others Emotional range is narrow Often does not feel need for therapy (there is a continuum range)

Narcissists have a continuum range of an inability to feel compassion or empathy for others. Because they are more disconnected from the feelings in their body, their consciousness cannot gather information to teach them how to imagine another person's reality with the information of past experience of their own feeling affect states. Although they can appear to imitate feeling states to engage others to get their way, they are imitating actions that they have observed, to ensure they can control the relationship to meet only their own needs. Their greatest fear is of abandonment and it is unconscious – hence the inner reflection of abandonment is the actual dissociation from their body feeling states. It is normal for them to disconnect or not feel empathy for others, as they really don't understand how that feels in the body. Life and being in the body is mainly a mental construct.

Both NPD and BPD individuals share a central fear of abandonment. In cases where there was abandonment and emotional needs not being met as infants,

these individuals will project and act out various scenarios of abandonment dramas with others. In a narcissist, this plays out as a difficulty to be able to recognize or acknowledge the needs or feelings of others. However, BPD individuals are often emotionally highly sensitive and can be over-reactive or over-responsive to others in an effort to not feel their abandonment[21] (including the feelings of shame and rejection that often go along with that). Anger may then begin to be felt due to some awareness of their own uncontrollable compulsion to constantly be aware of the other person's needs first.

Over time, for some BPD individuals, this will slowly build up as resentment and they will unconsciously start to set up conflicts in intimate relationships in order to act out a need to feel separate from the other. (This is actually a healthy need to individuate that is unable to be resolved and has become distorted[22]) (Marahi, 2008).

Again, for some BPD individuals, their anger can go very quickly into a rage response. They are very sensitive and can be extremely easily triggered. However, they can also feel embarrassed or even remorse for their actions, but they won't know how to stop or control this repetitive pattern of relating. For others, their anger can be suppressed and turned inwards into self harm behaviours (cutting), or depression due to a sense of hopelessness & despair at not being able to tolerate staying present to the core pain of abandonment, shame, disgust and/or rejection. They cannot change the ways they feel stuck in their unresolvable patterns.

Bipolar Disorder (BD) vs. BPD

BPD is also often confused with and misdiagnosed as Bipolar Disorder (BD). Occasionally it is co-occurring. They both share mood lability (poor affect regulation) and impulsivity, along with anger that is out of proportion to the current events, self-harming behaviours (high suicidal risk) and unstable relationships.

They also both have a tendency to think in extremes, such as you are all good or all bad. They have an inability to see people as having both good and bad within, as a complete concept of wholeness. You are one minute their closest friend and very quickly, you can become their enemy. There are varying degrees and levels in regards to how this trait of black and white thinking can manifest, but in general there is a strong tendency to not be able to hold two opposite extremes

21 *Borderline Narcissistic Personality Disorder Differences.* https://www.clearviewwomenscenter.com/borderline-narcissistic-personality-disorder-differences.html

22 Marahi, A. J. (2008) *Power and Control Struggles in Borderline Personality Disorder.* www.borderlinepersonality.typepad.com/my_weblog/2008/07/power-and-contr.html

at the same time and consider a view point that is more generalized or complex. This may reflect their inner state as separate islands of consciousness that are not able to hold together as a cohesive sense of self within. Table 3, lists the common similarities of BPD & BD.

Table 3 – BPD & BD – Similar Traits

BPD & BD – SIMILAR TRAITS
Poor Affect Regulation (mood swings/lability)
Impulsivity
Inappropriate anger
Self-harming anger, suicide risk
Unstable relationships Anxiety & depression
Black & white thinking

A key difference between BPD & BD is that the Self-image of a BPD client is essentially bad and the self-image of a BD client is that of a grandiose (often arrogant) sense of self.

BPD has a more distinct reaction of a perception of hostility and autonomy (fear of separation/abandonment) in others then a BD client. The mood swings with a BPD client can be quite frequent from a few hours to a few days, whereas a BD client will have distinctly longer periods of time of mania/hypomania or depression. There are also reported cases of rapid cycling BD patients. The emotional reactions for a BPD individual may be triggered by a (perceived or real) fear of abandonment[23], which is often deeply dissociated and may be the cause of an ongoing anxious state within.

A BD client will often not respond to a challenge or interpretation by a therapist whereas a BPD client will often have a strong emotional response – which can be expressed as anger/rage (somatic clues: increased agitation, hands clenching, foot tapping, increased tone {yelling}, become argumentative or defensive, etc.) or flight (somatic clues: eyes rolling away, head, foot or body turning to one side in an attempt to begin escape), dissociation (changing the topic immediately or 'spacing out'), actually walking out of a session, or not coming back, etc.[24].

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23 Lane, C. (2015) *Borderline Personality Disorder.* www.toddlertime.com/dx/borderline/bpd-ekleberry.htm

24 Gunderson, J.G., Hoffman, P. D. (2005) *Understanding and Treating Borderline Personality Disorder*. American Psychiatric Publishing, Inc. p. 43

Table 4 – BPD vs. BD – Differences in Traits

Borderline Personality Disorder – DIFFERENCES vs.	**Bipolar Disorder – DIFFERENCES**
Self image is essentially bad (chronic shame) Mood swings from a few hours to a few days Interpersonal sensitivity to hostility and separateness A more distinct reaction of a perception of hostility and autonomy (fear of separation/abandonment) Often has a strong emotional response – which can be expressed as anger/rage = in constant relational conflicts Alternating idealization and devaluation of others	Self image of a BD client is that of a grandiose (often arrogant) sense of self Long mood swings of several months usually with distinctly longer periods of time of mania or hypomania or depressions Interpersonal insensitivity Often does not respond to a challenge or interpretation by a therapist Uses avoidance and denial and may show poor insight

Post Traumatic Stress Disorder (PTSD) vs. BPD

A primary concern for individuals with BPD is the difficulty in regulating the physical affect of their emotions. According to a study by Ford & Courtois (2014), **BPD & PTSD overlap in 7 out of 9 DSM-V diagnostic criteria.** General PTSD symptoms are often present in BPD due to a heightened sensitivity in the neurobiology of the brain and difficulty coping with traumatic external environmental stresses. They can both experience constant anxiety as well as the feelings of hopelessness/despair about their inability to regulate or control their emotional affect. This can cause chronic states of depression. This difficulty is due to the concept in trauma of the fight, flight and freeze response. In trauma, the body can dissociate from the intensity of painful and negative emotions in order to simply no longer feel them. This creates low body feeling awareness and many dissociation triggers that continuously loop. This chronic dissociative looping, based on emotional numbing, creates a sense of inner emptiness that both BPD & PTSD share as they feel stuck in a constant hopeless place of despair, with no capacity to understand how to shift out of it. The intensity is very difficult to tolerate and without adequate support or information about why this happens, they eventually can become a high suicidal risk. In adolescence, this risk for both BPD & PTSD individuals can be very high. However, often in middle age, the

intensity of these symptoms can lessen, thus lowering the risk factors. Table 5 lists traits common to both[25] (Ford et al, 2014).

Table 5 – BPD & PTSD – Similar Traits

BPD & BD – SIMILAR TRAITS
Poor Affect Regulation (mood swings/lability) Self image is essentially poor (chronic shame)
Self-harming anger, suicide risk
Impulsive behaviour High anxiety Depression, despair or hopelessness Chronic Emptiness
Conflictual relationships (intense & volatile enmeshment)
Social detachment and avoidance Low body feeling awareness
Dissociation triggers Lack of ability to experience pleasure or positive emotions

The essential difference between BPD & PTSD is that with BPD an extreme terror of abandonment or rejection as well as a strong tendency to alternate between idealization and devaluation of others is felt. This does not occur in PTSD or complex PTSD (cPTSD). It appears that BPD has a greater tendency to have both an under and over regulation of affect states, as well a tendency to have more under-affect when early childhood developmental trauma is confirmed. Under regulation means when someone expresses their emotional affect in a strong, perhaps over-charged, or highly dramatic expression. And conversely, over regulated is when emotional affect is more held back, more controlled or suppressed in some form. Complex PTSD has a tendency to exhibit complex combinations of both positive and negative dissociations with under-regulated affect states. Positive dissociative symptoms relate to active defensive responses and may include intrusive traumatic memories, flashbacks, intrusive voices, as well as complex patterns such as re-enactments. Negative dissociative symptoms relate to passive defensive responses and generally relate to loss of function which may include memory loss, higher cortical functions loss, loss of feeling, loss of motor control as well as loss of somatosensory perception (e.g.

25 Ford, J.D., Courtois, C.A. (2014) Complex PTSD, affect dysregulation, and borderline personality disorder. BioMed Central Ltd.

numbness)[26]. PTSD clients also have more difficulty recognizing emotions than BPD clients[27].

BPD clients have different complex risk factors than PTSD that can be chronic and more dangerous to the self. They are also more likely to have co-morbidity traits with other disorders (such as Eating Disorders or Bi-Polar, etc.). They also appear to have a higher risk for re-traumatization in adulthood than PTSD clients. (Ford et al, 2014)

And finally, there is a small group of BPD clients that have co-occurring PTSD, as well as a small group of complex PTSD clients that have BPD as a subset grouping. There are distinct differences to be considered more in one category or the other. Table 6 lists traits that show the differences of both [28] (Ford et al, 2014).

Table 6 – BPD vs. PTSD – Differences Traits

Borderline Personality Disorder – DIFFERENCES v.	**Post Traumatic Stress Disorder- DIFFERENCES**
Terror of abandonment or rejection Alternating idealization and devaluation of others More complex risk factors (than PTSD) that can be chronic, or more dangerous More likely to have multiple co-morbidity traits (<10%) that are more difficult to deal with (highest in Eating Disorders {50%} & Bipolar {35%}) Higher risk of re-victimization in adulthood due to those with early developmental trauma (A subset group of BPD patients may sometimes have PTSD as well)	Complex combinations of both positive dissociation with under-regulated affect or negative dissociation with over-regulated affect (cPTSD) Has difficulties in experiencing and recognizing emotions Has both a varying ability to relate to beliefs within their own sense of self. (A combination of traumatic victimization and disrupted primary caregiver attachment relationships might be expected – BPD may be considered as a subset of cPTSD)

26 Urich, F.L. et al (2014) Neurobiology and Treatment of Traumatic Dissociation: Towards an Embodied Self. Springer Publishing Company, Pgs. 22–33

27 Ford, J.D., Courtois, C.A. (2014) Complex PTSD, affect dysregulation, and borderline personality disorder. BioMed Central Ltd.

28 Ibid

Attention Deficit Hyperactivity Disorder (ADHD) & BPD

Although there are studies of a high incidence of individuals diagnosed with ADHD as children that are re-diagnosed as BPD as adults, there are definite differences. What is strongly similar is the poor ability to regulate their affect of emotional states and their impulsivity. ADHD could be an early childhood precursor symptom of adult diagnosed BPD. Table 7 lists traits common to both[29](Ford et al, 2014).

Table 7 – BPD & ADHD– Similar Traits

BPD & ADHD – SIMILAR TRAITS
Poor Affect Regulation (mood swings/lability) Impulsivity Conflictual relationships
Inappropriate anger Interpersonal deficits
High anxiety
Low body feeling awareness
Dissociation triggers

BPD has traits that differ from ADHD in a few significant ways. There is a chronic feeling of emptiness that can be related to high-risk suicidality (along with shame, abandonment and/or rejection). There is a stronger tendency to dissociate. And although they both share a common trait of impulsivity, a BPD individual is driven by affective and interpersonal sensitivity aspects. ADHD is mainly about an inability to hold focus or attention, which is not a common characteristic of BPD. (While also similar for a PTSD individual, impulsivity for them is more related to deficits in attentional and cognitive processing due to behavioural inhibition problems.) There is also a tendency for some people with ADHD to always be moving in a constant hyperactive behavioural pattern. Table 8 lists trait differences between BPD and ADHD[30] (Matthies et al, 2014).

29 Ibid

30 Matthies, S. D., Philipsen, A. (2014) Common ground in Attention Deficit Hyperactivity Disorder (ADHD) and Borderline Personality Disorder (BPD): Review of Recent Findings. McGraw, A. P.

Table 8 – BPD vs. ADHD – Differences Traits

Borderline Personality Disorder – DIFFERENCES vs.	**Attention Deficit Hyperactive Disorder- DIFFERENCES**
A chronic feeling of emptiness Self harming behaviour and high suicidal risk A stronger possibility of a tendency to dissociate Impulsivity is primarily driven by affective and interpersonally sensitive aspects	Inability to hold focus (loses attention easily) and/or high focus on specific areas of interest Tendency to be always moving (hyperactive) Behavioural disinhibition\Disorganization Responds well to medication Deficits in attentional and cognitive processing account for behavior inhibition problems, referred to as impulsivity

Early Attachment & BPD

In the 1960's, Mary Ainsworth identified these basic forms of attachment: **Secure Attachment, Anxious-Avoidant Insecure Attachment, Anxious-Resistant Insecure Attachment/Anxious-Ambivalent Insecure Attachment**. Mary Main, a colleague of Ainsworth, added a significant fourth category of attachment: **Disorganized/Disoriented Insecure Attachment.** This is the most dysfunctional category of insecure attachment styles. According to Main, disorganized attachment occurs when the attachment to the parent is frightening, frightened or dissociated and is seen as a 'collapse' strategy of the client who experiences 'fright without a solution' (Wallen, 2007)[31].

Insecure attachment may develop with primary caregivers who have greater difficulties being fully present to their children for long periods of time during the first year of life, such as with: post partum depression, grieving a significant loss or terminal illness of a close family member (such as another child), experiencing severe relational stress with a partner (separation or divorce), a premature birth with incubation separation and/or a primary caregiver who may be in an accident or hospitalized. Adopted children may also develop insecure attachment due to separation from the biological mother and an unstable period of time with interim caregivers until an adopted primary caregiver is fully present in the baby's life.

31 Wallen, D.J. (2007) *Attachment in Psychotherapy*. Gilford Press, pg. 49

Mirroring: Peter Fonagy observed that secure attachment parenting was shown to be both 'congruent' and 'marked'. This means that the parent's **facial** and **vocal** displays correspond as an accurate and **true reflection of their infant's emotional expressions or affect states, rather than the parent's state** (Wallen, 2007)[32]. This became the basis of the child's first representations of their own emotional affects, called **contingent** or **emotionally attuned mirroring**, which is the foundation for the infant to be able to self-regulate emotions as well as impulse control. According to Fonagy in a BPD client, the link is possibly severed or mostly disconnected within their consciousness between their internal experience and their reflection of responses from their external world environment (Wallen, 2007) [33].

When the mother is present to the infant, but not responding well to the infant's experience it is called unmarked or non-contingent mirroring. **Unmarked mirroring** is when the baby can read the mother's face for her responses, cues or distress signals and ***the mother (or primary caregiver) responds with her own needs***, unable to give a coherent reflection that affirms a healthy response to the true needs of their child[34]. This unmarked mirroring is the core source of the developmental trauma form of BPD where there is an inability to be able to grow a secure attachment with the mother. **This eventually translates as a non-cohesive sense of self that the child reasons as something that is ultimately bad or wrong within them, thus establishing a chronic shame and disgust based sense of self.**

Non-contingent mirroring occurs when **the child is invited to internalize the image of their mother/primary caregivers as their emotional self** rather than be able to discover their own emotional self-state. This creates a vulnerability to a more narcissistic pathology and creates the split or illusion of a grandiose sense of self that swings back and forth with the empty sense of self[35].

Understanding the non-verbal emotional affects of mirroring provides us with critical information in regards to how important it is to accurately mirror with words, tone, facial and body language through the relational treatment between therapist and BPD client.

Chronic Shame of the Borderline

The core issues of the early developmental trauma form of BPD is one of insecure or disorganized attachment. Either causes their sense of self to become unconsciously associated with the feelings of shame. Due to this early developmental

32 Ibid 51
33 Ibid
34 Ibid
35 Ibid

trauma, they inherently believe they are bad. This also relates to their underlying intense fear of abandonment and/or rejection.

Chronic shame can also occur with other forms of BPD that may develop out of other external environmental stressors later on in a child's life. The next direction of this paper is to follow how this relates to the experience of negative feeling states with the corresponding somatic affect states in the body. When we can track one form of BPD due to early developmental wounding, we can find clues as to how to heal or repair it later on in life through the integration of effective psychotherapeutic interventions, along with heightened body awareness of both positive and negative emotional affect states.

Shame (A Negative Affect State)

Shame is the hardest, densest energy band of consciousness to heal! It is so painful for most people that splitting off or dissociating from it is an understandable coping mechanism. This is similar to what occurs when trauma affects the body. To understand shame, we need to begin with understanding the physiology of negative affect states and how they represent themselves in the somatic expression of the body.

Tomkins describes shame as an *indwelling* affect that is inherent in the biology of the body (Helfaer, 2007)[36]. Through the pulsation of expansion and contraction, the body energetically shrinks back when positive connection is interrupted. A child can incorporate a chronic shame-system or self-hate system that is the result of the need to re-establish love (positive connection) and the child eventually becomes more shame vulnerable (Helfaer, 2007)[37].

According to Donald L. Nathanson in his book Pride & Shame (1994)[38], there are nine basic emotional *affects* (based on the seminal work of Silvan Tomkins[39]), through which our body instinctually expresses feelings. An *affect* is defined as the biological portion of emotion. When your face smiles, you are showing the *affect of enjoyment*. The circuitry to produce affects is stored in the primitive portion of the brain (brainstem) also called the reptile brain. When an affect is triggered it activates *"a mechanism which then releases a known pattern of biological events"*[40].

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36 Helfaer, P.M. (2007) Shame in the Light of Sex and Self-Respect. *Clin. J. of IIBA, V17:57–79,* pg. 66

37 Ibid 62, 67

38 Nathanson, D.L. (1994) Pride and Shame, Affect, Sex and the birth of Self. Norton & Co. Ltd.

39 Conger, J. (2001) The Body of Shame: Character and Play. *Clin. J. of IIBA, V12:*71

40 Nathanson, D.L. (1994) *Pride and Shame, Affect, Sex and the birth of Self*. Norton & Co. Ltd., pg. 49

A feeling occurs when one becomes aware of an affect. Affects are an instinctual part of our bodies that we are all born with and express. From the minute we take our first breath we somehow know how to cry and scream for help or comfort. This occurs through a combination of the affects of fear, distress and perhaps also anger. Nathanson states that of the nine affects, there are two that are positive, one is neutral, and six that are classified as negative feelings. Next is a list of the nine basic *innate aff*ects from Nathanson's book, *Pride and Shame* (some of them are listed as a continuum of a range of feeling)[41]:

POSITIVE

1) **Interest – Excitement** (reaction to success/impulse to share) – smiling, lips wide and out, more charged energy
2) **Enjoyment – Joy** (reaction to new situation/impulse to attend) – eyebrows down, eyes tracking, eyes looking, closer listening, the feeling of pride, more relaxing energy

NEUTRAL

3) **Startle – Surprise** (reaction to sudden change/resets impulses, clears the mind) – eyebrows up, eyes blinking, hands may go up, body/head backwards

NEGATIVE

4) **Fear – Terror** (reaction to danger/impulse to run or hide) – a frozen stare, a pale face, coldness, sweat, erect hair, eyes wide open, eyebrows up
5) **Distress – Anguish** (reaction to loss/impulse to mourn) – crying, rhythmic sobbing, arched eyebrows, mouth lowered, an experience of deep grief
6) **Anger – Rage** (reaction to threat/impulse to attack) – frowning, a clenched jaw, a red face, foot or hand tapping (irritation/agitation)
7) **Dis-smell** [contempt/rejection] (reaction to bad smell/impulse to avoid – similar to disgust/distaste) – upper lip raised, head pulled back
8) **Disgust** (reaction to bad taste/impulse to discard) – the lower lip raised and protruded, head forward and down, may have nauseous feeling in abdomen
9) **Shame – Humiliation** (reaction to failure/impulse to review behaviour) – eyes lowered, the head down and averted, blushing

It is clear from this list that negative feelings far outweigh the positive 3:1. Shame is the hardest feeling to find and then to learn how to dissolve. Shame happens

41 Ibid 73–149

when the natural flow of either of the two positive affects, interest-excitement or enjoyment-joy, gets disrupted. Shame can limit empathy and intimacy by interrupting or interfering in consistent and safe connections with others. Quite often anger can be a response to the feeling of shame. This can be seen as a defensive response to not feel shame and an attempt to re-establish a positive feeling.

There are many other feelings, but Nathanson generally considers them as a combination of these basic nine affects. For example, he states that guilt is not a basic innate affect but an outcome of the combining of the innate affects of fear and shame together. Embarrassment & guilt are like shame, but they are about a *behavioural* response. Shame is actually a whole being concept, connected to one's sense of self as being deficient.

The affect of ***Disgust*** can also be joined with the shame affect:

> "Thoughts about being disgusting follow feelings of shame for several reasons. First it seems that the affect of disgust follows in the wake of disintegrating shame. Schore notes that in theories of development and psychotherapy, the affect of disgust is even more overlooked than shame. He cites a study that shows that persons diagnosed with borderline personality disorder or post-traumatic stress disorder (PTSD) – that is, persons suffering from severe developmental and relational trauma – are especially likely to have a disgust prone implicit self-concept. Disgust sensitivity is elevated in trauma-related disorders and this self-disgust is also likely to be dissociated." (DeYoung, 2015)[42]

Shame is like a dark cloak, laid onto you by someone else. It occurs as a response from an external, outside source. It is a relational emotion that is about ***hiding*** from other's projected judgments (perceived or real), harsh comments, criticisms or attacks.

Children are initially dependent on their parents to mirror their needs in positive responses or soothing, calming ways. When children experience a parent as raging or terrorizing in response to their needs, they will turn against their own positive life force, and eventually create an inner self that rages and is terrorizing against itself. This prevents healthy individuation and a great difficulty to honour or recognize their right to their own needs. This can also cause a constant experience of annihilation of their developing sense of self. Eventually they may repulse their own life energy – causing a self-hatred or disgusting sense of self[43].

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42 DeYoung, P. A. (2015) Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach. Routledge, pg. xiii

43 Baum, S. (2007) Living On Purpose: Reality, Unreality and the Life of the Body. *Clin. J. of IIBA, V17,* Pg. 157

> "Shame is an experience of one's felt sense of self disintegrating in relation to a dysregulating other … someone close to us whose emotional responses leave us feeling fragmented …" – (DeYoung, 2015)

The affect of Shame is related to the *sense of self*. BPD clients truly feel like they are inadequate at their core as a basic human being. **BPD creates a chronic core issue of shame and disgust about their sense of self**. The following words embody the intensity of the shamed (with some disgust) sense of self-feeling states:

> "Corrupted, Deficient, Not Good, Bad, Incomplete, Not Solid, Un-Definable, Un-Grounded, Un-certain, Un-worthy, Defective, Empty, Self-Hatred, Self-Damaged, Self-Sabotaging …"

Shame eventually can become an impediment to further positive affect. Over time, if one doesn't feel enough positive affects (or positive neural pathway links that create positive affects), they can begin to lose access to them. This is what can happen if there are possible avoidant, ambivalent, resistant, disconnected or disorganized forms of insecure early attachment. These forms of developmental trauma set up complexities of emotional dysregulation. The negative feeling states, like shame and disgust then become difficult to stay present with. One can dissociate from these feeling states and it becomes unconscious. Any form of trauma can have a tendency to keep pulling one back, or trigger one into a negative feeling loop. It was either rarely or never experienced from early attachment with the mother what a good, safe, stable feeling state was or else it eventually becomes harder and harder to remember what it was like to feel good.

The somatic affect of embarrassment (a mild behavioural form of the affect of shame) can be seen at first as a slight flush, with red colour going up from the chest, through the neck and/or up in to the face. With the affect of shame, the head can subtly turn down and the eyes can be lowered, avoiding eye contact. Shame can also feel somatically like a large elastic band between two people that initially holds them together in relationship and then get's dramatically and suddenly cut. The feeling as it snaps back to the person with the shame feeling is, "I must have done something bad or wrong to lose the connection". It can be very fast and can feel like a strong slap in the face or like a push away in the centre of the body or like a prickly dread feeling of something dropping inside the body. Children unconsciously interpret this affect feeling state as if they must be wrong.

When children lose, or are unable to consistently hold a constant and loving sense of connection with a primary caregiver, it truly feels like the end of the world. It brings a sense of annihilation: a repeated feeling of death, over and over that becomes an integral part of their sense of self. This causes a non-cohesive sense of self that in turn creates a difficulty to effectively regulate their emotions.

They can initially cry in reaction to the need to be connected (soothed, to feel safe and good again), however over time their system collapses and eventually the child gives up and dissociates to deal with this pain of dis-connection. This then eventually shifts into a chronic trigger of hopeless or despairing affect states and/or a looping anger state to protect and defend the self against the shame feeling state.

Healing Borderline Personality Disorder (BPD)

Working with integrated, somatic (body) based, psychotherapy methods can enhance the recovery healing work for BPD individuals. Discovering clues through the pre-verbal or non-verbal forms of expression during an infant's awareness in the first two years of life can help guide practitioners in how to support BPD clients in reforming and reclaiming stable affect regulation, along with more consistent and stabilizing positive feeling states. This includes facial expressions, eye contact, tone of voice, sounds, touch, posture, intensity of contact, as well as pace or timing.

Next, are a few suggested approaches that can be applied to healing BPD through new relational entraining, developing a positive sense of self that holds, modulating affect dysregulation, increasing containment, developing healthy boundaries, integrating somatic experiencing trauma protocols and healing chronic shame.

1. Reclaim a positive core sense of self with relational, body focused psychotherapy (such as Bioenergetic Analysis). Working with developing or reforming the body and right brain connections, the mind can retrain its awareness into a stronger, more cohesive sense of self. New body experiences of positive affect states, containment and emotional management, become a doorway through the right brain processing, into understanding ones' self as a positive and healthy individual. If there is early developmental or shock trauma, the therapist can support their client to grow and develop what is missing. Using body focused exercises, introducing new positive mirroring experiences, exploring the non-verbal, somatic attachment or relational issues allows the client to develop a new trusting and very real bond with their therapist. This in turn becomes integrated into a new relationship within themselves.

By learning methods that encourage positive body connections and cohesive emotional affect regulation, the client fills in the 'holes' that are missing in holding a healthy and consistent connection with their core self. A few ideas are presented here as introductory examples of how to work with developing a positive core sense of self through new somatic awareness techniques.

Understanding presence or being centred and grounded in the body needs to be developed. Presence is about embodying one's conscious self fully present

in the here and now. Trauma fragments the self and challenges the ability to be fully present in all aspects of one's life. Worrying about the future (anxiety/fears) based on traumas of the past hinders the ability to live in the present moment. Being centred is about bringing one's consciousness into balance within the body in the current reality. This can be done by developing a compassionate witness, by tracking sensory awareness of the various parts of self or how one organizes awareness of self through the head, heart or belly and in relationship to others[44] (Maley, 2002).

Developing a consistent practice of body scanning to be more present *in* the body on a regular basis is achieved by teaching the client a new language to link their sense of self with basic body awareness sensations such as; heat, cold, tension, pressure, tingling, pulsation, pain (sharp, diffuse, shape, size?), etc. This can also be taught through touching the body, regular self-massage and/or naming the feelings and sensations to anchor them more consistently into conscious awareness. An easy accessible bioenergetic tool is to work with a rope, stick or various sizes and textures of small balls and use them for work with the soles of the feet to support more grounding ability.

Schroeter (2009), talks about the importance of understanding the difficulty to ground through the legs for BPD clients and to begin with emphasizing the feeling of safety through the relationship with the therapist first. The therapist's body can be introduced as a new container for the self to safely and gently ground into, such as placing the feet or hands of the therapist on the client's feet or placing their feet on the therapist's belly/hips area. She describes the energy to either be split "***between the upper and lower halves, with a tense midsection, or between the head and the body***."[45] Schroeter suggests exercises that aid in developing positive, safe and grounding experiences in the body, such as holding the head and occiput area, as well as cradling the client's body around the therapist's back as they lie on their side, hugging the therapist with their whole body[46].

Practicing daily mindful awareness of the body through grounding exercises strengthens connections of fragmented mind/body parts. It is important for a BPD client to regularly exercise the body to stretch it, stress it and feel the embodiment of its strength. Simple grounding exercises such as stretching and rotating all the joints, bending the back in 4 directions and twisting a stretch in the spine helps to bring back blood circulation, warmth, energy as well as more cohesiveness to the body and mind relationship.

In working with a large exercise ball, with the client and therapist sitting back to back on the ball, a client can grow into more connection and awareness of the

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44 Maley, M. (2002) *Bioenergetic Fundamentals, A Self-Exploration Manual*. Body Smart Publications, pg. 22–23

45 Schroeter, V. (2009) Borderline Character Structure Revisited. *Clin. J. of IIBA, V19:46*

46 Ibid 48

spine[47]. Not only can one feel supported and 'backed' up, there is a corresponding sense of self that slowly begins to understand an experience of containment, connection, inner solidity or strength as well as gently encourage embodiment of their (missing or fragmented) parts. Bringing the spine back into relational awareness integrates the consciousness of the brain into the body more fully and supports greater connection to the core sense of self.

As the early insecure attachment form of BPD occurs somewhere in the 6–12 month stage of development, the back is learning to how to 'stand up for itself' as the baby transitions from crawling to standing. **By focusing somatic relational work with the head, abdomen and spine areas, the therapist is able to integrate the split between the body and mind or the lower and upper half of the body through *all* the stages of attachment development.** These forms of somatic interventions need to be repeatedly introduced in order to slowly entrain and hold the new conscious information into the body. They also should only be implemented with a body psychotherapist trained in the subtle and ethical awareness of touch in regards to early developmental relational work, trauma, sexual and/or cultural issues of body contact. Through new relational and somatic bonding experiences of safe, solid and positive physical contact with their therapist, the BPD client can develop a grounded and consistent, positive core self.

2. Understand Affect Regulation and develop new skills to modulate emotions. Affect regulation, the physiological expression of our emotions, are formed in the first couple of years of an infant's life. Bioenergetic Therapists are trained to be able to coach clients how to manage under regulated expressions of emotions such as intense fear or explosive states of anger. Clients can be taught that by taking responsibility for their emotions, they can also learn how to re-direct them in safer and healthier ways. (Anger, for example, can be expressed safely through hitting a bed or pillows, or by lying down and kicking with both arms and/or legs.) There are many techniques that can be explored to manage and slow down intense emotional affects as well as strategies of how to manage feelings of overwhelm, high anxiety, anger or hyper-aroused states.

Bioenergetic Therapists can also help clients get more connected to over contained or over regulated emotions that may be more suppressed or dissociated. They can guide a client to discover what might be the deeper feelings underneath a particular intense feeling state or what may be the core cause of what is triggering them into negative feeling affect states.

It is critical for BPD clients to learn how to develop a range of healthy, positive, **Resource Tools** (*see Item # 4 below for more about this*) that help them

47 Clauer, J. (2012) Neurobiology and Developmental Aspects of Grounding. *Bioenergetic Analysis. Clin. J. of IIBA, V21:100–103*

calm down, contain and regulate intense negative affect states. This can be done through a variety of techniques such as (and not limited to):

- **Practice subtle and deep breathing exercises to calm and slow down both body and mind.** Due to the split or contraction in the mid-section of the body, the diaphragm of BPD clients will be more constricted and tight[48]. Most BPD individuals will breathe more in the upper chest area, unable to contain their feelings more fully into their body and thus are under-regulated in their emotions. Practice breathing exercises such as counting as you breathe out (exhale for longer to expel more air) by counting to 5 or 7 slowly before breathing in. This slows the breath by forcing longer and thus deeper in-breaths through the diaphragmatic block and into the lower belly.
- **Release deeply held tensions and trauma in the body through simple exercises that encourage deep spontaneous trembling.** A good resource of one form of a Bioenergetic based practice are the **Trauma Release Exercises** (TRE) by David Berceli[49].
- **Include a Dialectical Behaviour Therapy (DBT) approach.** DBT is a more structural (left brain) approach that advocates client commitment and the ability to self-monitor and track on the part of the client. It includes a dialectical approach (a synthesis of opposites, non-absolutes, fluidity of change), mindfulness practices, new skills training and consistent follow through[50]. DBT helps clients become aware of and track triggers that cause emotional dysregulation, as well as tracking how effective their newly learned skills and coping strategies are working, which provides hope out of their despair state. This type of individual therapy, integrated with group therapy, works well as it connects the mind and body.
- **Express feelings through right brain explorations of movement, sounds and creativity.** Forms of dance that encourage spontaneous, intuitive or authentic movement allow the body healthy forms to express difficult emotional states. Drawing emotional states with intuitive, abstract expressions of colour and shape can move negative emotional energy through the arms, hands and out of the body. These drawings can also be interpreted afterwards, similar to interpreting dreams, to access the unconscious meanings. Spontaneous sounds, chanting or singing can also move distressing energy through the body and shift it into more positive or calming energy states.

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48 Schroeter, V. (2009) Borderline Character Structure Revisited. *Clin. J. of IIBA, V19:46*

49 Berceli, D. (2005) Trauma Releasing Exercises (TRE): A revolutionary new method for stress/trauma recovery. Book Surge Publishing. www.traumaprevention.com

50 Pederson, L. (2015) Dialectical Behavior Therapy: A Contemporary Guide for Practitioners. Wiley-Blackwell

- **Experiment with various forms of Energy Psychology.** Many forms of Energy Psychology follow Traditional Chinese Medicine (TCM) awareness of energy meridians throughout the body and supports triggered sensitive systems that get easily overwhelmed[51].
  - Learn **Emotional Freedom Technique** (EFT) tapping exercises (again, based on TCM awareness of shifting energy), which help reprogram the brain and body connection of intense negative emotions and belief systems[52].
  - Practicing **Donna Eden's Energy Medicine** exercises such as the 5 Minute Energy Balancing routine, or the Triple Warmer calming method helps to calm hyperarousal found in PTSD or BPD.[53] [54]
- **Explore Structured Therapy for Affective and Interpersonal Regulation with Modified Prolonged Exposure** (STAIR-MPE)[55] **or Trauma Affect Regulation: Guide for Education and Therapy** (TARGET).[56]

3. Containment Work. An important aspect of healing the core of BPD is strengthening and building new connections for a more contained and boundaried sense of self. Learning mindfulness techniques strengthens the mind to stay with the present moment and let go of future worrying or constant, unfocussed thinking patterns. It is helpful to join a meditation centre, take courses and/or go on regular silent retreats to develop these skills with others present, as group energies can support entrainment of new neurobiology patterns in the brain.

Journal writing is also a great form to track, explore and re-write one's personal narrative of how BPD individuals can view themselves. It helps to hold the memory of the split off parts as well as encourages self-reflection, problem solving or decision-making. It also offers opportunities to re-write the stories with

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51 Aung, S.K.H., Heather, F., & Hobbs, R.F. (2013) Traditional Chinese Medicine as a Basis for Treating Psychiatric Disorders: A Review of Theory with Illustrative Cases. *Medical Acupuncture, Mary Ann Liebert, Inc.*

52 Ortner, N. (2014) *The Tapping Solution*. Hay House Inc. 8th ed.

53 Andrade, J., & Feinstein, D. (2004) Energy Psychology: Theory, Indications, Evidence. *In D. Feinstein, Energy psychology interactive Innersource, Appendix 199–214*

54 Feinstein, D., & Eden, D. (2008) Six pillars of energy medicine: Clinical strengths of a complementary paradigm. Alternative Therapies, V14(1): 44–54

55 Levitt, J.T., Cloitre, M. (2005) A clinician's guide to STAIR/MPE: Treatment for PTSD related to childhood abuse. *Cognitive and Behavioral Practice V12(1):40–52*

56 Ford, J.D., Russo E. (2006) Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy V60(4):335–55*

new information, as one understands oneself on increasingly deeper and more integrated levels.

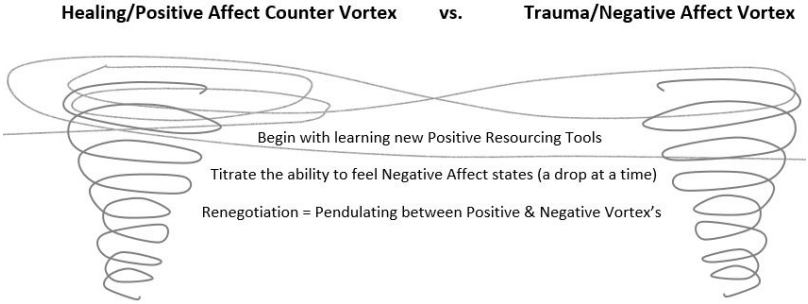
Anger and boundary work can often be important ways to help re-claim the body. For many people the affect of anger needs to be re-organized to support the self to get what it needs, rather than be turned inwards as self-harm or outwards in ways that can be sabotaging of intimate or work relationships. With early developmental trauma, anger can sometimes be a very difficult feeling to actually connect to and feel. Trauma may also *cut off* the feeling of anger or shame due to the freeze response of dissociation needed to separate from the pain of the event/s.

Boundaries need to be taught with an emphasis of how to actually feel them with the body. Although traditional talk therapy can be very helpful in creating a clearer narrative about who one is, working with the body can often make faster significant shifts that translate well into new modes of functioning in the outside world. Standing exercises with a string placed in a circle on the floor around the client (that they place) and walking towards them slowly (on all 4 sides of their body) can demonstrate how they respond (by neutrally observing breath, micro movements, facial expressions, sense of pressure, etc.), begins to teach a simple awareness of an energy boundary around their body. Or playing with pushing with their hands with the therapist (also while standing) and expressing push and pull movements with verbal expressions of 'No', "Go away" and/or "Come here" emulates the rapprochement stage of attachment and can teach new body/mind connections of a client's actual needs. Boundary work can also be explored on a number of other levels such as in intimate or professional relationships, learning how to write clear contracts with others, or perhaps in developing the discipline to organize and maintain an ordered lifestyle and physical environment.

Shapiro's work with Bioenergetic exercises of curling and uncurling the body through charging and containing can be extremely helpful for BPD clients. Developed as a gentle approach to help restore natural energetic pulsation, Shapiro's exercises provide containment for building boundaries through somatic experiences. Some of these exercises help to calm the system and others can charge the system (Shapiro, 2008) [57]. Shapiro's seminal guide, 'Bioenergeric Boundary-Building' contain an extremely helpful series of exercises that may also be explored (Shapiro, 2006)[58].

Exploring solo journeys in Nature can offer experiences of more self-reliance skills that can create space for a healthy individuation of the sense of self to develop. BPD individuals may have a general tendency to merge too much with others and rely on them to initiate events or make decisions. Independent, solo explorations include simple mindful walks in the park, biking on remote nature trails,

57 Shapiro, B. (2008) Your Core Energy is Within Your Grasp. *Clin. J. of IIBA, V18:65-91*
58 Shapiro, B. (2006) Bioenergetic Boundary-Building. *Clin. J. of IIBA, V16: 155–178*



solo canoe or kayaking day trips. Eventually one can go on longer wilderness, canoe or hiking trips to challenge themselves and experience successful adventures of independence on their own.

Finally, it is often useful in containment and boundary work to develop a personal connection with a form of spirituality that can transmute confused or negative attachments to a constant, loving, compassionate form of attachment. For example, shifting the experience of a negative mother to a positive form of "Divine Mother" can be extremely helpful and freeing.

4. Work Slowly with Somatic Experiencing Trauma Protocols: Resourcing, Titration, Renegotiation, Healing/Positive Affect Counter Vortex versus Trauma/Negative Affect Vortex (This section is largely based on the work of Peter Levine[59])

Resourcing: It is important to be able to re-organize the meaning of what it is like to be in the body in order to feel and heal negative affect states. Body sensations, fear, anger, shame, abandonment and/or rejection are often hooked together in trauma or early developmental injuries. To uncouple these negative relationships, the idea is to initially learn body awareness of experiences of pleasure and safety. The client needs to learn from scratch how to be able to contain, regulate or negotiate the intensity of their negative emotions. This will eventually give them some measure of control and safety to be able to come out of the negative sensorial feeling states in the body, on their own. Levine calls this **Resourcing** (1997) and there are a great variety of tools that one can implement to achieve and reconnect to positive affect states[60].

As trauma often causes PTSD symptoms, the body can get stuck in one or a few negative affect states. Anger or shame are often experienced as negative or bad, uncomfortable feelings. The experience of feeling overwhelmed or flooded

59 Levine, P. A. (1997) *Waking the Tiger*. North Atlantic Books
60 Ibid. 199

by too much (intense) feeling is part of the fear affect response. With trauma, fear creates a fight, flight or freeze reaction. In the freeze, there is numbing (being present to the trauma, but unable to move or respond in fight or flight) or dissociation (when the consciousness leaves the body and there is no memory of the event). This is an instinctual protection mechanism that is dealing with the trauma of an event.

When the body is stuck in the frozen state, coming back can be enabled by slowly going through the physical actions of the flight or fight motions in the body. This gets the energy unstuck and moving through again. **Individuals can be stuck for years with the affect state energy patterns frozen in an actual twisting in their spine or torso, or body part tremor, or a kind of numbness or deadness in a body part, etc.** With trauma, and with shame, the fear aspect of it causes a part of the self to leave the consciousness of the body. This is also what causes the intense emotional pain or discomfort that can trigger self-harming (Page number)behavior actions where anger comes through to try to create change and hits a block, or the stuck place in the trapped, traumatized energy and attacks the self instead, expressed as self-cutting or possibly even suicide.

In a trauma body, body sensations may initially be interpreted as negative sensations. The experience of feeling overwhelmed or flooded is a fear response. It is not pleasant to go into the body if it is in fear. Learning how to visualize and experience good feelings in the body becomes the initial focus of reclaiming the body mind emotional regulation work. Positive Resources can be used to create new systems to help self-soothe and regulate the overwhelmed nature of a trauma system. In this light, addictions (such as alcohol, smoking, drugs, food, etc.) can also be seen as a way to help regulate the affect of high anxiety and help to self-soothe. If a therapist is working with a client with any form of trauma, to remove an addiction prematurely before other resources are able to be introduced, integrated and effective, rarely works.

For a BPD client, once the level of a self harming threat crises is safely mitigated, the main goal is to teach self-soothing techniques to help calm the dysregulation of their emotional affects. BPD individuals are highly sensitive and constantly easily triggered. Teaching them that they do not need to feel like victims that cannot control their emotional liability, empowers them. Through learning with a variety of new relational experiences and different forms of exercises that they can practice on their own to manage intense emotional feeling states, gives them hope. They also can gain a greater understanding of what they can do to disrupt the negative feeling state in their system, with increasing speed.

Titration: Re-organization: Positive Resourcing needs to be learned slowly and takes time as any feeling (positive or negative) produces a charge of energy in the body and thereby creates more oxygen and life in the body. More feelings can activate an overwhelming response that floods the system causing panic, numbing or dissociation very easily.

Titration, another term borrowed from Levine[61], is standard practice in this kind of work. Allowing a drop at a time to enter the system, can slowly and gently re-organize the original experience to integrate safety into the body. As Jacqueline Carleton states, ***"... pausing in the account to allow the nervous system to – recycle, avoids iatrogenic re-traumatization. This can be done in a number of ways: by resourcing at the beginning and as it unfolds, by asking the patient to focus in the present, and by any one of a number of grounding and stabilizing exercises***"[62] (Carlton, 2009).

Establishing new resources of information that encourages body and mind to connect to feeling states of safety, pleasure and connection are the next steps. Learning how to calm the body down quickly, when triggered into a fear, angry or a hopeless/despair state, is essential in understanding how to regulate the affect states of intense emotions.

Renegotiation: The Healing/Positive Affect Counter Vortex vs. The Trauma/Negative Affect Vortex[63]: With heightened sensitivity to negative emotional states in a BPD individual, often something will be triggered that overwhelms the system and it can feel like one is falling backwards into some or all of the 'old' (from the past) feelings of: negativity, despair, hopelessness, annihilation, self-abuse/sabotage, rejection, exhaustion, collapse, and/or contraction. It may continuously feel like the past trauma or disruption of positive feeling stability intrudes onto the present reality. Working with a Healing/Positive Affect Vortex concept, includes having a number of different resourcing tools to counter-balance the **Trauma/Negative Affect Vortex** (Levine, 1994) experience.

Once the body begins to learn to feel safe and has had some experience of calm or pleasure, one can then begin to allow some of the more intense, negative feeling states to enter the therapy and become re-organized. This is a process called **Renegotiation** (Levine, 1994), and is the core work of how to introduce emotional regulation back into a dysregulated system.

To pendulate between the **Trauma/Negative Affect Vortex** and the **Healing/Positive Affect Counter Vortex** (Levine, 1994), allows for a slowly increasing ability to contain and transform the triggers and disruptions of the body mind relationships into new, positive experiences in the body.

Introducing humour and more playful approaches to connecting with the body can also be extremely helpful in transforming, reducing or shifting the negative affect states, including flight, fright or freezing responses that may occur

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61 Yalom, V., Yalom, M. (2010) Peter Levine on Somatic Experiencing. www.psychotherapy.net/interview/interview-peter-levine

62 Carlton, J. A. (2009) Somatic Treatment of Attachment Issues: Applying Neuroscientific and Experimental Research to the Clinical Situation. CA-SPR (Canadian Society for Psychotherapy Research) Montreal

63 Levine, P. A. (1997) *Waking the Tiger*. North Atlantic Books, pg. 199

when trying to integrate consciousness and emotions. This slowly grows an ability to modulate affect regulation more gently with the body.

5. Healing Chronic Shame. Self-acceptance and self-respect are the antidotes to shame. Through acceptance of the flawed, negative self (that includes shame, disgust, and/or hatred), we develop a form of self-respect that allows us to suffer these feelings, "*rather than suffer the effects of the struggle against them*" (Helfaer, 2007)[64]. Helfaer emphasizes the importance of understanding how the poles of the idealized/self-denigrated self can get played out in the dialectic of narcissism through the need to be seen as special (positive pole), or else as worthless (negative pole) (Helfaer, 2007)[65]. Self-respect is developed through the healthy integration of the positive and negative self.

Explore with the client their shameful as well as courageous and prideful stories. Supporting a BPD client to claim a narrative of their past shame helps to link and reconnect the dissociated parts of themselves into a cohesive whole. This needs to be done by a therapist whom they have developed trust and bonded with. Using the above trauma protocols of titrating positive resources into the body's somatic shame reaction slowly dissolves the hidden holes (or blocks) that shame creates in the core sense of self for BPD clients.

Following the shame narrative with stories of courage and pride, the therapist can often reframe the shame story segments through loving acceptance or being non-judgmental and filling up the neural networks in the brain with positive feeling states. Exposing the shame story of a BPD client, with the essential somatic and relational mirroring of the compassionate and caring eyes of a therapist 'seeing' them as they talk about it, can gently transform their chronic shame self into a more joyful and proud awareness of self.

When a client shares their shame and pride stories in a larger group setting, this allows the community to also 'see' them with compassion, in a larger collective reflection. Hearing the shame and pride stories of others in a group setting, can offer other clues to the dissociated, fragmented parts that may be missing in a BPD client, due to the way shame is so often lost and hidden to the self. This kind of group work reclaims missing parts and has the potential to transform shame at deeper levels.

In addition, although it is not in the general scope of psychotherapy, the somatic psychotherapist is interested in helping the client live a balanced life. As an adjunct to therapy it can be valuable to recommend support from the adjunctive fields of healthy eating or natural remedies. Many BPD individuals are highly

64 Helfaer, P.M. (2007) Shame in the Light of Sex and Self-Respect. *Clin. J. of IIBA, V17:*74

65 Ibid

sensitive or intolerant to sugar and/or other foods. Practicing a healthy diet and possible work with natural remedies can support a more balanced emotional regulation and aid their healing process. Also, with the heightened sensitivity of BPD individuals, they will likely be very affected by electrical and electromagnetic energies and alcohol or other drugs as well. This may constantly destabilize their energy into negative feeling states and scramble the energies of the body and mind causing a greater inability to focus or think clearly.[66]

Therapist Somatic Counter-Transference with BPD

For the body-oriented therapist, there are many opportunities to be aware of counter-transference or somatic counter-transference issues when working with BPD clients.

In general, counter-transference issues with many clients as well as BPD clients, can include the following in regards to the difficulty to holding boundaries:[67]

- A therapist can get drawn into more intimate physical or sexual behaviour due to the blurring of clear ethical boundaries.
- The therapist may offer inappropriate self-disclosure and not be able to hold a "personal information" boundary for him or herself.
- Ethical transgressions can occur with a sense of over responsibility for the client, trying to rescue and problem solve for the client (rather than encourage them to solve their own issues).

With BPD clients, there are a few more possible transference issues:[68]

- The therapist can get pulled in, loosening their professional boundaries and become too involved with their BPD client.
- The therapist can be manipulated to give the BPD client special considerations because they are seen as special and in order to ward off the client's angry responses.

The therapist can begin to develop loose boundaries by extending a session, allowing extra or excessive phone, text or email connection between sessions, deferring payment, or not charging a fee. It can be a complex process for a therapist to be clear about what is theirs and what belongs to the client. While this is generally true, it can occur more often with BPD's because of their own lack of clarity with

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66 Cryns, Ingrid (2012) EMF & Radiation FAQ's. www.somaearth.com/emf-radiation-faqs/

67 Lane, C. (2015) *Borderline Personality Disorder.* www.toddlertime.com/dx/borderline/bpd-ekleberry.htm

68 Ibid

personal boundaries. Depending on the severity of the wounding, a professional therapist may need extra support working on counter-transference in supervision or seek back up support within a clinical setting, their own therapy and/or group supervision.

A significant counter-transference issue can occur when a psychotherapist experiences alternating feelings of *fear*, *anger* or *helplessness/hopelessness/despair* that exists within the BPD client but is dissociated from their awareness. This can be experienced somatically in the body of the therapist during, as well as between sessions[69]. To be able to respond effectively with a BPD client it is important for the therapist to become aware of their own personal history of helplessness or anger and get clear on how those feeling states can manifest somatically in their current body physiology or be acted out.

> "They [BPD clients] can provoke feelings of helplessness and anger in service providers. It is, therefore, vital to set and enforce limits so that the treatment provider can remain involved, compassionate, reliable, and consistent (Oldham, 1990, p. 306). Sperry (1995, pp. 65–66) noted five points of consensus in treating individuals with BPD:
> – the service provider must be active in identifying, confronting, and directing client behaviors;
> – there must be a stable treatment environment;
> – BPD clients must learn to connect actions and feelings;
> – self-destructive behavior must be made ungratifying;
> – and countertransference feelings must receive careful attention."[70]

The triggering of the counter-transference of anger within the therapist is a challenging affect to work with. The client may create little set-up games without being conscious of it inspiring conflict. This has two possible directions. One is a natural desire to individuate. The other is about creating more focus and intensity so as to hold connection and be more present in the body, rather than disconnecting. To work with this, it is important to hold your own centre and simply not react. To start with you can lower the tension by agreeing quickly with the client's different point of view to diffuse the conflictual energy being presented.

The best way to work with the alternating states of anger and helplessness (or hopelessness/despair) is to gently begin to name the feeling state in *your* body and ask the client if they have any sense of this state in *their* body. It is important to do this repeatedly as they will likely be disconnected or dissociated from the ability to feel this state at first. Be prepared for denial initially and do not let it stall

69 Ibid
70 Ibid

you. Regarding the helplessness state, **to simply name it when it shows up and not show your own fear, or be overwhelmed with panic or hopelessness of the 'stuck' state. It is important to be able, like the mother or caregiver, to "mark" body-sensation and feeling with accurate mirroring reflections through voice, tone and body language affects. This will allow them to eventually simply be present to that state within themselves without judging themselves into a defensive or dissociated shame response.** Then you work with inviting gentle self-soothing techniques to feel safety and pleasure again to bring them back to a positive feeling state within the body.

A BPD client can create, within their therapist *"... a maelstrom of deadness, emptiness, despair, and terror with no exit"*[71] (Baum, 2007). Scott Baum talks about the concept of '*Soul Murder'*, as a direct effect of terror in the body that a BPD client may experience from the early developmental form of relational trauma. He describes it as a direct experience of annihilation that is like a '*living death*' within. Baum feels that it is critical for the therapist to be able to stay present to these terrible and intense negative states (also including helplessness, abandonment, rejection, shame, disgust, hatred, etc.) (Baum, 2007). It is important to be able to name and validate these negative affects and affirm the real truth of the agony of experiencing them. This allows the client a new opportunity to learn how to be able to emerge through them into a positive connection of self and other, through the transformational, healing relationship with their therapist.

The following is list of various feeling states that can be experienced somatically by a therapist as a potential counter-transference issue with a Borderline client. It is important to be very familiar with what these various feeling states feel like in the therapist's body, so that when they are experienced while being present with the client, the therapist can note his or her somatic states to gain clues as to the feeling states going on with the client. These clues can be explored by the therapist as to their counter-transference possibilities by knowing and owning their (the therapist's) own personal somatic states of emotional affect. Supervision with a body-oriented or Bioenergetic therapist can greatly assist this process.

Anger

BPD clients may often experience anger and aggression and may also at times deny their own sabotaging or angry state and set up a dynamic of triggering others into acting out their anger. They can also continuously get triggered into a shame response, and may deflect to anger, as a secondary emotion, in order to protect and defend the vulnerability of feeling badly about themselves. They can be very

71 Baum, S. (2007) Living On Purpose: Reality, Unreality and the Life of the Body. *Clin. J. of IIBA, V17:178–182*

destructive and their anger can get out of control with little affect regulation to moderate certain situations if needed. Their general aggression can be interpreted as a chronic and unconscious underlying rage at the absence, abandonment and/or rejection of a parent who was the primary caregiver.

As a secondary emotion, hidden underneath anger, there may be deep emotional pain such as ***grief, fear*** or ***shame.*** Anger can also co-exist with one or more of these secondary emotions. Sometimes this is possible, but this also makes it confusing to sort out what is really going on as the core reason of why there is anger, and what the *message of anger* could be trying to express in the client. The body is trying to achieve balance in some form. Anger can sometimes be understood as information from the body of a need that is not clearly identified.

Anger usually comes up because we ***are not getting what we want***. We want something to change in order to be released from a negative emotional discomfort in our bodies. Anger can make things happen. It can be an instrument of change with an expenditure of energy. Some people learn that with anger, there is a force that can *push through* to get them what they want.

Teaching self-reflection can start the process of loosening the block that the ***message of anger*** is creating inside the body. To help a client possible questions to ask are:

What am I holding back?
What am I holding on to?
What am I needing here?
What am I not getting?
What am I afraid of?
What am I not wanting to feel or see?
What (feeling or thing) might I be hiding from?

To manage somatic counter-transference it is helpful to be able to read the unconscious expressions of anger that the body will exhibit. Concentrating solely on the affect of anger, its expression in the body can be seen through the basic tensing and contraction of tissue and muscles. There are multiple variations of this such as the face going red (skin tissue inflamed, contracted), a frown (mouth muscles turning down, contracted), yelling (throat muscles tensing), and/or swinging out with the arms to hit (arm and hand muscles tensing and contracting).

One can also hide, repress, or suppress an angry affect in a number of ways. Some ways to hide anger are tensing your shoulders, clenching your jaw, clenching your fist or knuckles, tapping your foot, or feeling restless.

Irritable bowel symptoms can be the result of tension in the intestines related to feelings of fear and resentment (holding onto anger)[72]. Tradition-

72 Rogers, M., McKay, D. J. (2003) *When Anger Hurts: Quieting the Storm Within*. New Harbinger Publications, Pg. 27

al Chinese Medicine (TCM) suggests that liver issues may be created by an imbalance of anger and gall bladder issues may involve deep resentment or holding onto anger[73]. Skin irritations (eczema), muscle inflammation, or arthritis may all be expressions of somatised anger or rage in the system. In these ways anger can be somatized in the body without the mind having awareness of any anger.

It is also helpful to establish a secure bonding of trust with a BPD client and build positive resources of re-connection before getting into challenging the defensive strategy of continual anger looping. To begin to untangle the complexity of their negative emotional states, be aware that their anger defense allowed them to survive up to the point of therapy. It may also be helpful to explain to them that this anger is trying to protect them from what happened in the past, but now it is time to let it go, and to transform and re-organize their anger to be more effective in their current life.

It is critical to understand how to work with the high sensitivity aspect of a BPD client. Do you find yourself feeling afraid that you may trigger your client in an angry or rage state at the slightest thing? Try to not get defensive. Pull back, do some subtle breathing exercise work during the session to come back to your own body presence. Focus on reflecting back their angry affect state without judgment in either your facial expression or voice tone. Show concern and repeat their words back to them or explain their body action of their anger affect state. Help them make the link between the observed state and what they are actually trying to ask for in the anger reaction. Be consistent and clear about your limits, what you need to be safe and follow through with holding your boundaries. They need to feel these limits to feel safe themselves.

Abandonment

Clients may miss appointments or find it difficult to stay present or focused during the session. Do you notice them pausing, freezing or tuning out for a few seconds while they speak? This is a sign of dissociation, which can also be seen as an act of abandonment from themselves. It is a reflection that what was done to them in the past is occurring within them now.

The somatic expression of abandonment is a sense of disconnection from the sense of self. It feels extremely isolating and alone. You, (or your client) could feel "spacey" (in a dreamy state) or not grounded in your sense of self or in the body. Or you could feel nothing somatically in your body at all, which is often a strong sign of dissociation in the client. Anger can also be a response to abandonment. However, in early developmental trauma, the child's anger may have received no

73 Cutler, N. (2011) *Anger Inflames Liver Disease*. www.liversupport.com/anger-inflames-liver-disease/

response, in which case it becomes dissociated in the adult client and thus more likely to be felt in the body of the therapist.

Check in and ask yourself if you feel irritated by their abandonment, dissociation or denial of their issues? Are you aware of feeling the client's dissociated anger (from being abandoned)? Or do you feel nothing or feel like you are alone in the session with your client, perhaps trying too hard to get them to do anything? If so, you may be in the presence of a client in a fragmented, abandoned state.

Annihilation

Annihilation feels like either the person you are, or your point of view doesn't exist. It feels like you are unseen, unheard or invisible. The client can feel like a ghost inside an invisible body. It is such an intolerable and terrifying feeling that most people dissociate from it.

Annihilation has similar somatic states as abandonment with essentially no feeling in the body at all. As the therapist, do you feel like you don't exist to the client, or that your work/influence appears to have little or no impact on the client's progress? If so, you may be in the presence of a client experiencing an annihilation state.

Bewilderment/Confusion

Bewilderment is about feeling lost or confused as to what to feel or what is going on. The feeling of confusion can be induced by constant overwhelm or too many feeling states. It can be experienced as a kind of shock state. You (or the client) may feel spacey. The client's eyes may be open wider in a surprise/startle state. Or they may move around a lot trying to understand something beyond their grasp. The body can also feel numb or nothing at all – it can dissociate from too many confusing and varying feeling states.

In this case are you, as the therapist, aware of nothing in your body while with the client? Or do you feel stuck, bewildered or confused yourself while with the client? Does your client make you feel a little crazy (switching to many different emotional states constantly and so quickly)? If so, you may be in the presence of a client in a bewildered/confused state.

Despair/Helplessness/Hopelessness

You may find yourself at a loss as to what to do or how to respond to your client when they are in a stuck or helpless state. The ability to stay present with a BPD in the intense feelings of hopelessness and despair can be very challenging for most people.

Maybe you feel like giving up working with this client? Or do you feel that you don't know how to help them anymore? If so you may be in the presence of a client in a despair/helpless/hopeless state.

Are you familiar with or able to stay present to your own inner place of despair/helplessness/hopelessness? Have you made peace with or do you have an awareness of acceptance of this place as a part of yourself and the human condition? Are you able to sit with others with acceptance, compassion and/or space for this feeling state? Personal therapy for the therapist to explore this challenging and intense negative affect state, may be helpful to support this deep level of work with others.

Disgust

The affect of disgust comes up deep from the belly and it can feel a little nauseous or like you are about to throw up. The mouth can go into a frowning, pucker shape, with the tongue out a little, mimicking a regurgitation reflex. And the nose can wrinkle up slightly as if smelling something bad. Disgust is mostly about disliking or hating the core of the sense-of-self.

Perhaps you don't like your client, or maybe you really hate working with them? Or you may just know that you feel better than this client. Do you feel superior to the client? Does something about the client repel you? If so you are likely in the presence of a client in his or her own disgust state.

Fear/Overwhelm/Terror

The affect of fear has a continuum of expression from slight overwhelm, to mild anxiety, to occasional panic attacks, to various fears and phobias, to extreme terror. Fear causes the energy in the body to retreat from the periphery to focus into the core of the body, surrounding the organs and viscera in the centre of the body. An image of a full fear state is the body being in a contracted fetal position, lying down, curled up on one side. Both the body and sense-of-self contracts. Before this state, the body goes into the fight, flight or freeze mode. In full contraction, the body is in a freeze state and can then dissociate from the feeling states.

Terror is a more intense feeling of fear, one of falling apart and losing control. This can cause complete emotional dysregulation.

Again, use your body's somatic awareness for clues about the client's state. Is there dissociated fear or perhaps a stiffness or tightness in your body or in the client's body as you observe them? It can sometimes feel overwhelming to be with a BPD client because their intense affect states or constant swings in mood liability can be challenging for most people. Do you feel like screaming inside when with them or can you sense their inner scream of fear/terror? If so, you are likely in the presence of a client in a fear, overwhelm or terror state.

Self-Sabotage

Self-sabotage occurs as a form of unconscious anger that clients act out, which is ultimately harming to them. Self-sabotage is when the energy of anger implodes and get's directed inwards (part of a shame response) and unknowingly, eventually harms or destroys something for the client. It happens when anger gets distorted or suppressed and does not work in a constructive way to help them get what they need. Self-sabotage is more about how the client's actions are harmful to themselves, rather than as a somatic expression. However, self-harming behaviours such as self-cutting are a somatic form of harm to the body where the anger implodes and gets inwardly directed.

Can you catch if you are feeling angry with yourself for doing something wrong with your client? Or perhaps you let slip an irritation or judgmental remark with them? Or maybe you made a mistake with them because you may have been overwhelmed by their intense anger or fears. If so, you may be mirroring your client in a self-sabotaging state.

Rage

Rage is different than anger. Underneath rage is helplessness. If it gets fully expressed, body feelings can become completely dysregulated. Rage can also be about terror. It is a reflection of survival from a very primal place. The somatic expression of rage is a scream that comes through the whole body. To support clients in expressing this rage, allows them to be contained by your presence so that they can fall apart to let the scream through and find a place of peace afterwards by letting this out of the body.

Can you sense a scream inside your client's body? Do you as the therapist have a desire to scream when you are with your client? Does your client make you feel so distressed sometimes that you want to scream? If so then you are likely with a client struggling with a dissociated rage state.

Rejection

The somatic experience of rejection is very intense and most people do not want to feel this negative affect state. A client might feel like they cannot breathe or that they are suffocating. They can feel like their heart is split in half or fragmented in a million pieces or that their body is crumbling and all the muscles are going into spasms. It can feel like a sharp jabbing, knife like pain, or like a sharp slap in the face.

Do you find yourself being judgmental, or feeling contempt? Do you find yourself accidentally making your client feel bad or wrong during a session? Are you aware of your own story or feelings of rejection in your somatic history aware-

ness? Your client may be in a state of acute or chronic rejection, possibly co-occurring with shame and/or abandonment states as well.

Shame

As stated earlier, the somatic effect of shame can be seen with the head subtly turned down, eyes lowered, or eye contact avoided.

Are you making embarrassing mistakes, or do you feel that you cannot ever get it right with your client? It can be challenging to connect with the feeling of shame in the therapist's somatic counter-transference. If you are familiar with the somatic states with your own shame story, it will be easier to identify what you are experiencing when working with the client. The shame is either yours or may belong to the client who is in a dissociated shame state.

Summary of Clinical Counter-transference Issues

For psychotherapists, it can be very supportive to use a more body-focused approach when working with BPD clients. Self-regulation can be taught through body sensation awareness to link the feelings to the physiological expressions of the emotions, then to their conscious thought patterns. Non-verbal cues can be significant entryways to hearing what the body is actually trying to express in somatic trauma patterns. It is also important to let clients lead with their ability to stay present to the work (not dissociate) and handle the degree of slow body sensation awareness recovery work. It is supportive for the therapist to take the time to understand attachment neurobiology and how bonding can be reformed through eye contact, presence, authentic mirroring of the client's self, the sense of safety, loving gentle touch and/or respectful body contact affect regulation work. Repair through somatic resynchronization is possible and re-establishes basic trust, emotional regulation and a healthy maturation of self[74] (Bentzen, 2015).

Healing a dysregulated system requires the ability to learn how to trust that by letting clients go into intense negative feeling states, they will naturally be able to come back into a more regulated state. They can become deeply dysregulated (e. g. have flashbacks, fall apart), however through gaining positive resourcing skills that clients have practised, they learn safety and how to trust that they know they can come back again to a place of coherent regulation. This allows them to slowly build up a stronger containment of their sense of self into a new, integrated

74 Bentzen, M. (2015) Shapes of Experience: Neuroscience, Developmental Psychology, and Somatic Character Formation. *The Handbook of Body Psychotherapy and Somatic Psychology,* North Atlantic Books

whole that includes and slowly transforms the intensity of dysregulation of their negative feeling states.

The authentic and direct relationship with the psychotherapist is also an important component of healing a disrupted early attachment bonding with BPD clients. It may be helpful for the practitioner to educate their client by introducing ideas of how conflict can sometimes be an opportunity to repair the disruption or disconnection looping of the past and grow into a more consistent and permanent connection with their self in the present. Learning how to repair the trust that was lost with the 'other' and regain it back within their self is a significant step to building new neural pathway bridges in the brain, which translates as a stronger, more solid and contained sense of self. Learning to not lose themselves in the disconnection cycle, but to know that they can continuously repair and come back, over and over, is an important and significant new experience they can grow into within the relational aspect of the work with their therapist.

It is important to find therapeutic support that includes some somatic affect regulation training and/or some trauma PTSD awareness.[75] This work can also slowly shift the self-shaming shadow and stigma that often permeates BDP clients by not seeing their issues as isolating, and alone, or their fault, thus allowing them to change a chronic experience of powerlessness or victimization into one of growing empowerment.

Summary

This paper summarized how Borderline Personality Disorder is defined as well as described some unique features of how it is experienced. It compared the sometimes complex and co-occurring traits to similar disorders such as NPD, BD, PTSD and ADHD, to help more clearly differentiate the differences between these disorders. It described the somatic affects of chronic shame such as disgust, abandonment and rejection, as well as how to address this in therapy. It also presented an integrated model of healing BPD that includes a broad range of concepts, from Somatic Experiencing protocols, to supporting containment development and affect regulation. And finally, it addressed the complex aspect of counter-transference with a therapist's own somatic awareness and how to work with that awareness to be more effective in working with a BPD client.

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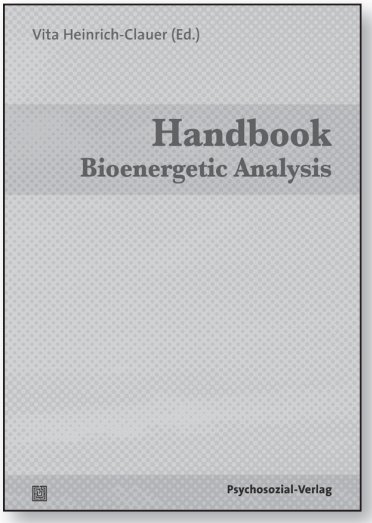

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This book is a selection of articles from Bioenergetic Analysis, that range from classical studies written in the Eighties (following Lowen) up to current theoretical contributions and case studies.

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