

# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

(Incorporating US Association for Body Psychotherapy Journal)

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EABP

United States Association for  
Body Psychotherapy

## International Body Psychotherapy Journal The Art and Science of Somatic Praxis

(Incorporating US Association for Body Psychotherapy Journal)

### Volume 11, Number 1, 2012

The International Body Psychotherapy Journal (IBPJ) is a peer-reviewed, online journal, published twice a year. It is a combined publication of the United States Association for Body Psychotherapy (USABP) and the European Association for Body Psychotherapy (EABP). It is a continuation of the USABP Journal, the first ten volumes of which were published by the US Association for Body Psychotherapy and can be ordered through the website [www.usabp.org](http://www.usabp.org).

The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice through ongoing discussion.

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## Editorial

### Volume II, No.1, 2012

This inaugural issue of the *International Body Psychotherapy Journal: The Art and Science of Somatic Praxis* is the culmination of a 10-year dream and a lot of hard labor on the part of many. Beginning in 2002 as the *US Association for Body Psychotherapy Journal*, Robyn Burns and I didn't really know what we were volunteering for. In a board of directors' meeting I volunteered to edit it and Robyn said she would figure out how to produce it. We were off! At first, garnering articles was like pulling teeth, but as the years went on, more and more higher quality submissions appeared for us to choose from.

Then, a few years ago, I realized that, although I had really enjoyed doing it alone, it might be interesting to investigate the possibility of a joint journal with the EABP. The failure of that possibility in 2001 was what had catapulted me into doing the USABPJ, but I wondered if we could go back and pick up some of the pieces. I had long been a member of EABP, taught frequently in Europe, attended EABP conferences and gotten to know some of the board and committee members. I liked them and thought they would be stimulating to work with. Jill van der Aa and Courtenay Young were particularly encouraging and insightful about the idea of a joint journal, but it began to become a reality at the Vienna Conference, when I met with Jill, Lidy Evertsen (incoming president of EABP) and others who were interested in the project. In her inimitable way, Jill made it happen and has continued to do so ever since.

I had seen the contents of the USABPJ as well as the number of submissions evolve over the past ten years from a narrower focus on the modalities represented in the USABPJ to inclusion and integration of affective neuroscience, mindfulness, relational psychoanalysis and attachment and trauma theory.

Both psychoanalytic and neuroscientific literatures are frequently cited. Themes such as mirror neurons, mindfulness, the I-Thou relationship, the autonomic nervous system and the right brain vs. the left brain, the role of awareness, polyvagal theory, and chaos theory are utilized and integrated. This evolution will, I am sure, be augmented by the co-sponsorship of the EABP

Body psychotherapy is no longer on the fringes of psychology and psychotherapy. Neuroscience has built a bridge. As our field continues to expand, the *International Body Psychotherapy Journal* can broaden the horizons of body psychotherapists and those interested from other fields by disseminating original theory, qualitative and quantitative research, experiential data and case studies as well as comparative and secondary analyses and literature reviews from clinicians and researchers practicing in all health care fields. It is our task to reflect, define and validate body psychotherapy.

We must continue to push the edges of our field as suggested in the following challenge from Larry Dossey, quoted by Mike Denny, in *IONS Noetic Science Review*, June-August 2002, just a decade ago:

In REINVENTING MEDICINE, Larry Dossey MD speaks of three eras in the history of healing. Era I is characterized by our conventional, causal, deterministic approach

of statistical, empirical science as it has been applied to healing methods since the seventeenth century. Era II involves the inclusion of mind-body phenomena such as found in psychosomatic and various alternative techniques. This era postulates that the mind has causal powers of healing within individual human beings.... They try to explain mind-body healing in terms of psychoneuroimmunology, skin galvanometer readings, or endorphins and other proteins circulating in the bloodstream, then they subject psychosomatic healing to techniques of standard, double-blind, statistical, clinical studies. In other words, although acknowledgment of mind-body phenomena is an advance in the care of the sick, it does not constitute a true shift of either consciousness or paradigm. Era III medicine attempts to include the strange discontinuities of quantum physics within healing methods. Proponents of Era III medicine focus upon the nonlocal, action-at-a-distance qualities of quantum particles as providing a rationale with which to support the theory that healing can occur between individuals at a distance.... (p.20)

Phenomena such as the resonance between therapist and client, non-verbal communication, etc., have been inaccessible to measurement by hard science with an Era II approach. We must begin to recognize the self-organizing complexity of psychological systems, taking into account chaos and catastrophe theory, and the emergent possibilities of human beings and nonlinear dynamic systems.

As Joop Valstar, writes so movingly in *Panta Rei*, our cover reflects these aims. We are fortunate that Joop not only designed the cover, but was able to secure an original and especially meaningful piece of artwork to adorn it.

We have also been gifted with an unusually varied group of submissions.

In *Gliding On the Strings That Connect Us, Resonance in Relational Body Psychotherapy*, Asaf Rolef Ben-Shahar concludes his four-part series on The Relational Turn and Body Psychotherapy, begun in the *US Association for Body Psychotherapy Journal* Volume 9#1, 2010, and continued in Volume 10 #1 and #2, 2011, which have examined the points of contact between body psychotherapy and relational psychoanalysis. This final article is a concrete representation of the link between the *International Body Psychotherapy Journal* and its predecessor, the *US Association for Body Psychotherapy Journal*, from which it has evolved. In it Rolef Ben-Shahar borrows from psychoanalysis, Jungian analysis and shamanic traditions to illustrate modes of action in both personal and case examples.

Maurizio Stupiggia explores a frequent symptom of trauma survivors in *From Hopeless Solitude to the Sense of Being-With: Functions and Dysfunctions of Mirror Neurons in Post Traumatic Syndromes*. His articulation of the intricacies involved in the treatment of early relational abuse is highlighted by excerpts from a moving case of a young woman he treated.

In *Anxiety and Panic in Reichian Analysis*, Genovino Ferri explores his chosen topic from etymological, historical, diagnostic, epidemiological, and ontogenetic perspectives concluding in a "Tree of Fear" which he utilizes as an organizing principle in the Reichian Analytic treatment of the various constituents of fear, panic and anxiety. He explores the interconnectedness of fear and anxiety and points out the significance of the effects of fear over a lifetime in the limits it imposes on individual freedom of thought and action.

Stanley Keleman, in *Forming an Embodied Life: The Difference Between Being Embodied and Forming an Embodied Life* elucidates the possibilities available to human beings to resolve cortical emotional organismic dilemmas by either relying on inherited responses or utilizing voluntary muscular influence and the formative dynamic to initiate what he terms an “evolutionary upgrade”. Reminding us of what neuroscientists are particularly fond of pointing out, that we act before we think or feel (bottom-up processing), he recommends voluntary muscular effort, voluntary morphogenesis, as a source of personal and collective wisdom of knowing.

In *Organismic Self-Regulation in Kurt Goldstein’s Holistic Approach*, Luigi Corsi engages in a close historical analysis of the evolution of Kurt Goldstein’s concept of organismic self-regulation, which was central to the thought of Wilhelm Reich and is now, characterized as affect regulation or emotion regulation, at the forefront of both neuroscientific research and a host of contemporary mind-body treatments. Articles such as this contribute to the understanding of the historical continuity of body psychotherapy and its relationship to other evolving psychotherapies.

*When the Therapist is Aroused, Sexual Feelings in the Therapy Room*, by Merete Holm Brantbjerg is the most straightforwardly clinical article in this issue. In it, she addresses a frequently expressed concern of psychotherapists and particularly of body psychotherapists, about how to handle and contain their sexual feelings in the psychotherapeutic interaction as they explore feelings, impulses and thought patterns within the ethical boundaries of the treatment situation. She elaborates specific psychomotor exercises, which she characterizes as “gender skills”, to promote awareness and comfort on the part of the clinician when exploring this very important aspect of human relatedness.

And finally, we have a pilot study from an outpatient practice reported by Ralf Vogt in *What Disgust Means For Complex Traumatized / Dissociative Patients*. Utilizing a questionnaire they designed and administered to 71 patients in their psychotherapy practice, he and his colleague found that those suffering from complex psychological trauma tended to suffer more from symptoms of disgust than other client groups and that these people also found it more difficult to overcome. The study, reported in detail here, raises a number of hypotheses regarding this hitherto neglected emotion. He points out that it often exacerbates existing aggressive behavior and shame and can usually only be relieved after considerable treatment in a body-oriented setting.

I hope you will enjoy the considerable range of offerings in this issue: theoretical, clinical, research, historical: examples of the richness inherent in our field. Please note that all abstracts have been translated into as many languages as we have been able to find translators, and these appear on the EABP and USABP websites.

Many midwives have helped to birth this inaugural issue, especially the members of the Editorial Committee. Jill van der Aa and Christine Hayes have done so much to propel this Journal forward that I would not know where to start listing their accomplishments. And Elizabeth Marshall has worked tirelessly translating Journal documents into German and German articles into English as well as encouraging submissions from German authors. Along with Christine and Jill, I have come to rely on her advice and good judgment. When he could spare time from proofreading and indexing his forthcoming *magnum opus*, which

has recently been translated into English, Michael Heller has also contributed his wisdom and energy. Nancy Eichhorn, editor of *Somatic Psychotherapy Today* has been an unusually thoughtful and informed consultant for many of the issues facing professional publication. Every member has been unfailingly responsive and supportive, even when other personal and professional deadlines loomed. And, Courtenay Young has given generously of his experience in publishing, which far exceeds that of the editor, making multitudinous suggestions which have vastly improved the content and appearance of the *IBPJ*.

Each article submitted is reviewed blind by three peer reviewers. They have been generous in not only critiquing but also mentoring authors. This is an important aspect of the peer review process, and I hope it will encourage submissions from people who have written little or not at all before this.

And, we are looking forward to making use of our august Advisory Board in the very near future.

Jacqueline A. Carleton, PhD  
May, 2012

## The Body: Common Ground

As president of the United States Association for Body Psychotherapy, (USABP) it is a pleasure and an honor to celebrate with the European Association for Body Psychotherapy (EABP) this inaugural issue of the International Body Psychotherapy Journal. The two organizations on their own have developed and expanded the field of body psychotherapy in clinical and scientific communities, but this joint publication brings the best of an array of languages, theories, science, and research together on our common ground - the body. It seems especially fitting that these two organizations cross the more superficial differences in language, therapeutic modality, or location on our planet to come together in the ways we are most similar, science and the body. The science is clear, discoveries in neuroscience and the impact of somatic response in understanding how people grow and change is without question at the forefront of psychology. Because body psychotherapy works directly with somatic reality, works directly with the body as the method of understanding and intervention, body psychotherapists hold a unique position in their ability to employ the new scientific principles in therapy. Mind and body are not separate entities; working with the body is working with the physical expression of ourselves as spirited beings. Developing this science through publications will bring this field into the mainstream of psychology.

Since the USABP was formed in 1996, the Journal has been a central core of the organization. Jacqueline A. Carleton, PhD, as editor has remained a steady and fierce proponent of publication in all areas related to body psychotherapy. Her skill and personal dedication have maintained a high quality professional publication, which will now be expanded in this international journal. Much like the newness of the field, Jacquie has brought new researchers and new writers along to produce a scholarly publication in this emerging field.

The next challenge in body psychotherapy today is to pursue and promote our similarities rather than differences. Since the variety of theories of body psychotherapy have been developed by individuals in many countries and from different theoretical stances, sometimes a similar concept is described in a different manner even though the basic concept is the same because it is reflected in the body. The IBPJ offers an opportunity to carry on these discussions without barriers, to identify our common philosophical roots, develop a common language for underlying principles, and incorporate similar foundational concepts in training body psychotherapists.

Coming together in the publication of the IBPJ we are stronger in our mission to develop the field of body psychotherapy and better able to promote the creative work of our members. Just as mind and body are together, we have brought together the whole field of body psychotherapy.

Katy Swafford, PhD, President, USABP  
April, 2012

## Body Psychotherapy: The Third Developmental Phase

It's an historical moment for body psychotherapy: together, the USABP and the EABP have created a Journal of Body Psychotherapy. I see this as the official start of *the third developmental phase* of body psychotherapy, in which two continents of the world are cooperating in order to develop our profession and show our face to the world.

Of course, we are not without our differences. For example, I prefer the word body, while my colleagues in the US prefer somatic. These differences, however, have only fed lively discussions and have been no hindrance to the creative process. I believe that this is proof that we body psychotherapy professionals have now reached the adult phase of our development.

It was during the EABP congress in Vienna in 2010 that Jacqueline Carleton from the USABP side and Jill van der Aa, Michel Heller and myself for the EABP, started a conversation about a joint Journal. That the various branches of body psychotherapy should unite in order to create a much stronger brand was exactly in line with the direction that body psychotherapy should evolve in.

Until the first decade of the 21st century, body psychotherapy was occupied with creating a lively community. However, the fact that it owed deference to many gods and many truths as a result of encompassing so many organisations, was good for body psychotherapy's first and second phases of development.

The first phase was the creation of many methods and modalities that knew how to let the body participate in psychotherapy. Of course you need the human gods, the creators, in this phase. We honour them and are highly grateful to them. The second phase needed organisations that believed in their own truths and served to let them grow. And we honour the perseverance and dedication with which body psychotherapists in that phase set up institutes, trained new therapists and established professional therapy associations.

I believe that we are currently in the third phase, one marked by a steady stream of neuroscience research that has radically altered the way we understand and approach the mind-body.

However, we have not yet been fully united and are still not known well enough throughout the world. I believe that this third phase should be dedicated to creating a united body psychotherapy community and a profession with its own, what I'd like to call, 'container theory,' in which the different body psychotherapy modalities, schools or currents can all position themselves. We need to create a community that welcomes diversity and allows cultural differences to enrich our profession and create an environment of fruitful exchange and dialectic influence.

Thank you all who have worked immensely hard to make this possible! I want to name one woman in particular, Jacqueline Carleton, who was the chief editor of the USABP Journal for many years and who provided the impetus to start this joint IBPJ.

I trust the IBPJ to become a leading professional journal that provides body psychotherapists with an international forum yet also encourages the development of research that will seek to explore what remains to be discovered.

Lidy Evertsen  
February 2012

## PANTA REI

The picture on the cover is an oil painting by Eugène Brands, entitled 'Everything Streams'. It is referring to 'Panta rei', the principle that everything moves, changes and transforms all the time (Heraclitus, Plato, Aristotle).

From the very first time I saw the painting it impressed me deeply. It reveals light and darkness, space and seclusion, concentration and rarefaction, contrast and fluency, volatility and substance, explosion and implosion, wideness and intimacy, pain and joy, serenity and brutality, tenderness and passion, danger and playfulness. It is introvert and extravert, defined and undefined. Even yin yang associations and the endearing panda may show up. It is like a random fragment of cosmic activity.

All the works of Eugène Brands reflect cosmic experience, space and movement, connectedness, poetry and beauty. Or, as he simply wrote himself, "In early spring, when under the old oaks in the fresh morning air, the first snowdrops, moving slowly in the wind, bask in the sunlight, I am in love with these snowdrops, with the morning, with my wife, my gouaches and my canvasses, the earth and the universe."

Eugène Brands participated in the Cobra movement, consisting mainly of painters and sculptors, shortly after WW II. The name is an assemblage of Copenhagen, Brussels and Amsterdam. The official years of the movement are 1948-1951, but there is a lot before and a lot after. Before the war there was already an undercurrent in Danish art fed by socialistic and Marxian ideas, which broke with artistic and social traditionalism and which promoted bringing art back into life, or, life back into art. They were open to meeting each other, to communicating and working together. At that time European artists eagerly visited Copenhagen. Bertolt Brecht and Wilhelm Reich were also there as refugees before they left for America.

After the war, with all its horror, there was a cry for freedom (see Karel Appel's painting of the same name), not only for liberation from war but also from the alienation that had made war possible.

In their manifests they talk about overcoming the dualism between matter and mind (Dotremont). Asger Jorn talks about a social community, which overcomes class-war splits, being one with body and nature, where art would be created out of a direct, vital urge. They talk about a longing for the security of an encompassing, meaningful perception of the world. They look for the origins of humanity; primeval resources, cells, nature, animals, drawings by children and mentally disturbed people, primitive and naïve art, archetypes and animism. They are in touch with poetry, jazz and folk music. They deny aesthetics and style but do have a language, an idiom. They are resistant to surrealist art, which connects too much to individual morbid Freudian issues. They look for spontaneity, vitality. They are process oriented, experimental, and physical. Karel Appel says, "These are the moments of ultimate beauty; the break-throughs, if suddenly when I paint the picture looms up out of the mass of paint". And, as Constant, another prominent Cobra painter said, "A painting is not a composition of colours and lines, but an animal, a night, a cry, a human being or all of them together."

Cobra isn't about relationship. Cobra relates.

What was essential was the hunger to meet each other, share, to make collective pieces of art, and to connect with poets, philosophers and architects. Typically, Cobra was a movement, an outburst, a strong reaction to war and reconstruction, as was the Dada movement after the Great War (1914-1918). Although the movement lost its utopian élan and its formal cohesion, the spirit and the vital way of processing of Cobra is still alive in art and resounds in other fields of culture and society.

Parallels with Cobra can easily be found in several movements in psychology and psychotherapy.

Wilhelm Reich fulminated against the political power control over society and its individuals' functioning. He searched for the nature of vital energy and discovered ways how to free people from their psychophysical blockades. Humanistic Psychology coined the term self-actualization as an urge and tendency to expand, develop and mature. Concepts as meaning, values, freedom, personal responsibility and spirituality were investigated. Gestalt highlights here-and-now sensory experiencing as the vital resource for coping with life.

Body Psychotherapy explains how the body encompasses as well the vital resources as the developmental history of the organism. Body and mind are seen as inseparable dimensions of human functioning. Working with functions such as breathing, movement, touch, sensory awareness and expressive action has been (re) discovered as a vehicle for self-regulation, growth and healing.

This impressive search through the last six decades is still moving on and developing. The study of the nature of organic life including the needed conditions and the hindrances is a main assignment for mankind in our era. Body Psychotherapy touches this common field of interest closely. The International Body Psychotherapy Journal – The Art and Science of Somatic Practice – aims to contribute to this ongoing odyssey.

Joop Valstar:  
May, 2012

About the painting:

Eugène Brands, 1913-2002

Title: Alles stroomt, 1988

Oil on canvas, 180 × 145 cm.

More information:

[www.eugenebrands.nl](http://www.eugenebrands.nl)

[www.cobra-museum.nl](http://www.cobra-museum.nl)

Many thanks to the Brands family, who generously gave us the permission to publish this painting on the cover of the IBPJ.

# The Relational Turn and Body Psychotherapy

## IV. Gliding on the Strings that Connect Us

### Resonance in Relational Body Psychotherapy<sup>1</sup>

**Asaf Rolef Ben-Shahar**

Teacher at the Israeli Centre for Mind-Body Medicine, Ramat-Hasharon and  
The Israeli Centre for Group Coaching, Shoham

Received January 2012; accepted April 2012

#### Abstract

This is the fourth and last paper of the series *The Relational Turn and Body Psychotherapy*. These papers examined the touching points between body psychotherapy and the exciting and encompassing field of relational psychoanalysis. The first paper *From Ballroom Dance to Five Rhythms* (Rolef Ben-Shahar, 2010), explored some basic concepts in relational psychotherapy. It also pointed out the relevance of relational thinking to the history and practice of body psychotherapy. The second paper *Something Old, Something New, Something Borrowed, Something Blue* (Rolef Ben-Shahar, 2011a) expanded the discussion on intersubjectivity and examined the balance between regressive and novel aspects of intersubjectivity. The third paper (Rolef Ben-Shahar, 2011b) explored connections between somatic, linguistic and relational organizations, and the place of the self in relational body psychotherapy. This last paper will demonstrate the use of resonance in body psychotherapy within a relational framework, borrowing from psychoanalytic framework, from Jungian and from shamanic traditions.

The paper is dedicated with love to Yanina.

Abstracts of all articles are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** relational BP, resonance, shamanism, intersubjectivity, transference

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#### 1. Could my daughter be Chinese?

“The mission ahead of you requires a surrender of the attempts both to be still and to be shaken. We must patiently wait to be caught by the medicine. We cannot take this medicine. The medicine waits to take us”.

Bradford Keeney, *Shaking Medicine*<sup>i</sup>

<sup>1</sup>This is the fourth article in a series by Asaf Rolef Ben-Shahar, Ph.D. Previous articles can be found in *The USA Body Psychotherapy Journal*, Vol. 8, No. 1, Vol. 9 No. 1, Vol. 10, No. 1, and Vol. 10, No. 2. They can be accessed online at [www.usabp.org](http://www.usabp.org). Please contact [usabp@usabp.org](mailto:usabp@usabp.org) if interested in ordering printed copies.

Last night, as I put my eldest daughter Zohar to bed she asked if we could play the make-believe game. In this game, we should both close our eyes (tightly) and describe what we see in our mind's-eyes, inviting the other to join. Throughout the day she had been a bee, buzzing from flower to flower drinking nectar and collecting pollen. So, as we lie I ask her to close her eyes and suddenly we are gliding over petals and playing on the flowerbeds, making nectar cakes (which the Smurfs like very much), made of roses, daffodils and hibiscus flowers. These cakes are yummy!

“Can you hold me really tight until I fall asleep?” Zohar asks, and I partly delight in the opportunity to spend some more time with her, but another part of me wishes to have some time for myself, or be with my wife and baby daughter, whom I have barely seen during the day. “Sure,” I say and stay with Zohar. I hold her firmly for a few minutes. At first our contact is all that I can feel, and it is the most precious gift I can think of. But then, my thoughts take over and I find myself preoccupied with the many things I need to do later that night and tomorrow. I'm waiting for Zohar to fall asleep, but she is annoyingly restless, “I cannot fall asleep like that daddy,” she says, “you are not sleepy at all; your thoughts wake me up.” And she is right, of course. So, I make myself a little bit more comfortable, allowing my body to sink ever so gently into the bed, and I close my eyes and slow down; the things I have to do can wait till tomorrow. Thoughts are still coming and going, but I let them pass as much as possible and they too slow down. I feel the little body of my daughter softening, her breathing is a bit deeper, as well as my own.

My mind is drifting as my body surrenders, yet I am not fully asleep. Zohar has fallen asleep, smiling, and I can imagine her little bee-wings as she travels from one flower to the next, and the sense of freedom that envelopes me is soothing and exciting at the same time. The choice is clear – I can either join her and let go into sleep, or get up now.

The capacity to sense another person through our bodies can sound, as I hope this description above does, as the most natural and innate human ability. At the same time, when skillfully honed, it can contribute to highly complex communication processes, ranging from the therapeutic (noticing the unspoken), to the forensic or even some so-called paranormal phenomena (mind reading, channeling, telepathy etc.). Therapeutic resonance can serve as a superb diagnostic tool, allowing us to feel into the relational-field, picking up shown yet unspoken fragments of communication. And my daughter, in her highly attuned nature, easily sensed my energetic activity and was unable to sleep.

Moreover, there is another side to resonance. If affective-fields indeed open wider-selves in which we partake, then surely changes we make in ‘our side of the field’ contribute to the whole system. Calming myself down and submitting into the rhythms of sleep affected Zohar and eased her falling asleep. When cultivated, resonance can prove a highly potent therapeutic intervention.

The famous parable of the rainmaker, which Carl Jung allegedly told in every possible seminar (Jung & Foote, 1976), can further demonstrate the value of resonance as an intervention tool. It goes something like this: There was once a Chinese village suffering a great draught. The village people thus sent for the rainmaker, who lived in the farthest corner of China (prophets frequently come from afar). As he arrived, and the elders of the village gathered around him, the rainmaker merely asked for a place to stay in solitude. He was provided with a small hut, where he sat and meditated for three days, while the entire village people impatiently awaited him. On the third day the rain started to come, and the rainmaker left his hut.

Excited and grateful, the village elders gathered around him curiously. “What have you done?” they asked. “Nothing,” he replied. “But you have brought the rain after so many months of draught.” “I don’t know about that,” answered the rainmaker, “in the village I come from people live according to the ways of the Tao. We maintain the dynamic balance of Tao – so people are sad, and people are happy, babies are born, and people die; the sun shines and the rain comes. When I arrived at this village I felt that I was totally off-balance, I couldn’t think straight or calm down. It had taken me three whole days to retrieve my inner balance.”

Jung’s concept of synchronicity describes the interdependency between objective events, both among themselves as well as with the subjective observer. In his preface to the *I-Ching*, Jung (1949) wrote: “The ancient Chinese mind contemplates the cosmos in a way comparable to that of the modern physicist, who cannot deny that his model of the world is a decidedly psychophysical structure. The microphysical event includes the observer just as much as the reality underlying the I Ching comprises subjective, i.e., psychic conditions in the totality of the momentary situation. Just as causality describes the sequence of events, so synchronicity to the Chinese mind deals with the coincidence of events” (p.6).

The traditional Chinese perception of interconnectivity seems to fit the relational understanding of self. Adopting such a point-of-view allows us to relate to resonance as the most natural and organic of phenomena. Could synchronicity be a more appropriate logical construct to explain resonance than causal attempts?

## 2. Non-cerebral consciousness: sensing the field.

“The brain is the seat of the ideal consciousness. And ideal consciousness is only the dead end of consciousness, the spun silk. The vast bulk of consciousness is non-cerebral. It is the sap of our life, of all life”.

D.H. Lawrence<sup>ii</sup>

That a great deal of the communication between people occurs nonverbally is both commonsense and broadly agreed upon (e.g. Benjamin, 2000; Farrelly & Brandsma, 1974; Klein, 1960; Knoblauch, 2000; Loewald, 1977; Ramberg, 2006; Shapiro, 1996; Stern, 2004).

“Considering that words account for as little as 7% of the perceived message,” wrote Jungian body-psychotherapist Gottfried Heuer (2005), “a *cure* exclusively relying on *talking* is an impossible endeavor indeed” (p.108).

*Resonance* constitutes a significant aspect of relational work. Resonance, as the term will be used here, describes a primarily nonverbal affective response to what is taking place in the other. It is a conversation taking place between bodies and unconscious processes, where the other moves and lives through us and is deeply felt through our bodies. Freud (1915) was deeply curious about this: “It is a very remarkable thing that the unconscious can react upon another, without passing through consciousness,” (p.126) he wrote. This is slightly less curious if the self is, as argued in the previous papers, primarily dyadic – if the ‘us’ precedes the ‘I’.

When a depressed client enters a room and the therapist immediately feels tired and low, or when we are able to complete the sentence that the other began with an inner, bodily, knowledge that we experience (not simply know about) the other as part of us, we enter resonant fields. A more analytic term for this specific form of resonance is body-countertransference, noting that our bodies serve as amplifiers of the system (which includes the other). Somatic resonance allows us to connect to the shared field in an attuned manner, responding to a *showing* that is not yet a *telling* (Schafer, 1992; Turp, 2000).

Resonance might be perceived as a necessary sociobiological skill that allows for impact within systems and in between them, like the neural network of a large village. When a cheetah approaches a herd of antelopes, it ignites a resonant response. As soon as one antelope senses its presence - a wave of fear passes through the herd almost immediately. An expression from the other (mostly non-conscious, frequently belonging to the autonomic nervous system) is making an impression on us, registering first and foremost through somatic processes. An antelope that insists on maintaining individualist consciousness and shuts off interconnected messages will probably end up as dinner.

The phenomenon of resonance receives poetic meaning when we consider it a marker of surrender to a greater-self. When the personal-self expands to partake in a larger, communal-self, sensing the other (resonating) is no longer an *interpersonal* act, but a process that takes place within the same system. While we partake in an expansive-self, this wider-mind (Bateson, 1979) is in turn within us: God manifests in our belly. Resonance could be considered the epitome of relationality: we are asked to surrender our narcissistic-solipsistic fantasy, namely, that the 'self' is an independent object, and that this object belongs to us. A basic working assumption for relational practice of resonance is that as soon as we enter a relational field, nothing simply belongs to us anymore: no thought, no feeling or image, no sensation is fully disconnected from the other and the relational-field. It is not *'the other person's stuff'* either. Rather, it means that once we have entered an affect-laden relationship, we partake in a larger system, and are a *part of* as well as *apart from* the other. Whatever we are exposed to is therefore also a manifestation of this shared mind.

According to traditional shamanic philosophy, assuming anything else is considered madness: perceiving the individual person as disconnected from its surrounding can seem absolutely crazy, for we are primarily a part of the whole (Capra, 1982; Castaneda, 1971; Jung, 1920; Keeney, 2005; Sheldrake, 1987). This worldview would be expanded later on in the paper. However, while our resonant sensory experiences are valid and evident, this doesn't mean that we are able to accurately interpret whatever newly acquired information we received in our dyadic intersubjective form. We cannot successfully and methodologically (without feedback) interpret the other, as what we sense is not the personal other but the emergent *Us*, a dynamic-self that is different to *I* and different to *You*. For example, if my client speaks of a new exciting relationship and my stomach begins to ache, my bodily response indeed indicates a movement (a dissonance of sorts) in the shared field, but it does not provide me (or us) with a linear causal explanation for the event. Instead, wondering about synchronicity might be a more appropriate way of intervening; we are seeking connections, rather than cause and effect. I might say for example: "As you were telling me about your new girlfriend, my stomach began to hurt. Can this have any meaning for you?"

When I enter an intimate connection and an image or sensation emerges, I therefore consider it as inevitably relevant to our shared affective-field; it cannot but be relevant to our, newly formed, dyadic-self. Could individual events be at all considered as meaningful outside their relational context? How can one genuinely be said to *have* any private experiences when one is in a relationship? Thoughts, sensations, emotions or memories all belong to the tension between private and public: their very domain changes. The relational dynamic is one of pulsating tensions between negotiating systems: a process that takes place within us (intrapsychic aspect), between us (interpersonal aspect), and within the system that emerges from our connection (intersubjective aspect) (Pizer, 1992). In this regard, the relational-self is a transitional phenomenon.

Resonance experiences, when shared appropriately, are among the most powerful tools in psychotherapeutic work. Traditionally, analysts noted their countertransference (which is

part of resonance) and kept it to themselves, or, if sharing, found a way to de-personify the event and minimise the relevance to themselves as subjects. Today, primarily thanks to the relational turn in psychoanalysis, sharing countertransferential material and resonance material sometimes takes a different form – of bringing the therapist's person more into the dyadic relationship (Aron, 1992; Davies, 1994; Eagle, 2000; Renik, 1993; Searles, 1979; Soth, 2005), and furthermore acknowledging the therapeutic-dyad as the affective, analyzable unit.

The therapist's disclosure of his resonance (or countertransference) can be powerful in mobilizing client's resources, in deepening relational aspects, and in 'hooking on' to what really is happening (Pizer, 1997, 2006; Rachman, 2001). When prematurely shared or insensitively executed, it may also prove a disruptive force that imposes pace, direction or otherwise interferes with the client's natural rhythms. Clinical decisions regarding the appropriateness of sharing resonance, and the amount of disclosure involved, require experience and practice (and mistakes).

### 3. Gliding on the strings that connect us: shamanism

The rope is the most important thing we know.

Cgunta I Kace<sup>iii</sup>

The last three papers delved into the conceptual and clinical juxtaposition between relational psychoanalysis and body psychotherapy. Now, let us take a detour into a third body-of-knowledge, and one that would portray similar understandings in a very different terminology: Shamanism. Shamanic worldview speaks in the language of magic, symbols, energy, and faith.

Shamanism emphasizes the unity of all that is alive and the aliveness of nature. Shamans believe it is possible to attain direct contact with the spirit world – but also with other people (Capra, 1982). Through focused attention the shaman can surrender to oneness with minerals, plants, animals, people and God.

These connections are made possible and conducted through (energetic) strings or ropes. There are strings that connect different geographical places (horizontal), strings that connect one person to another and to all living beings, and strings that connect us to other realms of realities (vertical) (Keeney, 2005). These strings are found cross-culturally in many shamanic traditions. For example, the strings have been described in the Bushman Shaman tradition (ibid) and can also be found in the Polynesian (Hawaiian) religion of Huna, where connection between selves is visualized as a cord and prayer activates its flow (Boadella, 1988). Don Juan's *men of knowledge* are experts in traveling along the fibers, which radiate from their stomachs (Castaneda, 1971, 1972, 1974, 1977; Mindell, 1982). The physical shape is understood as secondary to the principal organization process - connection and relationship – the organization between forms. Do these descriptions sound familiar? Are they not exemplifying resonance and intersubjective connections?

When we surrender to a relational-field, Don Juan explained to Carlos Castaneda (1971), we sense *the other* through those strings that connect us to become one. He elaborated: "Every man is in touch with everything else, not through his hands, though, but through a bunch of long fibers that shoot out from the center of his abdomen. Those fibers join a man to his surroundings; they keep his balance; they give him stability" (p.33).

Since the individual in shamanic cultures (and in relational psychoanalysis) is always seen as connected to his social and cultural contexts, illness is consequently never understood in isolation from the sociocultural balance (Capra, 1982). It is the responsibility of the entire social-structure to retrieve the balance, when an individual manifests (through physical or

mental illness) an imbalance. The shamans take the shape of the animals and plants they know to be medicinal (Jung, 1964) and administer these medicines *from within*, through sharing their psychic identity (ibid). Shamanic medicine is therefore a process of reestablishing lost connections (Levine & Frederick, 1997), between different parts of an individual, between the individual and others – and between those and realms of spirits. The shaman performs a similar act to the rainmaker, expanding his identity and making inner rebalancing rituals.

The shaman glides on the strings that connect us by mobilizing the center of self from the individual (skin-bound) self to the pulsating field-self (or relational-field). Could my daughter have done the same? I believe that empathy in general and skillful therapeutic resonance in particular, involves a very similar act. The shamanic worldview sits well with attachment theory and relational perspectives: we reclaim the context (relational form) that allows for flexible exploration (individuation).

#### 4. Transference dynamics and resonance

Transference is an unavoidable psychological phenomenon. In short, our early experiences of relating and interacting, particularly those we formed with attachment figures at the first five years of our lives, seriously influence and impact the way in which we relate as adults. Our early relationships provide us with sets of lenses (or veils) through which we look at later relationships in our lives. Principally speaking, it is impossible for us to relate to others except through those early matrices. When client and therapist meet, they both bring their biographical veils and together attempt to relate to one another not merely as actors in their past-dynamics (objects or part-objects) but also as here-and-now subjectivities. The unraveling of our veils is the psychodynamic endeavor, an attempt to retrieve subjectivity. These complex dynamics becomes even more complicated since we don't only bring our own biographical relationship-matrices (our own veils), but also, naturally and organically, respond to the other through *their* life story – we reenact their relational dynamics.

These two aspects of transference have been differentiated in the first of four papers (Rolef Ben-Shahar, 2010) as reactive and responsive transference (Racker, 1968), and will be expanded and reiterated below.

Reactive transference dynamics is easily understood. However much we have processed our history, we nevertheless bring our past ways of relating into new relationships, including the therapeutic relationship. We therefore tend, at times, to respond to the other through the beliefs, generalizations, limitations and distortions of past-relating. For example: Arielle came into the session uncharacteristically proactive. After many weeks of severe depression, accompanied by suicidal ideation and very little motivation to act, she was enthusiastically describing different job interviews she applied for. I wasn't focused on the content though, but was merely noticing how something in her was yet-again choosing life, and it made me smile. Arielle continued to speak, but as she spoke she became increasingly agitated. "What's going on, Arielle?" I asked. "Why are you mocking me, Asaf?" she replied. "Whenever I make a real effort to do something for myself I am mocked." She was shocked to hear that I smiled because I enjoyed seeing her alive. As both her parents mocked any effort Arielle made, it was easy to interpret my response as belittling.

To exemplify the parallel transference response in the therapist (reactive countertransference) we can look at Aaron, with whom I frequently froze. Every time Aaron was excited or wanted to emphasize a point, he would wave his finger at me. It took me a while to realize that, for me, the waving finger registered as a threat from my own early childhood. Awaiting punishment,

I would become silent and move very little which, in turn, communicated to Aaron indifference (so he waved harder). Our two life-stories interwove into a paralyzing and highly frustrating bond.

As explained in previous papers of this series (Rolef Ben-Shahar, 2010, 2011a, 2011b), traditional psychoanalysis considered reactive countertransference as a sign of insufficient analysis, while relational perspectives relate to countertransference (including reactive) as not only inevitable, but also as invaluable - holding a genuine therapeutic potential (Loewald, 1986; Mitchell, 2005; Orange & Stolorow, 1998).

Whereas reactive transference involves our own biographical buttons being triggered, the second type of transference describes a more complicated communication dynamics. Responsive transference (and countertransference) describes how we respond to the other person's biographical dynamics and become part of their repeated and reenacted story (and they do the same for us). A simple example is being late for an appointment with the one client you really don't want to be late for, since everybody in his life always forgets him. Projective identification (Klein & Khan, 1975) is based on responsive transference dynamics. It means that, inasmuch as we open to an affective field, we also accept (not by choice) a role in the other person's continuous life-story. With introspection and curiosity, these roles can be unraveled, understood and (hopefully) transformed.

While reactive transference is a highly fascinating phenomenon, at the moment I wish to wonder about the means through which we become actors in someone else's dynamics: how is responsive transference possible at all? Many theoreticians and clinicians attempted to explain projective identification. Kohut (1959; 1971) believed that the therapist provided the client with missing functioning (projected on her by the client) until the client was able to internalize these and self-regulate. Bion (1989) thought that the origin of the phenomenon rested in the mother's containment of her baby's negative feelings. But both clinicians explained why projective identification occurred but not *how* it came to manifest. Body psychotherapist Babette Rothschild (2006) understood projective identification as the psychobiological foundation of empathy. This brings us closer to looking at the mechanisms that enable transference: and I believe it is resonance (or the strings that bind us).

While transference dynamics is a psychological phenomenon, resonance is a socio-biological one. It means that, as social organisms, we are highly sensitive (attuned) to our environment. Should we adopt biological language we can speak of Damasio's (1994) somatic markers theory, which proposes that emotional experiences begin with a gut feeling which appears as a response to various stimuli, including empathy. When we attempt to understand how a client might feel, for instance, we tend to assume his affective and physical gestures. Research into Mirror neurons (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996; Platek, Critton, Myers, & Gallup, 2003; Preston & de Waal, 2002; Wolf, Gales, Shane, & Shane, 2001) also provides interesting arguments for the physiological nature of empathy, and thus of resonance and transference.

However, when explaining social and psychological phenomena, I find biological-causal-explanations insufficient and logically mistaken. Of course, mirror neurons demonstrate how we empathize, but we do not resonate and empathize because of them. Attempting to explain social phenomena using biological language is a class-error (Bateson, 1974; Capra, 2002) (this argument has been elaborated on in the third paper (Rolef Ben-Shahar, 2011b)). If we refuse to accept the biological explanation as cause, how are we then to explain transference phenomena? Can Jung's synchronicity support us here? How can we explain the way intersubjectivity exists? Shamans (as well as attachment psychotherapists, and Jungian analysts) might raise an eyebrow and argue that explaining how the individual exists without the system to which he belongs is futile, and that intersubjectivity (the dyadic-self, collective-self) – is the primary unit, only later differentiated as an individual.

Gregory Bateson (1972, 1979, 1987) perceived the mind (today he might have called it body-mind) not as an object but as a relational-field. He considered mind to be a process rather than an object. Therefore, when therapist and client sit together, affectively relating to one another, the mind (thought-fields, feelings, sensations, and insights) is not merely the two separate units but rather: two people together, the background they bring with them, their connection and the context in which they connect. Therefore, a therapeutic demonstration in a training-event will express a different mind to a therapeutic session in the privacy of a clinic.

The strong Western inclination (and need) to maintain the belief that the self (and therefore the mind) is a personal object - that our thoughts, feelings and sensations are ours alone - is understandable. During the process of identity-formation and organization, it would have been too big a challenge to tolerate the paradox that the 'I' is both a personal, and at the same time an interpersonal process. The capacity to tolerate such contradictory truths is a precondition for a flexible theory of mind and thus, according to Bateson (ibid), a sign of mature thinking.

If we truly adopt a relational (or shamanic and Jungian) perspective, then intersubjective phenomena, including resonance, become the clearest example of communication - we resonate, because we are a part of a system and we do it through our whole body-mind - the nervous system, the affective system, the energetic system: we glide on the strings because this is what we are made of.

In fact, we might argue that it is categorically impossible to ever get to know ourselves in isolation, let alone get to know another person. All we can come to know is the *me-in-relation* to you, or the *you-in-relation* to me: the us that was formed with the other. Fundamentally, we may only come to know ourselves as persons-in-relations.

To summarize, transference is a psychological phenomenon, which is expressed through the wider sociobiological phenomenon of resonance. Transference dynamics is a form of resonance but not all resonance is transference. Personally speaking, I am much more comfortable with explaining resonance (and thus transference phenomena) through synchronicity than causal logic (biological or otherwise) and through the shamanic notion of strings, rather than through mirror neurons, but this is clearly a matter of personal style.

## 5. Elle and the search for a self-object

I felt nauseated even before Elle stepped into the clinic room. Coming down to meet her at the waiting room, we greeted each other and I walked upstairs, Elle following behind. I was extremely self-conscious about my weight and body, and felt threatened by her watching me as I climbed the stairs. I tried to walk quickly so she would not have time to concentrate. I wanted to hide. We sat in our chairs and a good proportion of my attention, throughout the session, was my preoccupation with how I looked. These feelings are not foreign to me, but their magnitude and timing felt too peculiar to simply ignore.

During our second session, when I asked Elle whether she was bulimic, she shook her head vigorously: "No, I just hate my body and hate being fat, but I don't throw up." Asking her again, six weeks later, Elle responded with the same answer, but was agitated "you're talking about building trust," she said, "but you don't believe me." In hindsight, my questions were premature. Elle was referred to me by a colleague whom I thought very highly of and whom I desperately wanted to impress. Moreover, I wanted to hand my uncomfortable feelings back to Elle. I felt embarrassed and ashamed about my body, and wanted her to take it. I really wanted her to take it from me and own it, and was internally angry with her for not taking responsibility for her feelings.

Elle was a stunning thirty-year-old woman and everything seemed to go smoothly and easily for her. During the first two months of therapy, and although Elle was quite distressed, my main feelings towards Elle were envy and jealousy. I wanted to have what she had, I wanted to be like her in many ways, and couldn't understand why she was so unhappy. Her unhappiness made me angry, how ungrateful can she be! Elle was financially stable, studied something she was very passionate about and was doing well. She had a loving boyfriend who was ten years older than she, and Elle said he was everything her mother would have liked her husband to be. During the first year of therapy we discovered that her mother, whom she at first considered "my best friend, my soul mate, my twin sister" always used Elle to regulate her own emotional life. Elle was expected to comfort her mother from a very early age, to perform perfectly "to make mummy happy," to bring home the expected goods or else her mother would slip down her depressive slopes.

Elle therefore never attained appropriate differentiation, she continued to exist as a partial-system, unable to regulate herself on her own, entering symbiotic relationships where she disconnected and felt betrayed and lonely. Israeli Self-psychologist Eitan Bachar (2001) explored bulimia in terms of the difficulty to occupy space. He claimed that the role-reversal, commonly observed between the bulimic client and her early attachment-figures, represented a parental tendency to excessively use the child as self-object. Interestingly, during the early stages of psychotherapy with Elle I have done the same: my insistent questions regarding her bulimia were directed at regulating my own needs for acknowledgement and anxiety-regulation. My empathetic failure was similar to her mother's and this powerful transference dynamic was, as my supervisor helped me to realise, an expected re-enactment of her attachment dynamics.

With the help of my supervisor, and work in my own psychotherapy, I realised that in order to help Elle I had to survive myself, to self-regulate. For weeks, as she entered the room I would be bombarded with self-loathing internal-dialogues, an urge to cover myself or hide, and nausea. Going back to basics, I would practice conscious breathing techniques (Hendricks, 1995), and a lot of inner-child work. I felt slightly better, and the need to push Elle into saying things decreased. Her suffering was more apparent to me, and it was relieving to feel my therapeutic empathy returning and therapeutic positioning regained. About that time, Elle admitted to having been bulimic for five years: "it's just that your questions seemed invasive at first, I didn't even know you," she said.

When I was blindly drowning in the transference dynamics, I was too deeply ashamed to share any of my processes with Elle, but self-disclosure at that stage would have been easily understood by her (and rightfully so) as being used, again. It was only when I was more able to self-regulate that self-disclosure of my countertransference (or resonance) became valuable. It was as if the mother (or therapist) were now able to acknowledge her (my) needs and sufficiently differentiate, allowing Elle to take her own space. As Rachman and Ceccoli (1996) argued, therapist self-disclosure should occur within the context of empathic attunement and responsiveness, and in the psychotherapeutic process with Elle, it accompanied the growing differentiation, as well as connection, between us.

After two further years of therapy, Elle stopped her bulimic behaviour. During these two years, a significant part of therapeutic work was my own regulation of the invasive resonance (or somatic countertransference). Slowly I learned to tolerate and even like my body in her company, and it felt like we were both recovering from a painful addictive process. The change manifested in many facets of her life – and our therapy. From being held almost every session, we now sat facing each other. Touch was no longer necessary, but instead became a possibility that was gauged according to the need, and our shared dialogue.

I would like to return to the beginning of this paper and the description of bedtime rituals with my daughter, Zohar. The two processes share a contextual resemblance, even though the content is different. With both Zohar and Elle the attempts to “do something to” the other miserably failed, with both I had to closely monitor my narcissistic needs and attend to myself before attempting to support change in the system. Perhaps the rainmaker was right, and retrieving our own balance, inasmuch as we are part of the village, is the best that we can do?

Elle’s psychotherapy continued for three more years, and resonance experiences continued to be central to our work, but decreased in magnitude. It was as if the relational-field slowed down; our intersubjective-self held us close together and encouraged us to be separate, and belong to one another, and both at the same time.

## 6. Epilogue

The Good Walkers are those who “step out” in altered states of consciousness to “fight for the fertility of the field.”

Stephen Karcher<sup>iv</sup>

Resonance is organic and natural, yet it is also a skill that could be honed and calibrated. By opening to a *wider-mind* we drop into an expansive sharing space that is bigger than ourselves, a mind that includes us but is not limited to us or excluding the other from us. Resonance is not only a beautiful practice; it is also a skill that can be supported by, and deeply relevant to both body-psychotherapists and relational psychotherapists.

If psychoanalysis was originally based on letting go of the body and coming into the head, famously captured in Freud’s (1933) “Where id was, ego shall be” (p.79) and some of the early body psychotherapy replied with the notion of letting go of the head and coming to the body, as Fritz Perls (1969) wrote: “Lose your mind and come to your senses” (p.38), then modern body psychotherapy is hopefully less dichotomist; we can have both. And indeed, for good practice of resonance skills we require both the embodied capacity to open to our senses, and at the same time, the analytic capacity to name these for ourselves and appropriately use this information therapeutically. When we are able to reconnect with other fields of knowledge, we stand a greater chance at growing and developing as a profession, and as people. No longer is it satisfying to be a disembodied mind or a mindless body.

The way resonance is used depends on the orientation of the practitioner. While resonance can offer a deep and oftentimes quick sense of empathetic sharing, it is not about therapeutic fireworks. The therapeutic task of naming those surfacing aspects that are calling for recognition is a complex clinical practice. Premature disclosure of countertransference can be damaging for the client, the therapeutic process, and the therapist, who is also exposed.

How can we open and speak of that which hasn’t yet been opened and spoken of without hastening the process prematurely? How can we do so without shaming the other person, or dangerously exposing ourselves? I am still struggling to find answers to these questions. Perhaps one aspect of the answer can be found in the ongoing negotiation of and dialogue with these questions.

One of the cornerstones of a dynamic field involves being informed by and maintaining a continuous dialogue with the work of others. It comforts me to know that other clinicians have struggled with similar questions, and it inspires me to find myriad attempts to address such questions. In these four papers, I have shared some of my professional and personal inspirations with you, and I hope that you have been excited and moved, and that whether you’ve agreed or disagreed, the papers have managed to sustain your curiosity and aliveness.

When an intersubjective field opens between two people something bigger than the two comes into existence. This is a rich and fruitful ground for growth, for connection, and for change. Relational body psychotherapy is hopefully such a field. Unraveling between two separate, yet interconnected disciplines, relational body psychotherapy has the potential to become an aesthetic and pulsating novelty, where practitioners dare to surrender and “fight for the fertility of the field.”

I welcome feedback, questions or comments on the ideas, questions, and opinions expressed in these papers (asaf@imt.co.il) and wish to thank all the friends, and colleagues who supported the creative process. My clients and supervisees provided a dialogue without which these papers would not have been written. Thank you, Jacque, for the interest, challenge and support for the series. Most of all, I wish to thank my wife, Tom, whose astute, critical and loving reading is one of her many gifts.

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## REFERENCES

- Aron, L. (1992). From Ferenczi to Searles and contemporary relational approaches: Commentary on Mark Blechner's "working in the countertransference". *Psychoanalytic Dialogues*, 2, 181-190.
- Bachar, E. (2001). *The Fear of Occupying Space: The Self-Psychology and the Treatment of Anorexia and Bulimia*. Jerusalem: The Hebrew University: Magness Press.
- Bateson, G. (1972). *Steps to an Ecology of Mind*. Chicago: The University of Chicago Press.
- Bateson, G. (1974). Draft: Scattered thoughts for a conference on "broken power". *Coevolutionary Quarterly*, 4, 26-27.
- Bateson, G. (1979). *Mind and Nature: A Necessary Unity*. Cresskill, NJ: Hampton Press, 2002.
- Bateson, G. (1987). *Angel's Fear: Towards an Epistemology of the Sacred*. New York: MacMillan.
- Benjamin, J. (2000). Intersubjective distinctions: Subjects and persons, recognitions and breakdowns: Commentary on paper by Gerhardt, Sweetnam, and Borton. *Psychoanalytic Dialogues*, 10, 43-55.
- Bion, W. R. (1989). *Two Papers: The Grid and the Caesura*. London: Karnac.
- Boadella, D. (1988). *Lifelines and Light Streams (1987 Frank Lake Memorial Lecture)*. Oxford: Clinical Theology Association.
- Capra, F. (1982). *The Turning Point*. London: Flamingo.
- Capra, F. (2002). *The Hidden Connections*. London: Flamingo.
- Castaneda, C. (1971). *A Separate Reality*. London: Arkana.
- Castaneda, C. (1972). *Journey to Ixtlan*. London: Arkana.
- Castaneda, C. (1974). *Tales of Power*. New York: Simon and Schuster.
- Castaneda, C. (1977). *The Second Ring of Power*. New York: Simon and Schuster.
- Damasio, A. (1994). *Descartes' Error: Emotion, Reason, and the Human Brain*. New York: Penguin.
- Davies, J. M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues*, 4, 153-170.
- Eagle, M. N. (2000). A critical evaluation of current conceptions of transference and countertransference. *Psychoanalytic Psychology*, 17, 24-37.

- Farrelly, F., & Brandsma, J. M. (1974). *Provocative Therapy*. Capitola: CA: Meta Publications.
- Freud, S. (1915). The Unconscious. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 14). London: Hogarth Press.
- Freud, S. (1933). New Introductory Lectures On Psycho-Analysis, Lecture XXXI. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 22, pp. 1-182). London: Hogarth Press, 1964.
- Gallese, V., Fadiga, L., Fogassi, L., & Rizzolatti, G. (1996). Action recognition in the premotor cortex. *Brain*, 119, 593-609.
- Hendricks, G. (1995). *Conscious Breathing: Breathwork for Health, Stress Release, and Personal Mastery*. New York: Bantam Books.
- Heuer, G. (2005). 'In my flesh I shall see god': Jungian body psychotherapy. In N. Totton (Ed.), *New Dimensions in Body Psychotherapy* (pp. 102-114). Maidenhead: Open University Press.
- Jung, C. G. (1920). *Collected Papers on Analytical Psychology* (C. E. Long, Trans. 2nd ed.). London: Bailliere, Tindall & Cox.
- Jung, C. G. (1949). Preface. In R. W. (Trans) (Ed.), *I Ching - The Book of Changes* (pp. 1-27). London: Penguin.
- Jung, C. G. (1964). Approaching the unconscious. In C. G. Jung, M. L. von Franz, J. L. Henderson, J. J. Jacobi & A. Jaffé (Eds.), *Man and his Symbols* (pp. 18-103). London: Arkana.
- Jung, C. G., & Foote, M. (1976). *The Vision seminars: from the complete notes of Mary Foote*: Spring Publications.
- Karcher, S. (2007). Re-Enchanting the Mind: Oracles, Reading, Myth, and Mantics. *Psychological Perspectives*, 50(2), 198-219.
- Keeney, B. (2005). *Bushman Shaman: Awakening the Spirit through Ecstatic Dance*. Rochester, Vermont: Destiny Books.
- Keeney, B. (2007). *Shaking Medicine: The Healing Power of Ecstatic Movement*. Vermont: Destiny Books.
- Klein, M. (1960). *Our Adult World and its Roots in Infancy*. London: Tavistock Publications.
- Klein, M., & Khan, M. R. (1975). *Envy and Gratitude and Other Works 1946-1963*. London: The Hogarth Press.
- Knoblauch, S. (2000). *The Musical Edge of Therapeutic Dialogue*. Hillsdale, NJ: The Analytic Press.
- Kohut, H. (1959). Introspection, empathy, and psychoanalysis - An examination of the relationship between mode of observation and theory. *Journal of the American Psychoanalytic Association*, 7, 459-483.
- Kohut, H. (1971). *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorder*. London: Hogarth Press.
- Lawrence, D. H. (1928). *Psychoanalysis and the Unconscious*. London: Martin Secker.
- Levine, P. A., & Frederick, A. (1997). *Waking the Tiger*. Berkeley: North Atlantic Books.
- Loewald, H. W. (1977). Primary process, secondary process and language *Papers on Psychoanalysis* (pp. 178-206). New Haven, CT: Yale University Press, 1980.
- Loewald, H. W. (1986). Transference-countertransference. *Journal of the American Psychoanalytic Association*, 34, 275-287.
- Mindell, A. (1982). *Dreambody*. Henley-on-Thames: Routledge & Kegan Paul.
- Mitchell, S. A. (2005). *Influence and Autonomy in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.
- Orange, D. M., & Stolorow, R. D. (1998). Self-disclosure from the perspective of intersubjectivity theory. *Psychoanalytic Inquiry*, 18, 530-537.
- Perls, F. S. (1969). *Gestalt therapy verbatim*. Moab, Utah: Real People Press.
- Pizer, B. (1997). When the analyst is ill: Dimensions of self-disclosure. *Psychoanalytic Quarterly*, 66, 450-469.
- Pizer, B. (2006). Risk and potential in analytic disclosure: Can the analyst make "the wrong thing" right? *Contemporary Psychoanalysis*, 42, 31-40.
- Pizer, S. A. (1992). The negotiation of paradox in the analytic process. *Psychoanalytic Dialogues*, 2(2), 215-240.
- Platek, S. M., Critton, S. R., Myers, T. E., & Gallup, G. G. J. (2003). Contagious yawning: the role of

- self-awareness and mental state attribution. *Cognitive Brain Research*, 17, 223-227.
- Preston, S. D., & de Waal, F. B. M. (2002). Empathy: Its ultimate and proximate bases. *Behavioral and Brain Sciences*, 25, 1-72.
- Rachman, A. W. (2001). Beyond neutrality: The curative function of analyst self-disclosure. In J. Reppen & J. Schulman (Eds.), *Way beyond Freud: Post-Modern Conceptions of Psychoanalysis* (pp. 127-142). London: Opengate Press.
- Rachman, A. W., & Ceccoli, V. C. (1996). Analyst self-disclosure in adolescent groups. In P. Kymissis & D. A. Halperin (Eds.), *Group therapy with children and adolescents* (pp. 155-173). Washington, DC: American Psychiatric Press.
- Racker, H. (1968). *Transference and Countertransference*. New York: International Universities Press.
- Ramberg, L. (2006). In dialogue with Daniel Stern: A review and discussion of *The Present Moment in Psychotherapy and Everyday Life*. *International Forum of Psychoanalysis*, 15(1), 19-33.
- Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62(4), 553-571.
- Rolef Ben-Shahar, A. (2010). From ballroom dance to five rhythms The USA Body Psychotherapy Journal, 9(1), 41-50.
- Rolef Ben-Shahar, A. (2011a). Something old, something new, something borrowed, something blue: Individual selves and dyadic selves in relational body psychotherapy. *The USA Body Psychotherapy Journal*, 10(1), 58-67.
- Rolef Ben-Shahar, A. (2011b). Salsa lessons and the emergent self. *The USA Body Psychotherapy Journal*, 10(2).
- Rothschild, B., & Rand, M. L. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York ; London: W. W. Norton.
- Schafer, R. (1992). *Retelling a Life: Narration and Dialogue in Psychoanalysis*. New York: Basic Books.
- Searles, H. F. (1979). *Countertransference and Related Subjects*. New York: International Universities Press.
- Shapiro, S. A. (1996). The embodied analyst in the Victorian consulting room. *Gender and Psychoanalysis*, 1, 297-322.
- Sheldrake, R. (1987). Part I - Mind, memory, and Archetype Morphic Resonance and the collective unconscious. *Psychological Perspectives*, 18(1), 9-25.
- Soth, M. (2005). Embodied countertransference. In N. Totton (Ed.), *New Dimensions in Body-Psychotherapy* (pp. 40-55). Maidenhead: Open University Press.
- Stern, D. N. (2004). *The Present Moment in Psychotherapy and Everyday Life*. New York: Norton.
- Turp, M. (2000). Touch, enjoyment and health: in adult life. *European Journal of Psychotherapy & Counselling*, 3(1), 61-76.
- Wolf, N. S., Gales, M. E., Shane, E., & Shane, M. (2001). The developmental trajectory from amodal perception to empathy and communication: The role of mirror neurons in this process. *Psychoanalytic Inquiry*, 21(1), 94-112.

- i (Keeney, 2007, p.17).
- ii (Lawrence, 1928, P.47).
- iii Quoted in (Keeney, 2007, p.62).
- iv (Karcher, 2007, p.208).

# From Hopeless Solitude to the Sense of Being-With: Functions and Dysfunctions of Mirror Neurons in Post Traumatic Syndromes

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## Abstract

Here the focus is on the therapeutic relationship: the trauma of abuse is a relational trauma. It must be said that abused people are sensitive to gestures, sensory and motor fragments, etc. This work attempts to repair the relationship texture, as the person has lost the sense of *being-with* and feels desperately alone. The work of mirroring, the joined repetition of the key gesture, and the search for gesture-word connections help the patient to repair that breach. This methodology can promote the recovery of the functionality of the mirror neuron system, and the reactivation of the insula and the amygdala, thus restoring the previously lost ability to communicate.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** relational trauma, mirror neurons, key-gesture, being-with

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## The body of the subject and the subject of the body

A body psychotherapist, even if he is accustomed to the various reactions of his patients, may sometimes encounter unsettling or unexplainable physical sensations when treating a person with a history of trauma, such as sexual abuse. One patient may in fact report that experiencing the unpleasant feeling that their arm belongs to another person or that it belongs to them only up to the wrist. Another patient could report the inability to raise his voice in situations requiring it, even when he is emotionally loaded. By using a higher pitch or even by trying to scream, the patient may then come to realize that he's terribly frightened by his own voice, as if it came from someone else, inside or beside him.

In these cases, the body, when it moves in an unfamiliar way or is highly activated, is perceived as foreign. From a phenomenological point of view one may be tempted to say that the body contains more than one subject, and that there is a certain relationship between the subjects themselves. While it is obvious that the Other felt within is related to the story of abuse, it is not so obvious as to how to alleviate this sense of otherness and restore a minimum sense of identity.

What is clear, though, is the fact that *the body, in its way, is a carrier of meanings and is able to set up scenarios that outline the traumatic history of the subject*. We are inhabited by the Other, which may be the condition required for us to encounter the *Others*: “the fact that I carry an Other in me, that I am dual, plural and not monocentric in consciousness, is the condition of having awareness of the Other itself.” One may interpret this conjecture, that the body, the highest representative of individuality that reveals the origin and the relational nature of our existence, as paradoxical; we could almost venture that in these cases consciousness is always bad consciousness, but alas, Freud had already said this.

This is how the body reveals its “open” nature, its interface to the world, to let in, through its inner folds, the world itself, winds of a flow that suddenly change polarity like a Moebius strip: what a moment ago was the Self now is suddenly the Other-World. It is a play on words which becomes drama when ‘Self’ is not just a word, but a certificate of existence: this is what happens to people who survive very traumatic experiences.

The words of Merleau-Ponty have never been so pertinent as in this case: “The body is the only means that I have to get to the heart of things. “The phenomenological approach and the progression of neuroscience both seem to promote a return of the conception of human being as “one entity.”

It is in this direction that the neurophenomenology of Francisco Varela is moving. According to Varela, the attempt to look for the places or the neuronal correlates of consciousness (NCC: neuronal correlates of consciousness) is a problem without a solution.

Consciousness appears in an organism; it is an emergence, a distributed phenomenon. It isn’t “in the head” and the brain itself isn’t a bundle of neurons; it exists, rather, inside an organism concerned essentially with its own regulation and conservation. Naturally, the brain has a central role to play because it is the enabling condition of consciousness.

In other words, we can say that we are facing a complexity: not only does there exist a top-down connection of the phenomenon (from the cortex to the deepest layers of the brain) that corresponds, in a non-metaphorical way, to the body-brain relationship, but we also have a continuum of feedback generated by this opposite causal process, extending from sensory-motor to cortical processing. These two different directions, *top-down* and *bottom-up*, coexisting in a continuous mutual feedback loop, are the reasons for the complexity of the phenomena.

What I want to discuss in this article is the phenomenon of radical fragmentation inside traumatized and/or abused individuals. My hypothesis here is that mirror neurons constitute the neuro-biological basis for empathy and of the subsequent possibility of *being-with*.

## Trauma

There are events that go beyond the usual classifications, events that break the continuity of a person’s life, creating an indelible line of separation between the before and the after; they are experiences that transcend the individual’s ability to cope and thus produce a radical disruption in emotional and cognitive functioning: this is trauma.

Let’s start from the definition: with ‘trauma’ we mean an event, or series of events, related to a subjective experience of helpless impotence or inability to avoid the danger within it. In the words of Henry Krystal, “catastrophic psychic trauma is defined as a surrender to what is lived as an inevitable external or internal danger. It is the psychic reality of surrender to what is experienced as an intolerable situation with no way out that generates the abandonment of lifeguarding activities. Considering a situation as extremely dangerous and surrendering to it starts the traumatic process” (Krystal H., 2007, p. 200).

It is a widely shared opinion that the psychoanalytic treatment of cases of trauma can often face insurmountable difficulties. Therefore, many analysts agree on the fact that these patients “are not fit for true psychoanalytic treatment. If the trauma was severe or early enough it could have disrupted the development of the ego enough to preclude the capabilities needed for analytic work.

The patient may lack the capacity to establish a minimum therapeutic alliance; he may lack access to inner subjective experiences and emotions, as well as the ability to translate them into words; he may lack an introspective ability which involves a separation between an observer Ego and an action Ego; he may lack the will to confine his impulses within the verbal expression rather than extend them to action; and there could be an Ego that is not strong enough to prevent serious regression in the midst of powerful feelings, memories, or desires that will be evoked by such procedures” (Sugarman A., 1999, p. 14).

### The words to say it

“In those moments I’m paralyzed ... and words don’t come out ... I wish I could at least scream but I can’t do that either.”

“Sometimes I fall into an abyss for no reason ... I’m so tired that I can’t raise an arm ... and it seems that I could stay there, without speaking, forever! “

These are some of the quotes that express the state of sudden word interruption in people who have experienced traumatic events.

The question which arises concerns therapeutic intervention: how can psychotherapy work in such cases, when most of it cures through the act of speech? It is a crucial question, because abuse confronts us with sudden flashbacks, with out of context feelings, with moments of silent terror, etc.: with anything but a coherent narrative or contextualized memories.

It is natural to think that a verbal acknowledgement of the traumatic past is exactly what it takes for a patient of this type. This is absolutely true, because only a recovery of the stream of consciousness, of memory, and speech can heal these deep fractures. But the words are missing, and clinical evidence tells us that the use of exclusively verbal work is seriously insufficient.

Many cases show that the re-emergence of these experiences results from events in which the body, in using gestures and postures has a primary role; and that perhaps without these experiences some access to the trauma (memories) would remain unattainable. There is also scientific evidence from recent neurophysiological studies confirming what daily clinical experience shows us. One research study used PET techniques on patients with PTSD who were exposed to dramatic stories they had written about their traumatic experiences. The most significant result of the study is that during these moments of great intensity, a part of the brain, Broca’s area, which is in charge of the translation of personal experiences into communicable language, stops operating (Rauch, et al, 1996).

We shall conclude that this is reflected by the “silent terror” experienced by these patients, and as evidenced in their tendency to feel emotions as physical states rather than as verbally encoded experiences. These results suggest that the difficulties faced by patients with PTSD in generating words for their feelings is related to real changes in cerebral activity.

Another series of studies, in which the activation of traumatic memories is observed through *neuroimaging* techniques, seems to be largely consistent with the previous study cited. The overall picture is that during the activation of traumatic memories there is a simultaneous hyper-activation of the amygdala, a decrease in inhibitory top-down action on it by the ventral anterior cingulate cortex, the medial prefrontal and the dorsolateral cortex (with problem

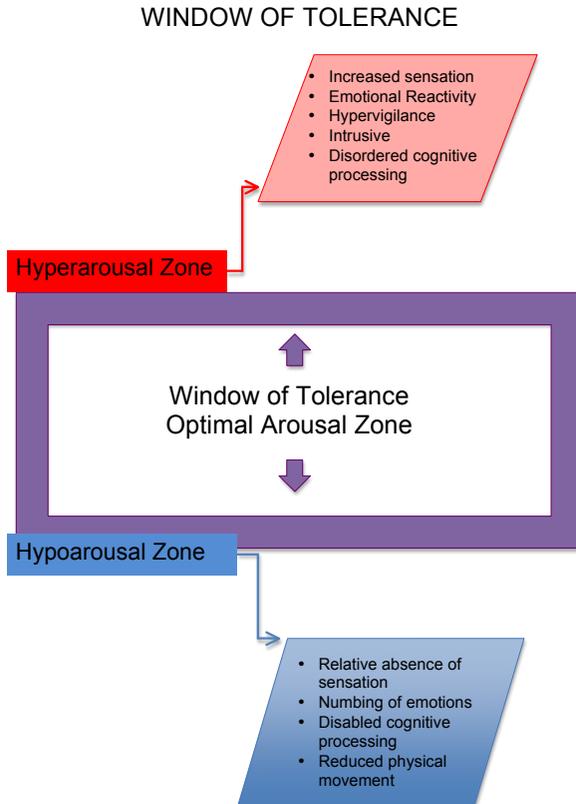
solving, answer selection, reflection functions), hyper-activation of the right cerebral hemisphere and, moreover, a hypo-activation of Broca's area. The person finds himself reliving the trauma as if it were re-occurring now, in the present having intense emotional experiences without being able to label them, regulate and control them adequately. He is also unable to elaborate on them in an effective verbal manner (Bremner, 1995).

### The window of tolerance

The critical importance of the ability to verbalize the event in cases of trauma is also confirmed by two other authors who are involved in the attempt to understand the complex phenomenon of emotional regulation: Daniel Siegel and Pat Ogden.

Daniel Siegel proposes the concept of a "Window of Tolerance" and places it among the essential components of emotional regulation. According to Siegel, "everyone has a 'window of tolerance'," a space in which emotional states of different intensity can be processed without jeopardizing the functioning of the system as a whole.

This means that, "states of arousal that exceed the limit of the window of tolerance can cause disorganized thinking and behavior." We can explain this in terms of the activity of the autonomous nervous system. When we enter a state of excessive sympathetic activity, we experience an increase in breathing and heart rate, culminating in a sense of generalized tension. This means that the subject has gone beyond the upper limit of his window of tolerance.



Adapted from Pat Ogden, *Trauma and the Body*, and W.W. Norton & Company.

Conversely, when the lower limit of the “window of tolerance” is reached, the parasympathetic system produces the opposite effect, creating a sense of numbness and a reduced responsiveness of the mind instead.

“In these conditions, higher cognitive functions such as self-reflection and abstract thinking are impaired; the circuits that connect these cortical processes to the hyperactive centers of the limbic system are functionally blocked, and rational thinking becomes impossible. The mind generates unorganized activities that can reinforce the maladaptive pattern: this is a state of emotional dis-regulation.”

Siegel’s work is of great importance for us because it shows exactly what happens in cases of traumatic experience, regardless of when the event is occurring in the moment or being relived. But we have to take another step. The last link in this elucidating chain is given by the considerations of Pat Ogden, who uses the concept of the window of tolerance to observe and treat patients with post-traumatic disorder.

Ogden notes that, in fact, traumatized people display behavior that overflows the limits of their window of tolerance in two possible directions: there are people who remain in a chronic state of hyper-arousal, resulting in excessive habitual alertness, aggressiveness, hyper-vigilance, responsiveness and motor agitation; or people who take the way of hypo-arousal, and therefore show a background of defensive passivity, characterized by chronic patterns of submission, inability to structure personal boundaries, a deep feeling of inadequacy, automatic obedience, and a tendency to repeat their role as a victim. Then there are people, probably the majority, who alternate between one state and another. In all these cases, rational thinking is likely to become disorganized and consequently the ability of verbal communication is seriously compromised.

### **The traumatized body**

It is the body that can give us more knowledge about what happens during these catastrophic experiences.

First we start with a basic assumption: the body’s first reaction to a situation involving a serious threat to its safety is primarily a response of “fear”. The neurophysiological correlates of this emotion are crucial for understanding the psycho-corporeal reaction of the human being to a traumatic event.

Fear is coordinated by a small sub-cortical gland called the amygdala. Some research suggests that many anxiety disorders may be associated with abnormal activation of this gland. Studies by Van der Kolk (2004) and Le Doux (1992) help us understand the neurophysiology of trauma and the role of the amygdala in PTSD. Sensory information arrives to the central nervous system via the sense organs and is transmitted to the thalamus where a partial integration occurs. The thalamus then transfers this semi-integrated information to the amygdala and to the prefrontal cortex, where processing activity continues.

Some information, however, travels through the amygdala before passing through the cortex. According to Le Doux this “early” sensory information allows the amygdala to process the experience at a higher rate than the cortex and to interpret its emotional significance. Thus, the emotional evaluation of a stimulus seems to precede the conscious experience of it. The information evaluated by the amygdala is then transferred to the pre-frontal cortex and to the hippocampus, the area anatomically adjacent to the amygdala and involved in organizing and storing long-term memory.

The hippocampal system contributes to the evaluation of the space - time relationship (where and when) between the new, incoming information and the previous information that has already been stored.

The thalamus, the amygdala, the prefrontal cortex and the hippocampus are all involved in the integration, interpretation and storage of sensory information. This integration, however, seems to be disturbed by high levels of neurophysiological activation (arousal), like those that are activated by fear while exposed to a traumatic event. While a moderate activation of the amygdala increases the declarative memory (verbal) mediated by the hippocampus, a high excitatory level disturbs its activity, facilitating a mainly visual or auditory sensory storage.

An excessive excitation of the amygdala generates emotional responses and sensory impressions based on fragmented information processing, rather than on a complete perception of the stimuli. The memories of traumatic events can thus be stored vividly as emotional states, in a sensory-motor mode, or as somatic sensations and visual images, but they are not properly integrated as a semantic memory.

From a strictly neurophysiological point of view this phenomenon can be explained by the role of a neurotransmitter essential for understanding stress: cortisol (or hydrocortisone). Levels of cortisol in stress situations are lower than normal, while those of adrenaline and noradrenaline (norepinephrine) are higher than normal. As one of the functions of noradrenaline is to activate the hippocampus, this may explain why we can remember emotional events better than others: under the extreme stress of trauma, noradrenaline, no longer inhibited by cortisol, might activate the hippocampus more intensively and for longer, facilitating excessively live memories which are re-experienced as flashbacks or intrusions. Thus, low levels of cortisol may represent a risk factor for PTSD.

Neuroimaging studies provide further evidence for understanding how information processing can be disrupted by trauma. While recalling a traumatic memory, the right brain hemisphere increases its activity in the areas involved in emotional excitement, i.e. in the parts of the limbic system more closely linked to the amygdala (Rausch, et al. 1996). These areas are more related to the experience of anxiety, and they have been named "the circuit of concern." In addition, while recalling the traumatic memory, Broca's area, the part of the left hemisphere responsible for the verbalization of personal experience, seems to be turned "off". As a result, the traumatized patient, instead of translating the experience into words, feels a "silent terror," that inscribed into the sensory memory as a somatic rather than a mental state.

Traumatic information is stored as sensory fragments and emotions are felt as physical states, rather than being verbally coded (Van der Kolk, 1995). To understand the "feeling" after a trauma more fully, we should also remember that when people are in danger they produce high levels of endogenous opioids, which can deaden the pain. Some people with PTSD continue to produce high levels of opiates even after the danger has ceased, and this may cause the sensation of dulled emotion associated with post traumatic syndrome. The important role of the hippocampus in processing traumatic memories is testified to by many studies that have revealed alterations in the right and/or left hippocampal volume and/or lower neuronal hippocampal density in people with extended trauma. However, it is unclear whether these reductions in hippocampal volume are a cause or a consequence of the development of PTSD. Gurvits and colleagues (1996) found that in individuals exposed to trauma, but who did not develop PTSD, the size of the hippocampus was not reduced. Abnormalities in the circuits of the prefrontal cortex and cingulate gyrus have also been highlighted with PET in both patients with PTSD and with major depression (Bremner, 2002).

A crucial issue is the correlation between these studies. The first hypothesis is that stress hormones might have caused the neurological disorders. Some data, however, do not seem to support the idea that these hormones are particularly high in those who develop PTSD (Orr, Pitman, 1999). An alternative hypothesis is that the reduced size of the hippocampus might be a risk factor for PTSD (Gilbertson et al., 2002). These authors, even though they found a 10% reduction of hippocampal volume in the brains of war veterans with severe PTSD, noted the same hippocampal volume in monozygotic twins of patients not exposed to war.

Furthermore, the severity of PTSD does not appear to be associated with the severity of the traumatic experiences, but rather with the reduction in hippocampal volume.

This dispute, however, doesn't change the most important aspect of a psychocorporeal therapeutic approach to trauma, i.e., that the neurophysiological aspects of trauma correlate to the traumatic experience inscribed predominantly within the sensory-motor component of emotion in addition to the cognitive-verbal one.

Since traumatic experiences seem to be initially stored as body sensations and emotional states, they are more difficult to access through semantic elaboration and therefore therapies based on verbal processes may be less effective. Traumatic memories, in fact, seem to be reflected primarily in the right hemisphere and processed in the emotional limbic brain.

Most psychotherapeutic approaches facilitate a cognitive processing of emotions that can significantly relieve the symptoms of trauma. However, when the posttraumatic psychopathological picture displays somatic symptoms (McFarlane, 1996), the effectiveness of treatment can be considerably increased by sensory-motor interventions. This does not mean that the sensory-motor processing alone can be enough to manage post-traumatic symptoms, but that it is an essential contribution to this process (Ogden and Minton, 2000).

## Hopeless solitude

So far we have seen the difficult cohabitation between narrative plots and emotional memory and the frequent separation of words and experience; now we have to emphasize a further complication: the breaking of connection with other people, the radical relationship separation.

Cases of trauma, and particularly cases of abuse, defined as "relational trauma" since it usually occurs within significant human relationships, generally show a crucial sense of extreme loneliness and sense of bleak alienation from the rest of mankind: the abused person does not perceive himself as belonging to the rest of the human community, but rather as ruled out, different or even dangerous to the peace of others. A therapist listening to a person who has experienced such events is impressed by the profound destruction of trust in human relationships, with a resulting sense of isolation which apparently dampens the constant feeling of imminent threat. We witness an experience of "expulsion" from the social world and an "invisible segregation" which emerges forcefully when someone decides to get closer than usual to the traumatized person.

The clinical example I want to present exhibits this sense of hopeless solitude, highlighting what we have just outlined. It is the case of a patient, Anna. I will recount a sequence of three short phases of the care process based in an individual setting.

Anna is a person with a history of sexual abuse perpetrated by her father and repeated for years, with the mother's tacit collusion. Her brother and her sister (both younger) remained unaware until the day that Anna decided to reveal to them the facts of her experience. This happened while she was being treated by a psychotherapist. This therapy, which lasted for about

two and a half years, ended abruptly and in a negative way, because, as she says, “I felt betrayed and abandoned by his behavior.” After this therapy, “which however has been very useful and important,” Anna turned to me because she found out that I had written a book about therapy techniques in sexual abuse cases. Although she hadn’t read it she decided to consult me anyway.

The three fragments, extracted from the long work of therapy, while far from being a complete documentation, serve to illustrate the specific issue that is frequent in abused people, the sense of extreme loneliness, almost of isolation, which becomes a heavy feeling of being totally different from the rest of human beings. The feeling of being in what I term ‘hopeless solitude’.

Very often abused people feel “rotten inside”, “like a fruit gone bad” that everyone can see and judge. Anna also described feeling this existential state of being. This case shows a way of working through the methods of mirroring, imitation and key-gestures used to get deeply in touch with the patient while simultaneously maintaining an obvious sense of respect for their boundaries. The therapist attempts to capture a significant gesture of the patient and repeats it with her. It happens that Anna calms down, goes into a state of relaxation, develops a positive image, and then shows a change in her primary theme of loneliness.

Anna had consulted me asking for help with her relational problems: she wasn’t able to have a lasting love relationship that would give her a sense of confidence and well-being. In the first two sessions she had been able to tell me much of her dramatic story, composed of terrible events, a disturbing ambience and moods close to madness. I could understand her feeling of total exclusion from the world of human beings, the constant feeling of not being understood and the ice of her eternal loneliness. With this deep sense of isolation it was obvious that she could not build an on-going relationship and that she always felt driven back into the depths of her terrible solitude.

### First fragment (third session)

A few minutes into the session this dialogue begins:

Anna: “I feel as if I don’t have the *ability* to sustain a relationship.”

While saying this, Anna makes a particular gesture with her hands joined and the fingertips touching each other and moving from bottom to top, as a blooming flower or an erupting volcano.

Therapist: “The *ability*. . . (T. repeats the keyword and reproduces the gesture of the patient showing it to her, leaving the sentence suspended without adding his own words) “What is this? (indicating the gesture) How is it? Did you notice that you made this gesture?”

A: Yes, It is true I did that, I don’t know why. I don’t know. . . I would say that. . . I don’t have the ability to feel inside and come out. . . to live. . . to let it in. . . I don’t know how to say it. Yes, maybe it is just like this movement (Anna makes the gesture again and watches it).

At this point the therapist explains the meaning of working on the gesture: “It may be important to pay attention to the gestures and movements that accompany our speech, because sometimes they open us to deeper dimensions of our being, they reveal intentions or aspects we’re not aware of, and reveal ideas and personal meanings that can show us a possibility and a way to new solutions.”

Anna listens and confirms with subtle nods, then she takes a breath and says: “Usually I try to live a relationship with a man externally, as someone aloof who sees things from the outside. I don’t even call the men I know by name: I call them with abstract nicknames:

the engineer, the Roman, the restless, and so on. . . . I got used to the distance, even mental, from them.”

T: “But this (repeating gesture) is something different, right? It is different because it comes from yourself. . . it comes from within and it emerges. It is not external like men. . . this is the ability to. . . as if it was born from within, right? . . . How do you feel seeing this?”

A: “Well, I wish it were like that.”

T: “Can we repeat this gesture together?”

Anna doesn't answer, but nods her head and immediately begins to move her fingers searching for the movement and the feeling; she dives instantly and completely into the movement, not just her hands, but also her arms, her shoulders and torso, they all move as if they were emerging, floating from a remote underground cave.

T: How do you feel while you're doing this?

A: I do not know, it is weird. . . is beautiful. . . it is. . . like Christmas with my family. I really like Christmas with my family. It gives me a feeling of warmth and affection.

T: And the feeling in your body?

A: Relaxed. I feel...I feel my body!

T: I am impressed by your voice right now. It seems different than a few minutes ago. Do you realize the difference too?

A: I feel cozy. . . I see myself as if I were immersed in a cloud.

### **Second fragment (fourth session)**

Session opening dialogue:

T: How are you?

A: Very well after the last session, because I was impressed by your gesture along with mine, and this gave me a strong sense of relief. I felt like not being alone. I didn't feel that extreme solitude. . .

For three or four days I recalled your gesture with mine, and this relieved me and almost moved me. By contacting this gesture that expresses a form of solitude, I felt that now there is a person who can accompany me. I moved this feeling of loneliness away for a few days and I was fine. I haven't felt so good in a long time.

### **Third fragment (one month later)**

Dialogue at the end of the session:

A: I feel a great pain. But I don't feel it only because it is here right now: It has always been here. I denied it for some kind of survival.

T: A great pain?

A: Yes....and I'm almost happy to feel it. There are many of us suffering like this.

T: This is important. Sometimes you told me about a sense of loneliness, of isolation.

A: I'm coming up with an idea that it is not true that we're different from the others. “You're not like the others” they always told me, especially my mother: a sense of “being different” is certain for those affected by trauma in childhood. When you're growing you're not like the others, so it is a huge imprint, but what I begin to feel now is that we're not different from the others.

And as she speaks, something very interesting happens: Anna remakes exactly the same gesture from which this whole process started, but this time she doesn't stop, she goes on and

she produces a new sequence: her hands, after describing that flower or that volcano, separate, and vibrating gently, they lay on her own cheeks. Anna stops, as if suspended; she opens her eyes slowly and sighs. She looks at me and with my eyes I show her the new position of her hands, and I don't even have to say anything and she nods saying, "Yes, I see. . . I did a new thing. . . a new gesture for me, I usually never stroke myself. I would say that. . . now I'm here with you, Anna!" Here the last part is unclear who is speaking.

Later, Anna remembered that portion of her therapy, that phase of work she described as "getting out of the well", and with great surprise she thought about the simplicity and almost banality of our interactions, which had so impressed and changed her. She was incredulous about the fact that a simple gesture repeated and reflected upon could have produced such an effect; and even more surprising to her was the resulting feeling of gradually regaining a body, her body, "as if a beneficial water had begun to soak her, waking her up."

### **The key gesture**

How is it possible to contact an experiential core theme so quickly and deeply in order to reorganize its sense by using an involuntary and almost unconscious gesture?

Here we need to describe in detail the steps we made utilizing support from the latest discoveries in neurophysiology, in order to build a meaningful and coherent hypothesis that can justify what is now evident in the clinical experience.

Let's start with some recent studies that investigate how the brain works while performing certain functions. The act of learning what we call "motor skills", such as cycling, skiing or other activities of this kind, makes this clear to us. Larry Squire and Eric Kandel (2000) have studied the issue for a long time and have clearly shown that there are various forms of memory, which are represented in different areas of the brain.

An important conclusion has been reached, which is that motor skills don't refer to explicit or declarative memory, the one with conscious awareness of remembrance, but that they are part of the broader field of implicit or procedural memory.

Motor skills or habits, once they are learned consciously with the participation of the prefrontal and parietal cortex and of the cerebellum, gradually become more and more automatic, since the control of the action is made by other brain areas such as the motor cortex and the neostriatum. The brain areas involved in attention and awareness seem essential at the beginning of learning, but they gradually decrease their activity when a task is repeated for the benefit of deeper brain areas, such as the motor cortex, the caudal nucleus and the putamen (which constitute the neostriatum). More simply, our conscious part occurs only at the time of the original skill learning, while routine repetition de-activates our awareness and activates our automatic and unconscious areas. After having understood how to do it, we no longer need to think and reason how to do it anymore.

Packard, Hirsh & White (1989) have gone further and have shown through some brilliant experiments how the hippocampus is involved in those exploratory tasks that use information related to events which occur occasionally, that is, events that can't be categorized as frequent or routine. On the contrary, in tasks involving the routine repetition of certain experiences, the caudate nucleus is involved, and no function is affected by a possible lesion of the hippocampus.

In short, we can conclude that routine physical activities initially involve the higher brain centers, leaving them right afterward to be stored in circuits that don't have any contact with certain cortical areas and especially with the hippocampus.

This last detail is very important regarding the impact of trauma on hippocampal

connections and the consequent memory disorders. We have already mentioned the fact that trauma, disconnecting the hippocampus from the amygdala, can produce an isolation and dissociation of traumatic memory, resulting in a range of symptoms that have no cognitive connection with the event. Sensations and movements, therefore, have partial autonomy.

The following steps are utilized in the Biosystemic approach:

- Highlight the gesture
- Reflect the patient
- Make the patient repeat
- Increase and / or amplify
- Allow to develop and transform.

We need to comment briefly on these steps. For example, why should we highlight one gesture rather than another? What makes us decide? After years of clinical work I can say that we need to refer to the principle of salience, according to which something is significant and important when it emerges from the background and differs from the basic continuum. Anna's gesture impressed me because it was slightly discordant with the verbal content of her speech.

Sometimes certain gestures are concordant with the context, but shift the center of the speech. For example, a person is talking about something and suddenly his hand unconsciously settles on a part of his body, like pointing out something related to the words. This is a key gesture.

The second step is simple but extremely important. It represents the sense of "doing things together" suggested by the therapist, that diminishes any possible sense of ridiculousness that a person may feel while directing his attention to that gesture. It is also the first step in which the patient observes something of his own; It is the beginning of the activation of an observing and aware consciousness.

The third step leads us directly into the heart of the work. Here we must be careful that the person doesn't stop repeating the gesture, otherwise the deep brain areas won't activate and everything risks remaining technical and flat. Therefore, it is important for the therapist to follow the patient, reflecting in part the related movement or sound.

The fourth step is the most delicate because it connects directly to the memory archive, and can trigger strong and surprising emotions and reactions. Here it is necessary for the therapist to follow the patient staying a bit lower, as to strength, rhythm and intensity.

The fifth and final step is the most creative, because it is totally unpredictable; we don't know what new plot will develop. Thus it is necessary to pay attention to those micro-gestures that precede the different directions of the movement, and that open up new horizons of sensation.

We have seen Anna passing through her initial gesture and arriving to do, feel and stay in an emotional position that was unpredictable at the beginning of the session. We started with a gesture, which we call "key-gesture," and highlighted it, repeated it, amplified it and followed it in its own spontaneous transformation: this procedure has revealed an experience that has led to a completion of the bodily expression and to a proper verbal narration. The crucial question is: why does a series of apparently common gestures make something so significant come out?

If we think of Levine's idea of trauma (1997) as "an incomplete biological response", and remember that the traumatized person is in a state of chronic tension, due to an action started and never completed, we can add that this person may also express a series of actions and motor patterns that constantly "start" and never finish. These are physiological attempts to respond to trauma that have remained trapped in the terror of menace. Moreover, if we observe that even here there is a disconnection of the hippocampus, we have a very strong analogy with the structure of routine and established motor skills: disconnected from consciousness, stored outside the hippocampus, identical in repetition.

Summing up and simplifying, we can say that the incomplete responses to trauma “behave” as our most ordinary motor skills: skiing, cycling, etc. The fundamental difference is that the first are never complete, and are often dysfunctional and cause agitation and discomfort. Both are the result of a disconnection from the areas of consciousness, but whereas the second carry along with it all the advantages of this step, the first are the result of a life failure.

Exemplifying more, we assume that the traumatized person consciously begins to produce motor responses to the threatening event, but then, overwhelmed, the person undergoes a disconnection of consciousness (hippocampus and cortex) but continues to produce fragments of actions that are never completed and are stored in deep brain cells that subsequently become unconscious.

At this point the work technique adopted with Anna is clearer. It is basically an attempt to go through the traumatic process again: highlighting the gesture allows conscious and vigilant attention to become involved; repeating the movement knowingly and voluntarily connects the higher brain centers (cortex and hippocampus) to the deep ones (caudal nucleus and putamen) again; amplifying the action helps to reconnect with the level of activation present at the time of trauma (state-dependent memory); and following the free development of the gestures it helps to find the interrupted motor frame and build a new narrative.

It is also interesting to note that the word “narrative” contains in itself the idea of the development of a story, and at the same time it contains the sense of the recovery and repair of a fabric.

### **Autistic isolation and mirror neurons**

However, there is a further theoretical element to add in trying to understand Anna’s process of reconstructing her sense of *being-with* the other as an outcome from desolating isolation.

While many methods of intervention operate primarily on the patient, here the focus is on the therapeutic relationship: the trauma of abuse is a relational trauma. The intention of the therapist is to restore harmony in a safe environment, through a consistent attitude and, above all, through the restoration of body tuning.

It must be said that abused people are sensitive to gestures, sensory and motor fragments, etc. This work attempts to repair the relationship texture as the person has lost the sense of *being-with* and feels desperately alone. The work of mirroring, the joint repetition of the key gesture, and the search for gesture-word connections help the patient to repair the breach. Another useful study is linked to the discovery of mirror neurons and to recent hypotheses on neurological defects in autism cases.

Mirror neurons are adjacent to motor neurons and are activated when the subject merely observes the intentional behavior of another person. The pattern of excitation induced in the observer imitates exactly the same motor pattern that he would activate to reach that object. In other words, the visual information we receive when we observe the actions of others is summarized in our brain, in equivalent motor representations thanks to the activity of these mirror neurons.

This allows us to participate directly in the actions of others. We experience the other as if we were doing his action, feeling his emotion, expressing his voice or feeling his own physical contact. Through this “participation” in the mental life of others we can “understand” and “feel” it in ourselves, with particular regard to his intentions and his feelings.

Vittorio Gallese (2005), one of the discoverers of mirror neurons, sums it up in a very impressive concept: “the embodied simulation”. Mirror neurons could therefore be the basis of

the phenomenon of empathy and social liaison that we experience in our lifetime. But things don't always work. In many cases the capacity for empathy and the feeling of connection with others may be lost: an extreme example is provided by autistic people, who live in a world deeply separated from contact and from relationships with others. And we now know that "high-functioning autism subjects" are able to recognize and imitate the expression of some basic emotions, but they do so using different brain circuits than those activated in people without autism.

Individuals with autism show a complete lack of activation of the pre-motor mirror neuron and an under-activation of the amygdala and the insula, but a hyper-activation of the visual cortices. (Dapretto *et al.*, 2006). Thus, we can hypothesize that empathy deficits in people with autism depend on dysfunctions of the mechanisms of embodied simulation, as determined by a malfunction of the mirror neurons system. (Gallese, 2006; Nishitani *et al.* 2005; Oberman *et al.* 2005; Theoret *et al.* 2005) While traumatized patients are clearly not autistic, we can define them as patients who generally operate with some portion of an autistic core (F.Tustin, 1990).

We can then assume that when we observe the phenomena of progressive social seclusion, isolation, feelings of extreme loneliness, relationship fracture (a situation that recalls autism), the function of the mirror neurons decreases. It should also be noted that the amygdala and insula activity decreases in these cases, and this coincides with Pat Ogden's observations on post-traumatic submission behavior where the amygdala is inhibited and the individual functions below the limit of the window of tolerance.

In people with dissociative PTSD, the insula is de-regulated, since the insula is necessary for perceiving and mapping the internal sensations of the body, functioning as a bridge between the motor areas of the mirror neuron system and the amygdala (Lanius 2006).

From this point of view, it is important to focus on the functioning of the therapeutic relationship in its global, psycho-corporeal dimension: the methodology of mirroring, key gestures and body tuning can act to promote the recovery of the functionality of the MIRROR NEURON system, the reactivation of the insula and the amygdala, and thus restore the previously lost ability to communicate.

Therefore given this various research on the brain and how we store and experience traumatic events, we conclude that when the therapist imitates the patient through key gestures, he creates the possibility for activation of the mirror neuron system, which can help the patient to literally see himself. (M. Iacoboni 2008)

### **Audio-visual mirror neurons**

The latest developments of the research of mirror neurons are consistent with the considerations taken so far, because they always obtain more numerous experimental confirmation, and because they expand and multiply the application fields. In fact, we have Mirror Neurons system based therapy for emotional disorders (T. Yuan, R. Hoff, 2008). These methodologies provide a non-invasive approach to the treatment of emotional disorders observed in autism patients, post-stroke patients with depression, and other mood dysregulation conditions.

In the last few years we have discovered that some mirror neurons may respond to sounds that correspond to certain actions— these have been termed "audio-visual" mirror neurons. This suggests that hybrid therapies that employ both visual and auditory stimulation would maximize clinical efficacy. Furthermore, virtual reality may create such an environment. Recent neuroimaging studies indicate that music, like language, involves an intimate coupling

between the perception and production of hierarchically organized sequential information, which links meaning to emotion via the mirror neuron. We believe that music could be a potent component in mirror neuron-based therapies, as recent findings in the domain of stroke rehabilitation have shown.

In conclusion, as therapists, we have seen that the treatment of trauma involves large areas of resistance to mere verbal therapies, which are in part due to the peculiar characteristics of how trauma is originally experienced in the non-verbal area of the brain and later integrated, interpreted and stored in a sensory-motor mode, as somatic sensations and visual images.

Traumatic memories often seem “encapsulated” within the psycho-corporeal structure of the individual, and when they emerge they tend to escape from a narrative plot, coming out suddenly in the form of intrusive sensory fragments.

In addition, after a traumatic event, we note that the emotional system of the victim can collapse, jeopardizing the three basic dimensions of its existence. Subsequently, we observe:

- A loss of self-esteem and confidence (psychological dimension)
- A state of neurophysiological hyper or hypo-activation (body dimension) as discussed using the window of tolerance.
- Difficulty seeking and accepting (relational dimension), thus feeling forever trapped in what I refer to as hopeless solitude.

The treatment should pay extra attention to the corporeal and the relational dimensions, thereby not making the mistake that some therapists make by ignoring and not approaching the problem with intervention techniques that may allow for better access and expression of deeply traumatic events.

The aforementioned authors offer conceptual tools that therapists can use to “open the black box” of the patient in order to help them regain an important part of themselves, and ultimately, an essential portion of the Self. Used together, these tools can help the patient overcome their sense of hopeless solitude.

As Siegel says (2001, p.225) the scope of the work is to widen the limits of the Window of Tolerance, “to allow the system’s self-organization process to return to a stream of states that move in a balanced way towards a greater complexity, avoiding, at the two extremes, an overly restrictive or an overly random and chaotic activation”.

## BIOGRAPHY

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## REFERENCES

- American Psychiatric Association. (n.d.). *Diagnostic and Statistical Manual of Mental Disorders* (4 ed.). Arlington, VA: American Psychiatric Publishing.
- Bonaiuto J., Rosta E., & Arbib M. (2007). Extending the mirror neuron model, I: Audible actions and invisible grasps. *Biol Cybern*, 96, 9–38.

- Bremner, J.D. et.al. (1995) MRI based measures of hippocampal volume in patients with PTSD, *American Journal of Psychiatry*, 152.
- Bremner, J. D. (2002). *Does stress damage the brain?: Understanding trauma-related disorders from a neurological perspective*. (1 ed.). New York, NY: W. W. Norton & Company.
- Caruth, C. (Ed.), *Trauma: Explorations in Memory* Baltimore, MD: The Johns Hopkins University Press.
- Gallese, V. (2005). Embodied simulation: From neurons to phenomenal experience. *Phenomenology and the Cognitive Sciences*, 4, 23-48.
- Gellhorn, E. (1967). Principles of autonomic-somatic integrations: *Physiological basis and psychological and clinical implications*. Minneapolis, MIRROR NEURON : The University of Minnesota Press.
- Gurvitz, T.V., Shenton, M.E., Hakama H., et al. (1996). Magnetic resonance imaging study of hippocampal volume in chronic, combat-related posttraumatic stress disorder. *Biol Psychiatry*, 40(11), 1091-1099.
- Kandel, E. R., & Squire, L. R. (2000). Neuroscience: Breaking down scientific barriers to the study of brain and mind. *Science*, 290(5494), 1113-1120.
- Kohler, E., Keysers, C., Umiltà, M. A., Fogassi, L., Gallese, V., & Rizzolatti, G. (2002). Hearing sounds, understanding actions: Action representation in mirror neurons. *Science*, 297(5582), 846-848.
- Krystal, H. (1988). Integration and self healing: *Affect, trauma, alexithymia*. (1 ed.). London, England: Routledge.
- Lanius, R.A., Blum, R., Lanius, U., Pain, C. (2006). A review of neuroimaging studies of hyperarousal and dissociation in PTSD: heterogeneity of response to symptom provocation. *Journal of Psychiatric Research*, 40(8), 709-729.
- LeDoux, J. (1998). *The emotional brain: The mysterious underpinnings of emotional life*. New York, NY: Simon & Schuster.
- Levine, P. (1997). *Waking the tiger: Healing trauma*. (1 ed.). Berkeley, CA: North Atlantic Books.
- Liss, J. (2005). La neurofisiologia delle emozioni e della coscienza: ricerca recente. *Societa Italiana di Biosistemica*, Retrieved from <http://www.biosistemica.org/articoli.htm>
- Liss, J. (2007). Il flusso di coscienza nella vita quotidiana e l'impasse: La base neurofisiologica dell'inconscio sottocorticale. *Societa Italiana di Biosistemica*, Retrieved from <http://www.biosistemica.org/flusso1.pdf>.
- Lowen, A. (1989). Bioenergetic analysis. In R. Corsini & D. Wedding (Eds.), *Current Psychotherapies* St. Paul, MIRROR NEURON : Brooks/Cole Publishing Co.
- Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6(3), 19-20.
- Ogden, P., Minton, K., Pain, C., Siegel, D. J., & van der Kolk, B. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. (1 ed.). New York, NY: W. W. Norton & Company.
- Orr, S. P., & Pitman, R. K. (1999). Neurocognitive risk factors for ptsd. In R. Yehuda (Ed.), *Risk Factors for Posttraumatic Stress Disorder* (pp. 125-142). Arlington, VA: American Psychiatric Publishing.
- Packard M. G., Hirsh R. H., and White N. M. (1969). Differential Effects of Fornix and Caudate Nucleus Lesions on Two Radial Maze Tasks: Evidence for Multiple Memory Systems. *The Journal of Neuroscience*, 9(5): 1465-1472.
- Rausch, S.L., Van der Kolk, B. A., Fislis, R. E. A., Nathaniel, M., Orr, S. P., Savage, C. R.,

- Fischman A. J., Jenike, M. A., and Pitman, R. K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. *Archives of General Psychiatry*, 53(5), 380-387.
- Sarkamo, T., Tervaniemi, M., Laitinen, S., Forsblom, A., Soinila, S., Mikkonen, M., Autti, T., & Silvennoinen, H. N. (2008). Music listening enhances cognitive recovery and mood after middle cerebral artery stroke. *Brain*, 131(3), 866-876.
- Shore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. (1 ed.). London, England: The Psychology Press.
- Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. (1 ed.). New York, NY: The Guilford Press.
- Stupiggia, M. (2007). *Il corpo violato: Un approccio psicocorporeo al trauma dell'abuso*. Molfetta, Italy: La Meridiana.
- Sugarman, A. (1994). *Victims of abuse: The emotional impact of child and adult trauma*. (1st ed.). Madison, CT: International Universities Press.
- van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (2006). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. (1st ed.). New York, NY: The Guilford Press.
- Yuan, T.F. & Hoff, R. (2002). Action representation in mirror neurons. *Science*, 297, 846

## Anxiety and Panic in Reichian Analysis

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### Abstract

Having underlined evolutionistic aspects, the constituent moments of the 'fear' phenomenon in a descriptive interpretation are evaluated, as well as clarifying the original roots of the words, which sink their definitions into corporal expression. The anxiety disorders are reviewed later, from a clinical perspective, linking them to significant epidemiological data which is useful in order to classify them three-dimensionally in negentropic-filogenetic time. This interpretation will lead onto a clinical-analytical proposal for three-dimensional classification (The Tree of Fears) on the negentropic-ontogenetic arrow of time. The work will conclude with the description of analytical-therapeutic lines on the subject from the Italian School of Reichian Analysis (SIAR) itself.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** anxiety disorders, Tree of Fears, Arrow of Time, negentropy, Reichian Analytical-Therapeutic Treatment

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In Reichian analysis, fear is seen as an indicator of the intelligence of the living being and is, in many ways associated with one's sensitivity to pain. From a phylogenetic-evolutionist perspective, a finite distinction between fear and anxiety does not exist. Over the lifetime of the living being, fear is foreshadowed by anxiety, which is understood as the complex cognitive by-product of the organism's capacity to foresee danger in time and space. Fear, when it '*crosses the threshold*,' becomes a powerful and terrible enemy of freedom, the effects of which should not be underestimated. While fear should be respected, it should also be surrounded by all the means we have at our disposal; '*lay your eyes upon it*,' i.e. learn to recognize it and accordingly develop a deeper understanding of its origins.

A linear reading of fear might represent the constituent moments of the overall phenomenon as follows:

1. If something threatening should suddenly fall upon a subject, who lives their experience of being in the world in terms of acceptance and protection, the fear is '*fright*,' and what frightens is usually something known and familiar.
2. If what is threatening is characterised as being largely extraneous to the individual inquestion, then the fear is '*horror*.'
3. When what is threatening is horrible but is also characterised as being sudden and unexpected, the fear is '*terror*.'

4. When terror is as intense as it can be, then ‘*panic*,’ which is characterised by an impulse to blind flight from the world in which they find themselves, occurs.

However, learning to recognize fear and developing a deeper understanding of it also necessitates moving vertically; ‘*lay your eyes upon the words*’ and read them in all their depth. Words are repositories of phylogenetic intelligence that are accessible to genes. They bear the stratified negentropic arrow of time ‘*from bodily expression to verbal expression*.’ In the various lexemes, this sentiment is expressed in three different ways:

1. As pain and worry
2. As running, jumping, moving, and trembling
3. As experiment and risk

- From an etymological standpoint, there is *pavere* (to be frightened), a verb that indicates the state of being knocked down by a shock. There is also *pavor*, a noun with the suffix -or, which typifies something animate and which designates a force in action rather than a state. The principal meaning of *pavor* is ‘*I am hit*,’ which can even indicate a future threat.
- Another word that can indicate fear is *timor*, as in ‘*timid*’ or ‘*timorous*.’ The original verb is *timéo*, which means to condense, to squeeze, to coagulate or to stick. It can also refer to movement that expresses stiffening, petrification or paralysis.
- ‘*Terror*’ is derived from *terrere*, meaning to tremble, vibrate, or shake.
- Then there is ‘*horror*,’ from *horrere*, meaning to bristle, to straighten up or to stiffen – a physical sensation which gives you goose pimples and makes your hair stand on end.
- There is also the Greek verb *phobos*, meaning to frighten or to cause to flee, from which the word phobia is derived.
- ‘*Anxiety*’ can be traced to *anxia*, the feminine form of *anxius*, something laboured and troubled that follows from fear and desire.
- We derive ‘*anguish*’ from *angere*, meaning to squeeze or to suffocate. It is a painful sensation of tightening of the epigastrium which is accompanied by great difficulty in breathing and profound sadness.
- We get ‘*panic*’ from *panikós*, which refers to Pan, the woodland divinity with horns and goat’s feet who provoked sudden, maddening fright with the sound of his pipes.

There is a clear link between body and language, and to illustrate how fear manifests in the body, Charles Darwin’s description of fear (1837) is most appropriate:

“Fear is often preceded by astonishment ... the eyes and the mouth are widely opened, and the eye-brows raised. ... The heart beats quickly and violently ... the skin instantly becomes pale as during incipient faintness. ... under the sense of great fear we see in the marvellous and inexplicable manner in which perspiration immediately exudes from it. This exudation is all the more remarkable, as the surface is then cold, and hence the term a cold sweat. [...] The hairs on the skin also stand erect and the superficial muscles shiver. In connection with the disturbed action of the heart, the breathing is hurried. The salivary glands act imperfectly; the mouth becomes dry, and is often opened and shut. I have also noticed that under slight fear there is a strong tendency to yawn. One of the best-marked symptoms is the trembling of all the muscles of the body; and this is often first seen in the lips. From this cause, and from the dryness of the mouth, the voice becomes husky or indistinct, or may altogether fail.”

In a horizontal, clinical interpretation fear is not taken into great consideration – it would, in fact, only be seen as “a response to an external threat or danger which has been consciously recognised.”

“Before what are we frightened?” asks Martin Heidegger (1919). What frightens is always something that we encounter in the world and which is characterised by menace. Therefore to recognise it clinically

is to recognise it in its internal declinations. The DSM IV-TR is a manual of diagnostic criteria which is highly debatable, but which is certainly a point of reference known to all of those operating in the field. Its merit is that it has created the opportunity for there to be a common starting point in the '*psy-world*' from which we can move on: compare and contrast, and make progress.

### The essentiality of anxiety disorders

It is to be noted by Reichian analysts that the way in which DSM IV-TR refers to anxiety and panic compresses internal time and does not distinguish between anxiety and anguish. The word panic is misused in that it is even applied to an anxiety attack. Neurosis is no longer even contemplated.

According to DSM IV-TR, a panic-attack is a period of fear or intense unease during which four or more of the following symptoms suddenly appear and intensify, peaking in around ten minutes:

- palpitations, heart palpitations or tachycardia
- sweating
- trembling or shaking
- dyspnoea, or the feeling of suffocation
- feeling of asphyxiation
- chest pain or discomfort
- nausea or disturbed stomach
- feelings of loss of balance, instability, light-headedness or of being about to faint
- de-realization (sensation of unreality) or depersonalisation (being detached from oneself)
- fear of losing control or of going crazy
- fear of dying
- paraesthesia (feeling of numbness or tingling)
- shivering or hot flashes

If the panic attack is recurrent, it will develop either with or without agoraphobia, anxiety associated with finding oneself in places or situations from which it would be difficult or embarrassing to get away, or in which there might be no help available should the person suffer an unexpected panic attack. Agoraphobic anxieties typically concern characteristic situations such as being outside alone, being in a crowd or in a queue, being on a bridge, or travelling in a bus, train or car. These situations are either avoided or a friend must be present.

A specific phobia is a pronounced, persistent fear that is excessive and unreasonable, and is triggered by the presence or by the expectation of a specific object or situation. Exposure to the stimulus which is associated with the phobia provokes an immediate response in terms of anxiety, which may assume the form of a situational panic-attack. The person recognises that this fear is excessive and unreasonable and that it interferes significantly with their performance at work, their social interaction, and their leisure activities.

Specific phobias are categorised as '*animal*' if the fear is caused by animals or objects, as '*natural*' if caused by thunderstorms, heights, water or snow, as '*blood-infection-injury*' if the fear is provoked by the sight of blood, by having an injection or by other invasive medical procedures and as "situational" if the fear is caused by bridges, tunnels, lifts, driving, flying or by enclosed spaces.

Social phobia is a pronounced, persistent fear of social or performance-related situations in which the person is exposed to unfamiliar people or to possible judgement by others. The individual is afraid of behaving in a humiliating or embarrassing way. The individual recognises that this fear is excessive and that it interferes significantly with their performance at work, their social interaction, and their leisure activities.

### Further epidemiological-evolutionist statistics

Some statistical considerations clarify the nature of the phylogenetic, negentropic arrow of time:

Only 5 - 7 % of panic attacks in the general population occur with the frequency and intensity which signifies the presence of a disorder. In the vast majority of cases, at least 90%, the first attack occurs outside in the street, on or in a means of transport, or in public buildings. Less frequently, the first attack occurs at school or at work. Many people seek help by asking to be taken to the accident and emergency services at the nearest hospital or by having a doctor visit them within 24 hours of the attack.

Only slightly more common in women than in men, in co-morbid cases Panic Attack Disorder presents most frequently with alcoholism. It is almost certain that all cases of alcoholic syndrome, which are cured by anti-depressants were originally panic attacks.

Similarly, 20 - 30 % of cases of social phobias are co-morbid with alcoholism and phobias are the disorders with the greatest prevalence. Specific phobias represent the most frequent psychiatric phenomena in women and the second most frequent in men.

From the genetic perspective, modern human beings should still consider themselves to be Stone Age hunter-gatherers. Our genetic composition is practically the same as that of our ancestors from the late Palaeolithic era 30,000 years ago, though the environment we live in today is very different from what it was then.

The delay in the adaptation of the human genome to the new environmental conditions is understandable considering how recent these environmental changes are: while all of these changes have taken place since the advent of agriculture about 10,000 years ago, many of these significant changes have occurred in the 200 years since the industrial revolution began. These differences help explain the apparent irrationality of some phobic reactions and the greater prevalence of certain phobias.

In 1897 Stanley Hall (1881) wrote, "in 1701 people I have been able to describe 6456 different fears ... it seems that the most feared are thunderstorms, then reptiles and then, immediately after, the dark and strangers, while fire, death, pets, disease, wild animals, water, ghosts, insects, mice, thieves, storms and loneliness represent decreasing levels of fear."

Modern epidemiological studies confirm this classic account. In a sample of 8098 people aged between 15 and 54 (Curtis CG et al, 1998) it emerged that 49.5% had or had had at some time during their lives at least one episode of excessive or irrational fear. The most common phobia-inducing stimuli were reported as being: animals (22.5%) with snakes being largely responsible, heights (20.4%) and blood (13.9%). It is clear that the mechanisms which control fear are calibrated to respond to dangers which were frequent and lethal in the environment in which man lived for a significant part of his biological history. Despite the fact that incidents of fatal snakebites are now much rarer than fatal accidents on the road, phobias about snakes are still much more widespread than those about cars, which are practically nonexistent.

Other phobias, including for example thunderstorms, spiders, heights, enclosed spaces and blood, are very widespread, while those concerning firearms or pesticides are practically unheard of. Similarly, children are frightened of the dark and of sudden noises, but not of electric sockets or cleaning products. Notwithstanding substantial publicity campaigns, it is difficult to instil a fear of smoking or of high-fat diets. Most people are more frightened of a simple surgical suture than they are of an x-ray, even though they are aware of the risks associated with exposure to ionised radiation.

From these statistics it is clear that the mechanisms which regulate fear are not adapted to handle recently-evolved situations.

One should also bear in mind that the environmental dangers which threaten physical survival and the dangers which can compromise emotional relationships are two very different types of threats in terms of biological adaptation.

In fact, the purpose of phobic fear is avoidance or flight from situations which threaten physical well-being or the possibility of survival, whereas the adaptive function of fear of separation is to preserve the bond with the figure that the person is attached to and to favour protection by those with whom emotional bonds have already been established.

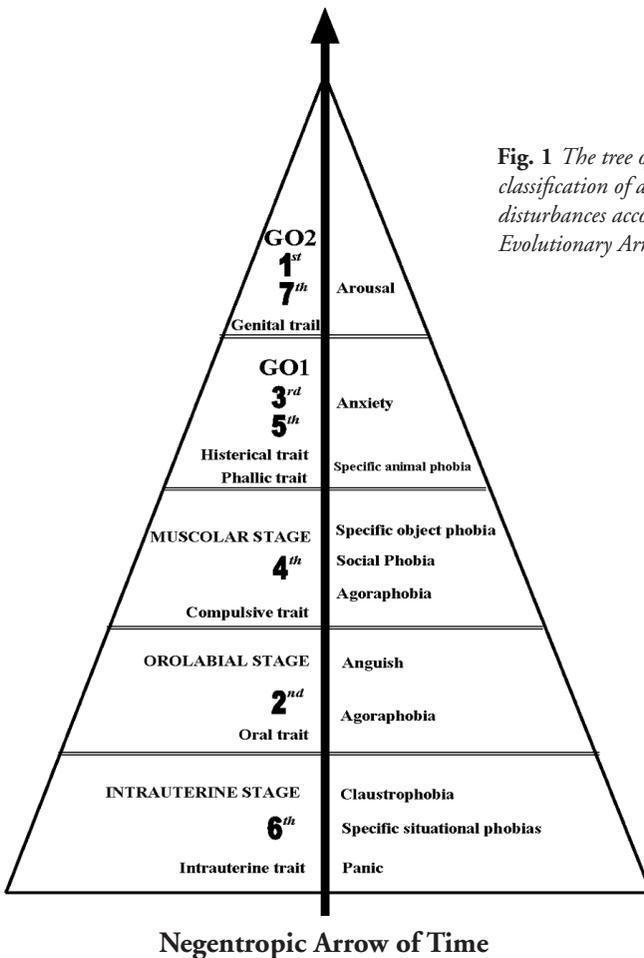
The distinction between fear of separation and phobic fear is commonly accepted medically and the two conditions are treated with different types of drugs. In the early sixties, Donald Klein (1964) demonstrated that imipramine (Tofranil) was an effective treatment for agoraphobia and panic attacks whereas benzodiazepines were able to limit the degree of fear expressed towards objects of phobias.

“How true this distinction is even from the perspective of Reichian analysis!”

This takes us straight to the fear of castration, understood as life threatening to the Self, and to the fear of separation, understood as the possibility of the Self losing the object.

With these we can move on to reading the Tree of Fear (Figure 1) starting from its trunk, which represents the ontogenetic, negentropic arrow of time.

**The ontogenetic when, where, and how**



*Fig. 1 The tree of fear: classification of anxiety-based disturbances according to the Evolutionary Arrow of Time*

### *A) Explanation of the left-hand side of the Tree of Fear*

The character is a set of traits and other aspects. It is a unique combination and it is also unique in its diversity as far as both its contents and the container itself are concerned. In Reichian Analysis the prototypical trait constellations go as far as the intra-uterine stage, because an overview in terms of the negentropic arrow of time would consider the whole existence of the person from conception onwards.

The evolutionary stages identified by Freud (1899) have been extended and expanded to include pre-natal, intrauterine life. In this way the following stages can be identified: the autogenous stage which lies between insemination and implantation; the tropho-umbilical stage, which is between implantation and birth; the oro-labial stage, which lies between birth and weaning; the muscular stage, which runs from weaning up to the Oedipus period; the first genito-ocular (GO1) stage, from the Oedipus period to puberty, and the second genito-ocular stage (GO2), from puberty to maturity.

Six fundamental character traits are distinguished (intrauterine, oral, compulsive, phallic, hysterical and genital) with numerous 'subtype' derivations according to the incised marks, the evolutionary stage in which the events occurred, how the passage from one stage to another occurred, the specific object relationship with the 'other than self' at that moment in the stage and previously established imprints.

The imprints and the incised marks fix themselves in privileged areas in the body, and the Reichian bodily levels are the areas in the body which bear these. They represent the first receivers of the object relationship with the other than self and constitute areas of resonance with the emotions experienced in the 'there and then'. These areas function as the peripheral interfaces with the associated, successively-dominant, evolutionary stages. In complex readings, these imprints appear and narrate our stratified life-stories in both psychic expression and, three-dimensionally, in the associated physical 'marks.'

Wilhelm Reich (1933) delineated seven bodily levels in people and defined them as the "set of those organs and groups of muscles which are in functional contact amongst themselves and which are reciprocally capable of inducing an emotional-expressive movement." In this he elementarily identified the 1<sup>st</sup> level, ocular segment, consisting of: the forehead, the eyes with tear ducts, the cheekbones, the nose and the ears; the 2<sup>nd</sup> level, oral segment: lips, chin, throat, and upper occipital nape; the 3<sup>rd</sup> level, cervical segment, lower neck muscles, sternocleidomastoid; the 4<sup>th</sup> level, thoracic segment: intercostal muscles, large pectorals, arms, hands; the 5<sup>th</sup> level, diaphragmatic segment: diaphragm, epigastrium, lower sternum, stomach, solar plexus, pancreas, liver; the 6<sup>th</sup> level, abdominal segment in which there is the first large mouth (umbilical area), that is to say the area that corresponds with the second of the two phases of intrauterine life; the 7<sup>th</sup> level, pelvic segment: pelvis and legs.

Today, putting them in the order in which they occur on the negentropic arrow of time, we propose a sequence that starts from the 6<sup>th</sup> and goes to the 2<sup>nd</sup>, the 4<sup>th</sup>, the 3<sup>rd</sup>, the 5<sup>th</sup>, the 7<sup>th</sup> and then to the 1<sup>st</sup>. Bodily level, therefore, with its associated functional dominance, is precise and corresponds to the prevalent evolutionary phase over the life story of that particular individual.

By including the negentropic arrow of time, the life-story and the concept of bodily level as peripheral expression of a particular stage, a clear correlation can be established between evolutionary stage, object relationship, bodily level, character trait and possible psychopathological disorders.

In our school the symptoms, the syndromes and the crisis states are highly relevant because they are collocated at an analytical moment and they express a historical aspect, as well as being the expression of a character structure which is energetically and relationally unsustainable in the here and now. It is a reading which recalls another of Reich's ideas (1933): "the difference between character neurosis and symptomatic neurosis is that in the latter the neurotic character also produces symptoms."

### ***B) Explanation of the right-hand side of the Tree of Fear***

In Reichian Analysis, the phobic trait is considered to have intrauterine influences. When combined with and together with traits from later evolutionary stages, the phobic trait can result in 'beyond threshold' expression as is confirmed by certain symptoms and syndromes.

The arousal in the GO2 window is a type of alertness which has not reached pathological levels but is, rather, a reaction to awakening and still represents negentropy.

The anxiety in GO1 is a kinetic, motor phenomenon which is qualitative, horizontal, and from an agitated energy field and, significantly, is close to the surface. This expresses the importance of the motor-kinetic attitude over the visceral in that person.

Animal and object phobias are spread between the GO1 window and the upper muscular stage, while social phobias are expressed by the window of the lower muscular stage, in which the leap in terms of relationship from stage 2 to stages 3, 4 and 5 was historically difficult. Situational phobias are the 1<sup>st</sup> and 2<sup>nd</sup> agoraphobias of greater or lesser gravity if occurring in spaces relating to the periods after birth or after weaning and claustrophobia (fear of remaining shut in, of being surrounded or of being inside) which certainly originates at an earlier point on the arrow of time than the agoraphobias. The fractal relating to the claustrophobia is to be followed back to the intra-uterine period.

Anguish is expressed purely as pre-muscular and is a movement of increasing or declining energy, poorly blocked by contraction and which remains in a retracted area and in a centripetal direction. Visceral qualities are connected to anguish – the area of the first great separation, of the tropho-umbilical phase, of Oedipus and of deep transference.

Panic, which can be identified as being either primary or secondary, reactive panic, comes, however, from fear of separation and/or castration, and is collocated in the deep intrauterine region in which a kind of reptilian dominance is present, although only for brief periods in conjunction with the most severe symptoms.

### **Reichian Analytical-Therapeutic treatment**

We all have three possible response patterns when we are confronted by fear:

1. Paralysis-petrification
2. Avoidance-flight
3. Courage-attack

While the lexemes of '*courage*' typically include '*strong*', '*robust*', '*to be full*', '*to move with force and strength*', but there is also etymology rooted in knowledge and understanding: '*setting eyes upon*.'

There is another in which there is daring and moving towards and there is even a lexeme rooted in the heart - enough material to suggest therapy!

We have 5 ways to try to defeat fear:

The first is precisely the courage-attack position, which permits us, when we are confronted by fear, to increase our energy levels and to modify our position in the relationship with the

object or objects which are causing the fear. This is achieved by activating those bodily levels which are capable of confronting it: the eyes, the neck and the chest.

The second is to do Character Analysis: the analyst awakens the patient's interest in their character traits, so as to be able to explore their origins, analyse their meaning and to show the patient the link between their character and the symptoms. In practice the initial phase of this method is no different from the analysis of a symptom.

What Character Analysis adds is the isolation of the character trait through continuous contrasting and comparison of the patient with the trait itself, until they begin to see it objectively and can transform it into an ego-dystonic symptom that they wish to free themselves of.

For example: if we take a person with a degree of fear, which we can call the phobic nucleus, or a phobic trait, then we can draw a diagram in which 'a' (Figure 2) represents our global personality, and 'b' (Figure 2), represents the phobic nucleus, which when normally present occupies 5 – 10 % of our personalities. If a meaningful life-event occurs in the story of object relationships for that person, this nucleus is amplified and becomes dominant (Figure 3.) If it remains for a meaningful length of time everything will be influenced by its style and it will determine the way of interacting. In reality that little nucleus has become a trait. It has obtained a whole series of quantitative positions within the personality and has become a dominant trait with a phobic-avoidant style.

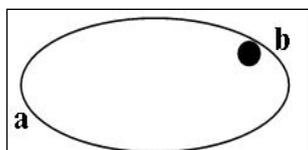


Fig. 2 – *Phobic nucleus*

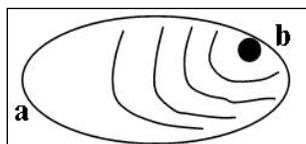


Fig. 3 – *Phobic trait*

What is a phobic nucleus? From a systemic-negentropic viewpoint, it is an entropic black hole that attracts higher stratified levels, phagocytising them in a powerful contraction in which internal time stops, as does vital movement.

The third means of therapy is Character-Analysis Vegetotherapy and, especially, affective, assertive and affirmative actings. Character-Analysis Vegetotherapy is a bodily methodology developed by W. Reich and expanded and systemised by Ola Raknes and Federico Navarro (1974). It induces neuro-vegetative phenomena and emotions which constitute true message-expressions of body language, an absolutely essential component for an accurate reading of personological aspects.

The next phase of the methodology is the verbalisation of sensations, emotions and freely produced associations to grasp the essential systemic and relational dynamics. While body language is the most meaningful form of communication that Reichian Analysis makes reference to, it must be viewed in the context of other ways that the patient expresses themselves in the setting: from dreams, slips of the tongue and metaphorical symbols to phantasmal life and liberating fantasies.

In practicing Character-Analytic Vegetotherapy, its function is to investigate the body's psychic and energetic significance through a series of exercises, or 'actings,' which function on the 7 levels.

These specific, progressive actings go over the experiences of psycho-affective development and emotional maturation, reintroducing ontogenetic movements of the evolutionary stages.

However, it is one thing to think of saying ‘no’ to the object of fear and another thing altogether to express it verbally. It is one thing to think of showing our teeth to the object of the fear and another thing altogether to express it ethologically, really exposing it:

“It is the Acting which modifies my Relational Position with the Object, it gives me a new incised mark and increased range of possible relational patterns, as well as an altered energetic state.” Vegetotherapy puts us in contact with incredible resources because it permits an action which is aimed at that specific branch of the tree of fear and at the specific type of fear whether it is of castration or of separation.

All this skill in planning must be set in a Character Analysis of the Relationship - the fourth means. Character Analysis of the Relationship defines the Relational Container, a highly specific arrangement of the analytical-therapeutic relationship and it considers the architecture of the relationship to be the privileged partner. Architecture “which contains” any therapeutic act, from listening to transferral elaboration of a trait and from the interpretation of a dream, of a gesture or of a liberating fantasy to the suggestion of Character-Analysis Vegetotherapy acting, although it could even be the simple prescription of a psychotropic drug. We define the “relational container” as being the appropriate “Position” and the appropriate “Means” of the therapeutic-analyst, which is necessary to establish a counter-transference of trait- bodily level, which is functional for the disturbance and or to the specific structure of the trait / bodily level of the person being analysed. As well as verbal language and bodily language, there is also a meta-language: the language of traits! Placing yourself in the counter-transference position of character trait and of corresponding bodily level, which is useful for the fear on that branch and for the fear of separation or of castration on that branch, is to bring the chest, the neck, the eyes and all of the armament that the analyst has at his disposal, when faced by fear, into the analytical-therapeutic relationship and to counter-transfer them to the relationship itself and to the patient.

The fifth means is the use of psychotropic drugs, including those aimed at the areas of fear of separation and fear of castration, namely anti-depressants for the former and anxiolytics for the fear of castration. There are areas, which we are not able to reach from an analytical position, despite assuming a courage-attack position, using Character Analysis, Character-Analytic Vegetotherapy and a correct counter-transference position.

So to maintain an ‘open project’ and to limit clinical suffering, we also assume responsibility for the use of psychotropic drugs, which are substances that are capable of silencing those areas that have too much reptile-lymbic noise and which impede the dominance of a more adult ego capable of heading towards freedom.

We know that these can mechanically bring a person back up, without going through emotional journeys or facing up to the egoic presences in the chest-neck and eyes. However, this too is a way of moving the dominance of a person to another character trait which is far from the phobic trait and at more evolved stages and higher bodily levels. Therefore, psychotropic drugs are provisional allies in a functional project, which sees the shared involvement of the person in the project and the central basis of the therapeutic relationship as open to any act which will effect a cure.

## BIOGRAPHY

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## REFERENCES

- American Psychiatric Association. (n.d.). *Diagnostic and Statistical Manual of Mental Disorders* (4 ed.). Arlington, VA: American Psychiatric Publishing.
- Baltes P.B., H.W. (1984). *Larco della vita come prospettiva in psicologia evolutiva*. Hillsdale: Herlbaum.
- Capra F. (1982). *Il TAO della fisica*. Milano: Adelphi.
- Capra F. (1984). *Il punto di svolta*. Milano: Feltrinelli.
- Capra F. (1997). *La rete della vita*. Milano: Rizzoli.
- Curtis, G. C., Magee, W. J., Eaton, W. W., Wittchen, H. U., & Kessler, R. C. (1998). Specific fears and phobias. epidemiology and classification. *Br J Psychiatry*, (173): 212-217.
- Darwin, C. (1872). *The expression of the emotions in man and animals*. Torino: Boringhieri.
- De Marchi, L. (1970). *Wilhelm Reich biografia di un'idea*. Milano: SugarCo.
- Ferri, G., Cimini, G. (1992). *Psicopatologia e carattere*. Roma: Anicia.
- Ferri, G., Cimini, G. (1999). Analytical Setting: Time, Relation, and Complexity. *Annals of the New York Academy of Sciences*, (879).
- Heidegger, M. (1927). *Essere e tempo*. Milano: Bocca, 1953.
- Klein, D.F. (1964). Delineation of two drug-responsive anxiety syndromes. *Psychopharmacology*, (1964 - 5): 397-408.
- Navarro, F. (1988). *La somatopsicodinamica*. Pescara: Discobolo.
- Prigogine, I. (1997). *La fine delle certezze*. Torino: Bollati-Boringhieri.
- Prigogine, I., Stengers I. (1981). *La nuova allenza*. Torino: Einaudi.
- Raknes, O. (1972). *Wilhelm Reich e l'ergonomia*. Rome: Astrolabio.
- Raknes O. (1985). Presentation to the 13th Congress of Psychology. Stockholm, 1913. In: Energy, Character and Society.
- Reich, W. (1933). *Character Analysis*. Milan: SugarCo, 1973.
- Reich, W. (1942). *The function of the orgasm*. Milan: SugarCo.
- Reich, W. (1948). *Listen, little man!*. Milan: SugarCo.
- Reich, W. (1949). *Ether, God and Devil*. Milan: SugarCo.
- Reich, W. (1951). *The Murder of Christ*. Milan: SugarCo.
- Semi, A.A. (1990). *Trattato di psicoanalisi*. Milan: R.Cortina.
- Stanley, H.G. (1897). A Study of Fears. *American Journal of Psychology*, 8(2): 147-249.
- Tiezzi, E. (1996). *Fermare il tempo*. Milano: R.Cortina.
- Troisi, A. (1999). Le basi evolucionistiche delle fobie. *Aggiornamenti in psichiatria*, 17(5), 3.

# Forming an Embodied Life: The Difference between Being Bodied and Forming an Embodied Life

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## Abstract

The human's ability to make transitions in its age shapes, socially and personally, produces distress, anxiety, and doubt about how to behave. One response is to become overly reliant on inherited responses. An alternative response is to use voluntary muscular influence and the formative dynamic to manage and resolve cortical emotional organismic dilemmas. The body is an organized environment, a structure of excitatory vitality and experiential knowledge, and a source of the personal and collective wisdom of knowing. Voluntary muscular effort extends this power, making it possible to participate in how we give body to experience and make memories.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** being bodied, being embodied, embodying, Formative Psychology  
voluntary muscular effort

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The bodied life is a life of morphogenesis, a process of continual change of somatic shapes. But being aware of and experiencing our soma and the morphogenesis in a bodied life does not constitute what I call an embodied life.

The body's forming process is at the heart of animate existence. The body changes its shape involuntarily by following an inherited program of development and adaptation. It also changes its anatomical shape by the application of voluntary effort such as learning to walk and talk, read and write. The ability for voluntary effort requires the cooperation of muscle and cortex. The cortex makes and remembers neural maps of muscular activity. The involuntary muscular system in relationship with the cortex allows the development of voluntary muscular effort. Voluntary muscular effort permits the organism to differentiate its inherited behavior. This voluntary effort of differentiation is a gradation of muscle effort and tonus which changes the intent and outcome of inherited acts. The ability to influence muscular tonus and change an inherited pattern of action is the single most important evolutionary step that has changed hominid behavior into human behavior.

The ability to alter programmed behavior is the basis of developing voluntary self management and of creating alternate behaviors to those which are inherited; this ability of cortex and muscle to create novel behavior, experiences that have not existed before, is the difference between having a bodied life and forming a personal embodied life. Voluntary morphogenesis is how the organism learns to influence its inherited behavior and form repeatable memory structures of how it influences, recalls, and forms new expressions. Voluntary morphogenesis uses voluntary muscular effort and creates a personal life field that also has personal meaning and social value and is what I mean by an embodied life.

Living the embodied process depends upon the organism's use of voluntary effort to generate experience and to form memories of the body's relationship with itself. This remembering is an anatomic process which is experienced as "I can do this; I can organize a personal behavior different from my inherited reflex response." Voluntary muscular effort facilitates excitatory patterns and is able to give them body by making new expressions so the organism does not fall into old reflex patterns of response and can organize a personal somatic reality and influence how to be specifically bodily present as needed. This is a continuing education associated with the desire to form an autobiographical formative identity.

Being embodied is a formative process. It is imperative for the organism to develop voluntary motor acts to facilitate forming a personal somatic excitatory life field that rebodies its involuntary and voluntary somatic experiences into behaviors that are not programmed. This asks that, over time, each person endeavor to develop fine motor skills for differentiating reflex motor patterns into new behavioral expressions and relationships that generate and develop the soma's life field and a motoric excitatory emotional cognitive aliveness. Voluntary effort is not mental will power; it is a muscular neural effort that brings about anatomic morphogenesis that bestows experiential awareness of past and present excitatory events and possibilities that can be made part of a personal embodied behavior. Living an embodied life takes voluntary muscular effort which influences inherited somatic behavioral shapes, like reaching, approaching, and withdrawing, which generate motoric sensations, feelings, and cognitive feedback. Voluntary muscular effort mobilizes old muscular memory structures and organizes new acts. Forming helps the organism transcend its inherited life which makes the organism an agent of its own embodied destiny of a personal life.

The forming process has four organizing phases: the motile, mercurial, short-lived phase; the porous, malleable shapes where frail stability appears; the firmer, semi-rigid, reliable, repeatable shapes; and the least changeable, dense, compressed shapes. These involuntary somatic shapes are part of a developmental continuum that can be influenced and differentiated by voluntary effort to organize a semi-rigid, malleable, and focused structure, a pulsatory excitatory muscular synaptic life field of aliveness. By making a commitment to use voluntary muscular effort to give body to our experiences we participate in personalizing the continual morphogenesis of animate existence.

### **The human situation**

#### **Living in the age of the cortex**

By the formative dynamic, I mean the ability of the organism to recognize its experienced motoric gestalts and develop new motor connections and a synaptic world

of created human feelings, thoughts, and memories that becomes part of its personal field of experience. This personal somatic world, called “I”, develops by its rules of organizing actions, is a generator of experience, thought, feeling, and images, and is the narrative of our identity over a lifetime.

As differentiating somatic shapes have come more and more under the influence of the cortex and voluntary muscular effort, the human’s ability to influence its transitions at all ages has created a personal behavioral excitatory life field that is not genetically programmed. The evolutionary upgrade we are living is not how the brain controls the body but how it has brought a voluntary dialogue between muscle, brainstem and the cortex into existence.

The cortex’s ability to respond, image, and reorganize its acting time and the intensity of its excitement toward an intended target and make new connections and memories that can be recalled and edited through the use of voluntary muscular and cortical interaction, transcends the capacity of the brainstem and limbic system. The body, learning to relate to itself and to remember i.e. make anatomic structures with duration, is responsible for creating a human sphere of existing at work, in love and in sexual relationships.

How the organism uses voluntary effort to influence its somatic emotional cognitive transitions throughout every stage of human existence has brought great change to the human condition. We can influence how we behave, feel and relate to ourselves and others. We can disassemble and reassemble the muscular patterns of acting, and learn to influence instinctual or habitual patterns such as fight-flight, confusion, avoidance, helplessness, defeat, or despair. With voluntary muscular cortical effort not only can we reorganize the over-intense structure of fear or anger in many intimate situations, but we can also bring differentiation to the soma’s innate, involuntary pulses of excitement. Using voluntary muscular and cortical effort to influence behavior gives us a personal experience of satisfaction and vitality as we age. Voluntarily embodying our efforts and experience is a continual education that keeps forming new relations and memories throughout the cycle of our bodied existence.

Many people seek help because they can’t manage the experience of themselves in certain life situations. They are either in a somatic shape of helplessness or resignation, or the hyper- alertness of startle and are experiencing a loss of direction or the inability to satisfactorily organize work, a love life, and personal meaning. They may present themselves in a pattern of somatic rigidity accompanied by feelings of isolation, or their somatic structure may be compressed, dense, or hunkered down in despair. Their gestures and expressions are exaggerated, muted, or rotated as if they want to turn away and avoid contact, but are stuck in having to face forward. Inherited patterns of frustration include stiffening, twisting away, and compressing, or becoming porous, diffuse, and seeking to merge. They are accompanied by limited ranges of action and the sensations, images, feelings, and thoughts associated with a restricted or fearful world within themselves. The body’s cortex and its connective tissue vitality have been muted, as has the formative process of rehearsing, dreaming, and imaging possibilities to enact. The experience is an overall loss of optimism and cheerfulness.

When people in such a somatic state make their postural emotional attitudes, expressions, and gestures more vivid through the use of measured voluntary muscular effort, their cortex immediately engages in making a muscular model and a neural map of the act. If the intensified muscular emotional attitude is disassembled in measured

steps to prevent rapid disorganizing and loss of boundaries, the cortex develops its ability for voluntary muscular management. Voluntary motor acts stimulate the cortex to engage in editing the inherited reflex organization and permit different somatic shapes to appear; for example, to be less dense or less rigid, or more rigid and less porous. The repeated practice of voluntary acts influences the established behavioral, emotional, and cognitive organizations and presents modified behavior to practice in real life situations. In this way the organism empowers itself and grows a new identity rooted in the mantra “I can do this.” The formative practice grows a library of new experiences that makes a personal life. This is the formative dynamic that creates the formative life over time.

### **Forming an embodied existence**

Formative Psychology® is a pragmatic approach to daily life. It educates a person about how to use voluntary muscular effort to influence emotional structures, cortical beliefs, and psychological beliefs in order to continually form their adult self in a changing world. Few people realize the significance of the statement “Anatomy is destiny.” Most of us do not realize that our emotional, sexual, and cognitive patterns of behavior depend on the innate pattern of acting which provides the reference for our experiences of behaving. Most of us are not able to grasp the reality that the body acts before it feels or thinks. Being able to inhibit, plan, or carry out an action does not deny that it is built on an innate pattern of response. The impulse to attack, to retreat, or to dispose of comes into play without thought or feeling. Once in play it is almost impossible to inhibit without considerable practice. In fact, there is little or no emotional accompaniment of an action until a certain level of muscular intensity has been reached. Only then will feelings and thoughts of revenge or images of triumph appear. When the innate reflex is enacted with voluntary muscular effort, its muscular pattern can be differentiated or made more semi-porous or less intense. This in turn makes the voluntary influence more rewarding. Voluntary formative effort has its own psychology, its own organizing dynamic and time, for the development of being personally embodied in daily life, which creates a personal somatic emotional cognitive reality.

Formative Psychology's® practice is an experiential approach for managing and differentiating emotionally complex situations in relationships and life transitions. It is of urgent importance to practice voluntary muscular effort in order to more effectively govern one's responses and accumulate motoric memories and their associations throughout the cycle of existence that organizes one's adult life field. People engaged in working with voluntary muscular cortical effort to mobilize patterns of behavior, to go forward with determination, or to mobilize a pattern of withdrawal, for example, can voluntarily mobilize muscular effort to make a muscular model which also organizes a neural map. The model can be voluntarily disassembled with deliberate cortical effort by altering one's anatomy and widening the field of possibilities for voluntary action. This differentiated muscular cortical pattern becomes a new reference for behaving differently. Thus, making a muscular model of an emotional expression teaches the person to use themselves bodily to acquire an experiential knowledge of how to alter the way they act, feel, and think and how to use themselves differently and not be overwhelmed or confused in situations.

Voluntary muscular effort which mimics or intensifies a muscular pattern allows the cortex to help disassemble excessive tension. This adds to the chain of remembered voluntary acts. For example, if squeezing our body is a protective holding pattern, from our voluntary effort we can learn how much we over squeeze and how to make layers of holding that do not inflict harm on or overwhelm ourselves. Voluntary muscular effort helps us learn a personal style of organizing and disorganizing an anatomic emotional cognitive behavior pattern, which helps the organism have a relationship with itself in which it can respond to its creativity and form a personal embodied existence. To use voluntary muscular effort with oneself is to touch one's self, make connections within one's self and develop contact with and knowledge of one's bodily self. While learning to develop voluntary muscular effort over time is the key to influencing our instinctual and habituated behavior, voluntary muscular effort consists of much more than inhibiting or differentiating an action or emotion; voluntary muscular effort also develops degrees of behavioral time frames and layers of somatic shapes which become a thick labyrinth of connections between rich memory structures that function as a fountain of felt satisfactions and wisdom.

### **Conclusion: E-mails with a client**

Dear Stanley,

The bodying exercise is giving me new experiences of a world within me that I feel is a bigger and deeper world than I usually have. When I can assert measured muscular force at the surface of my body, a deep layered nonverbal ocean appears in me that is bigger than me. I realize more and more how voluntary effort makes me alive and other ways to be more personally bodily present in the world as a personalized me that has embodied my experiences. My efforts to give body to my experiences gives me a connection of me and a remembered me. The work with myself forms a field of lively peace and confidence from being able to help myself make a personal me in me even in tiny steps. Living an embodied life takes work, Stanley, but it's better than being victim to storms of emotions and excitement that wash me away.

Many thanks.

Dear A,

We start where we are, and develop, creating our somatic future. Human nature is always organizing its future; this has been a personal truth since we stood upright and began to have a horizon. Sometimes it takes a lifetime to prepare ourselves to be ready to develop or form some aspect of our somatic nature which we live, or continually dream about without knowing it. The body keeps forming and differentiating its basic inherited gifts which the cortex and muscular effort munch on. Each person needs a voluntary practice that fosters muscular cortical interaction to create and give their style of existing body, form. The body is a formative agent, an artist that can, with voluntary muscular effort, grow a personal second adult, which also is a formative agent. We can all be artists growing a personal second adult, even at 75, slowly shifting into forming new acts and perceptions that form a new world. Working with VME forms an inner somatic garden which can meet the adaptation challenges of existing in every age our body lives. That is what it means to live an embodied life grounded in our voluntary efforts.

STANLEY KELEMAN

In the course of living a life we all have the opportunity to form it. However, few of us know how to participate in giving shape to our tissues and the organism's pulsatory organizing waves within us that connect us to the vast ocean of life both in and around us, without losing our personal formed identity. VME is a powerful tool for getting to know the mystery of our excitement, the ebb and flow that helps us live in the waves of our earth's biospheres as well as in the waves of society and family. Voluntary muscular cortical effort connects the organism to its own pulsatory patterns that form its multi-layered life and is the royal road to a kinder, embodied life.

### **BIOGRAPHY**

Stanley Keleman PhDHC is the director of the Center for Energetic Studies in Berkeley California, where he teaches the Formative Approach to human development. Awarded a PhD in Human Letters from Saybrook Graduate School in 2007, he is also the founder and developer of Formative Psychology, the director of research at the Center of Form and Development in Zurich, Switzerland, and a visiting lecturer at the Spectrum School of Humanistic Psychology in London, England. He has authored the pioneering books *Emotional Anatomy*, *Embodying Experience*, *Your Body Speaks its Mind*, *Insults to Form*, *Living Your Dying*, and *Myth and the Body*, in addition to numerous clinical books.

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## Organismic Self-Regulation in Kurt Goldstein's Holistic Approach

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### Abstract

The author presents a brief intellectual biography of Kurt Goldstein which focuses on the concept of organismic self-regulation – the true *leitmotiv* of his entire theorization, beginning from the Frankfurt (1914-1930) and Berlin (1930-1933) periods, across the long period spent in the U.S. (he was one of the first victims of the Nazi persecutions), and up to his death in New York in September 1965. In particular, emphasis is given to the gradual shifting of his thinking from an unmistakably neurophysiological plane, which in *The Organism* leads to the formulation of the “basic biological law”: Equalization toward an “adequate” average level in an “adequate” time – a “law” that seemingly takes us back to Walter Cannon’s homeostatic regulation principle – to a more philosophical, existential, and ontological plane, which underlies the concept of *self-realization*.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** equalization, organismic constants, *individual* norm, self-realization

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One of the “most important, most contradictory, and now most forgotten figures in the history of neurology and psychiatry” (Sacks, 1995, p. 7), Kurt Goldstein (1878-1965) and his work can be thought of as a large city buried under the ashes of time. “The destiny of a buried city”, Ellenberger writes, referring to Janet’s production with the same simile, “is uncertain: it can remain buried forever; it can remain hidden and be sacked by plunderers. But it can also be that it is one day dug up and brought back to life instead” (1970, chapter 6). Goldstein’s poor reception is to be related to the turbulent events that the Old World has experienced over the last century.

I like to define this author as one of the most captivating sons of Weimar’s culture (1919-1933). Anne Harrington, before me, named this intense and productive period of Goldstein’s life “Reason, Courage and the Making of a Weimar Hero” (1966, pp 154-159). Indeed, still today his voice is imbued with echoes of the ultra-millenary tradition that has matured “on the east side” of the Atlantic – a tradition which had its origin in the ancient Greek civilization and was to become an archetypal symbol of fragmentation and dismemberment (the Berlin wall was built in 1961, only four years before his death). Just like Weimar’s culture, in its melancholic wane, he echoes those issues and those debates which took place immediately

before the “catastrophe”. The Kantian heritage, gathered during his studies in Heidelberg and profoundly and repeatedly meditated on in the continual exchange of ideas with his cousin on his mother’s side, Cassirer, glows for the last time with an enchanting and crepuscular light.

By and large, Goldstein is famous for having placed a strong emphasis on the functioning of the organism as a whole. Behavior, he asserted, is never the mere summation of single reactions which can ultimately be traced back to reflexes, but it is the individual’s “performance” that, in relation to his *milieu*, always acts as an organized whole. By virtue of this priority importance assigned to the whole with respect to the parts, he is acknowledged as the father of the holistic approach in biology – a theoretic and methodological orientation which contrasts with the dominant paradigm, then as today, defined as atomistic.

More in particular, the years he spent studying medicine at the University of Breslau, where he specialized in neuroanatomy and neurophysiology, were those that occurred in the middle of what has been defined as “the golden age of the cerebral localizations” (1870-1918). It was in this period that, by means of ablation, electrical and mechanical stimulation experiments, the first mapping of the cortical lobes and circumvolutions was achieved, with the attribution of a specific sensory or motor function to each area. The brain, and presumably mental life, was thus becoming a highly complex machine which functioned according to the principles of linear causality.

Goldstein was born in 1878, and, towards the end of the century, when “we can affirm that the ‘revolutionary’ phase of the studies on the functioning of the nervous system ideally ends” (G. Cimino, 2002, pg. 58), he was studying at university under the protection of Edinger and Wernicke. The holistic theory that he was to elaborate over the following two or three decades deserves special interest for how it chronologically falls into the history of localization neurophysiology. Indeed, to use Kuhn’s terminology (1962), if the years in which he specialized went through the phase that we may call “of *normal science*”, during his later work at the *Institut zur Erforschung der Folgeerscheinungen von Hirnverletzungen* [Institute for Research on the After-Effects of Brain Injuries], which he founded in 1914 in Frankfurt, Goldstein had to deal with the consistent emergence of “abnormalities” and with the consequent proliferation of supplementary theories formulated for explaining them.

“For a while”, he recalled, “it seemed the ideal of a complete brain map was coming closer and closer to realization (Head calls this the era of the ‘diagram makers’). So strong was the suggestion that emanated from these brain maps that most investigators had not the slightest doubt that the research was on the right track. Until one or two decades ago, the tenor of the entire literature was, in general, one of extreme assurance. Of course, more and more cases became known in which the symptomatology could no longer be fitted into these schematic constructions and in which the anatomical facts by no means corresponded to the theoretical premises. However, these difficulties were overcome by special, usually ad hoc explanations, which were presented and received with a surprising lack of critical attitude” (Goldstein, 1939, pp. 203-204)<sup>1</sup>.

His fundamental book, entitled *The Organism* (1939), is imbued with an inexorable *vis polemica* in this respect, to the point that it seems difficult to also make out a *pars construens* that can rearrange the “data” acquired through the research in neuroanatomy of that century. Yet Goldstein does not appear to renounce light-heartedly “any attempt to form a concept of the

<sup>1</sup> Heretofore all quotations from *The Organism* will be reported as (Goldstein, 1939), which is the first English version of *Der Aufbau des Organismus* (Goldstein, 1934), though the pages will be referred to the last, more recent publication (see in bibliography Goldstein, 1995).

differential significance of the various parts of the brain for different psychological functions. The differences of symptoms, when the lesions are localized in different places”, he writes, “are much too convincing” (p. 204). It is therefore interesting to notice the provocative role played by his figure in relating to tradition and to contemporary neurology, always moving between continuity and distance, between conservation and revolution, or to the desperate search for an impossible synthesis between the two. For the history of neuroscience, all this can represent a subject to be expanded elsewhere.

Intuitively, I read into this “provocation” a re-emerging of that philosophical trend that has always accompanied the course of his scientific research (Goldstein, 1959, p. 5). In 1934, when he wrote the very first draft of *Der Aufbau des Organismus* in German, he was in exile in Amsterdam, fleeing as a Jew from Nazi Germany and awaiting a visa for the U.S. Novalis’s words come to mind: “philosophy is after all nostalgia; it is the desire to feel at home anywhere” (Fragmente, 24). From It. trans., 1976, pg. 41). From this moment on, he was to return sentimentally to the bedside of his homeland – a Germany that was falling into the abyss of World War II – only through Kant, Heidegger, Goethe.

Marianne Simmel (1968) reports that Goldstein never felt completely rooted in the United States; he never again felt at home. Regardless of the fact that he had become an American citizen in 1940, “His comment on news of victories [of the Allies] was typically: ‘Das haben die Amerikaner doch eben grossartig gemacht’<sup>2</sup>. Not once”, she adds, “did I hear him say ‘we’ in this connection. He always felt a stranger among friendly natives. He was grateful to the country where he and so many others had found asylum first, and then a new home – but it was still a home in exile” (p. 9).

During the years of exile in the U.S., the purely “experimental” tone in *The Organism* that characterizes the rigorous close observation of the “data”, withdraws to the background and leaves room for psychotherapy practice and a “phenomenological” reflection on behaviour, on life-experience, and on the concrete experiences of human beings, whose ultimate goal can be identified in the tendency towards self-realization. Goldstein’s reflection, moreover, reconfirms that basic concept, postulated in *The Organism*, of isomorphism between biological knowledge and biological existence, retraces the contrast between his own “biological” point of view and the physicalist view of the world, and eventually presents a theory of knowledge that is articulated around the dialectic pair, *The Holistic Approach and the Analytic Method in Science* (1940, pp. 1-33)<sup>3</sup>.

The levels of Goldstein’s theory are multiple: from methodology – the true generative moment of the entire argumentation – to theoretics, and from here to epistemology and further on to actually speaking of ontology; all this without ever renouncing situating his theory within the framework of reference of *biological science* (1939, pp. 313, 409). Obviously, in the meantime, the scope of biology as a science expands to the point of resembling a “paradigm”, of a *Weltanschauung* - a vision of the world. Goldstein’s epistemological problem was never to be dealt with in a systematic manner (Goldstein, 1951). Perhaps it should have been dealt with in his last work, *From anatomy to philosophy: Late and early writings in the holistic approach*, but this project was never accomplished (Harrington, 1996, pp. 171-172, 261 note 146). The author often mentions Rubin’s famous image, which may appear as a white vase on a black background or as two black profiles on a bright background (Goldstein, 1939, pg. 125; 1940, pp. 19-21).

<sup>2</sup> So the Americans have ultimately, magnificently made it.

<sup>3</sup> An important achievement during the U.S. period consists in the construction of the famous *Goldstein-Scheerer Tests of Abstract and Concrete Thinking* (Goldstein e Scheerer, 1941, 1945).

He uses the image quite freely; he first of all applies it to the “figure” of excitement within the nervous system, simultaneously to any “performance”, but he later extends its application to the aforementioned various levels.

In the disapproval of localization, for example, such an unconventional use of the figure-background leads to conclusions that are as enigmatic as the perceptive effect of the image we are discussing: we do not know whether to believe that it is a vase or two profiles. “Our view”, he writes, “does not deny, by any means, the special significance of specific structure... Indeed, the organism consists of qualitatively different structures... But the specificity itself arises within the functional pattern of the whole to which each part, by functioning, contributes a very specific qualitative tonality” (1939, pg. 216). Here is a small work of art: the art of giving with one hand and taking with the other. In other words, granted that our science must move forward and that it can only do so in an atomistic way, let us thus move forward; however, everything that can be discovered operating this way is fictitious, unnatural, and unreal. It is only by contextualizing the various phenomena within the global process of the organism that we may correctly evaluate the relative contribution which each cortical structure supplies to the performance in progress.

From a theoretical stand point, the alternation of analytical-holistic knowledge works, minute by minute, according to the same formal organization principle figure-background. The reader eventually feels that Goldstein captured a dualistic vision, at least as regards theory, with each of the two complementary terms always present as *background* also in the other, holistic or analytical, cognitive process, which at a given time emerges as *figure*.

Among the authors Goldstein mentions in *The Organism* (pg. 281) there is Walter Cannon (1871-1945), physiologist from Harvard, who formulated during the 20's the concept of “emergency reaction” of the organism or *sympathetic arousal* - a preparation for an attack or an escape (fight or flight response), and who in 1932 published *The Wisdom of the Body* (New York, W. W. Norton), in which he presented the “homeostasis” concept, namely, the tendency towards the *self-regulation* of the organism (maintenance of steady blood pressure, body temperature, blood-glycaemia levels, etc.). Postulating the principle of “Equalization toward an ‘adequate’ average level in an ‘adequate’ time: a basic biological law” (1939, pp. 104-105), Goldstein's theory presents in this regard significant analogies with the aforementioned homeostatic conception of organismic functioning.

The tendency towards *preferred behavior*<sup>4</sup>, towards a suitable regulation of the *organismic constants* (which for Goldstein too are the respective average levels in the various physiological indexes: muscle tone, blood pressure, pH, and glucose concentration in the blood stream, etc.) and, through this, towards *Self-realization*, is what distinguishes the functioning of living creatures from physical processes of inorganic matter.

And in case of brain injury or severe damage to the body, the organism reacts globally; it reorganizes the average levels of the constants with extraordinary plasticity, and does its best to restore its performance and behavior. Through practically automatic modalities which were completely unknown to the subjects themselves, the behavior of Goldstein's patients carried on according to a mysterious holistic principle of organismic self-regulation. During his work alongside the psychologist of the Gestalt, Adhémar Gelb, at the *Institut* in Frankfurt, on the rehabilitation of the brain-injured soldiers who returned from the war front, he realized that *the symptoms are not the direct consequence of the brain damage, but are the responses of the whole*

<sup>4</sup>In order to interpret correctly the meaning of this “preferential” characteristic, shown by the behavior of an organism, see Goldstein, 1939, pp. 265 ff.; and 1940, where the author writes: “this term [preferred behavior] does not imply any conscious awareness or choice of a special way of performing” (p. 174).

*organism to the change that took place after the damage itself.* “Recovery is a newly achieved state of ordered functioning, that is, responsiveness, hinging on a specifically formed relationship between preserved and impaired performances... in the direction of a new *individual norm*, of new constancy and adequacy” (pg. 334).

However, at least to some extent, the “constants” are unpredictable, if it is true that in the laboratory they “are reached at the expense of performances very essential for the organism. The constant determined in this manner is certainly not the one that corresponds to the natural conditions” (pg. 281). But, how can we then distinguish what is “essential” and “natural” from what is not? The criterion appears about twenty pages further on (pg. 305): “The constants themselves”, Goldstein asserts, “are still somewhat equivocal because they are also obtained by an isolating procedure<sup>5</sup>. After all, the method of determining constants depends on a formal criterion: the ordered condition in other parts of the organism, whenever a genuine preferred behaviour occurs in one field”<sup>6</sup>. And yet, this ordered condition is to be exposed to the experience of “catastrophe”, which is, in disease, “shock and danger for existence” (pg. 328), but also a normal phase of healthy life, a dynamic principle and an inherent element of the evolution process (pp. 392-393).

Although the idea of organismic self-regulation remains central in all the literature of the following period, the reflection on the constants and on preferred behaviour soon arrives at a dead end. In *Human Nature*, Goldstein goes as far as envisioning a possible factorial analysis to identify the constants and to formalize their correlations. But every case is unrepeatable, he keeps telling himself; and indeed his approach always privileged the study of the single case (cfr. *ibid.*, pp. 41-42). As a matter of fact, in everyday life the “real” constants set in only in accordance with the individual norm, which in turn is determined by the condition of the whole organism in its coming to terms with the world. Thus, once again, every typology is rejected, and any definite pronouncement on the structure of personality (1940, Chapter 7) is postponed to an indefinite time.

His holistic concept of self-realization must have seemed to him sufficiently general to discourage any attempt to elevate and hypostatize a particular constellation of personality factors, be they the drives and the psychic structures of psychoanalysis, the various motivation principles of other theories, or the functional specificity of cortical areas or lobes. It is certainly a sufficiently general concept, but also, I wish to add, far too generic. As early as in *The Organism*, constants appear everywhere: physiological, behavioral, affective, constants regarding the sensory and motor threshold, intellectual characteristics, constants as expression of the essential nature of the species and of the individual organism under consideration, time constants in the temporal and rhythmic course of processes and so on (Goldstein, 1939, pp. 282-283).

Moreover, the term “equalization” brings to mind the processes of energetic nature. As the history of psychoanalytical ideas has shown, however, the energy metaphor has always proven to be, in psychology, of little use for explaining the meaning of human behavior (Klein, 1976). It

<sup>5</sup>Goldstein uses various synonyms to designate the “analytic” or “atomistic” method or procedure in scientific research. To be found among these are the terms “anatomizing” or “dissecting”, or also “isolating” (1939, pp. 69, 398, note 27).

<sup>6</sup>Another one of Goldstein’s peculiar concepts is the “field of performance” (1939, p. 34). His point of view may be considered ecological, because it tends to substitute the term “function” with “performance”, the latter having to do with the actualization of the essential nature of an organism according with and in relation to its environment or milieu: “The performances of the organism correspond to these constants. It would be better not to speak here of functions. The term ‘function’ may be better reserved for the formal structure of the activity, while ‘performance’ means the concrete action in which the organism actualizes itself. Goethe spoke in this connection of ‘*Dasein in Tätigkeit*’ (‘Being in actuality’)” (*ibid.*, p. 282).

can, indeed, be traced back to the universe of the discursive procedure of physics rather than to the experiences of patients. The latter have always to do with the concrete behavior, performances and feelings, and with the abstract attitude that frames all that in symbolic systems. In *The Organism*, for each specific organism in every given situation, the concept of equalization toward an adequate average level in an adequate time is matched with a constellation of concepts: “the tendency toward the preferred situation corresponds to the equalization process” (pg. 281), to the maintenance of the average levels of the constants, to the execution of an “ordered” behavior, to the adequacy of “coming to terms” with the world<sup>7</sup>; it furthermore corresponds to a performance which is “the best” to actualize all potentialities, the essential nature, of an organism; and, eventually, it is associated with feelings of well-being and safety.

Equalization, for each given organism, is always determined by the total situation which includes the individual’s performance and its environment. From a phenomenological viewpoint the unit of investigation is the “performance” (or “performance field”), namely “a *coming to terms* of the organism with environmental stimuli” (pg. 42, my italics). In defining performance as a “coming to terms”, it is obvious that the organism as a whole is always called into question.

The nervous system is a network that never rests and always functions as a whole, un apparatus well-differentiated from an anatomical point of view but extremely dynamic and flexible in functional and adaptive terms. Within this system, “the total excitation pattern is not confined to a definite anatomical structure but represents a definite excitation Gestalt that can utilize, for its course, any available structure [...] The performance is based not on the activity of certain mechanisms but on certain potentialities of the organism that realize themselves by utilization of all sorts of substitute means when the ‘normal’ means are out of order” (pg. 187).

Goldstein’s theory suggests a neurophysiology of performances, understood as holistic processes whose common denominator consists in the goal of the individual “coming to terms” with the world and so attaining Self-realization. The author shows, through examples of laboratory experiments, *the relative independence of the performances from the functioning of a specific locality to which “normally” they are related*. Thus, for example, in the *sequelae of amputation* after awakening from anesthesia, the operated animals learned immediately to bring on the “right” movements and so to accomplish the performance which the situation required (pp. 188-190).

The original German term *Selbstverwirklichung* has been translated into the English self-realization. We must, however, bear in mind that this term “means nothing but *the realization of all capacities of the organism in a harmonious way so that the ‘existence’ of the organism is guaranteed*. Indeed, the term fits the human organism fully only after the development of the ‘self’. When we use it in relation to the infant who has not yet a ‘self’ or to animals, where we cannot speak of a self at all, we do it because the essential meaning of the term is related to the unitary character of what we call a living being, which in the human being manifests itself in the experience of ‘the self’. To avoid misunderstanding I shall use the phrase realization of the particular nature, instead of self-realization, when we are not dealing with adult human beings” (Goldstein, 1957, pp. 179-180).

<sup>7</sup> In his controversy with Benussi, Koffka spoke of “the concept of ‘biologically adequate’ stimulation, which he had probably encountered in the writings of Frankfurt neurologist Ludwig Edinger” (Ash, 1998, p. 143). The meaning of “stimulus” was thus redefined on the basis of the functional relationship between the latter and the organism. In Goldstein, the biological framework of reference expands, and what is ultimately meant by “adequacy” is a condition of “reality”. The world is “real” only if the subject is in an “adequate” relationship with it, only to the extent that both the stimulus and the reaction “correspond to the nature of the organism” (1939, pp. 310-312).

<sup>8</sup> Cfr. *The Organism*, pp. 61-62: development of a so-called pseudo-fovea in patients with injuries to the calcarine cortex and with functional impairment of one half of the retina.

Therefore, the meaning of this “self”, which, based on what has been stated, would lead us to think of the “self” of the academic psychology, is actually traceable to the concept of “nature” according to Goldstein – a concept which is not very scientific, mystifying and can ultimately be defined as “romantic”. For example, readers may be left with a doubt as to whether the person who is writing is a scientist or a mystic when in *The Organism* they read: “... the organism is a Being enduring in time, or if we may say so, in eternal time; for it does not commence with procreation, certainly not with birth, and does not end with death [...] ‘birth’ and ‘death’ are merely certain landmarks like others, for example, like puberty and menopause. Their real *nature* is yet to be determined” (1939, pg. 387, my italics).

All living things share the same destiny: their potentialities are driven to actualize themselves. The tendency towards self-realization shall be considered the only true *basic drive* (fundamental ambition or motivation) not only in human beings but also in all living organisms. In the wake of criticism expressed towards the psychological doctrine, however, Goldstein hardly ever mentions this in the usual psychological terms, but rather in biological, philosophico-existential, and even ontological terms. So, ultimately, his Holistic Biology almost magically seems to us transformed into Philosophy of Existence. Ash (1998, p. 281) too notices this expansion of perspective: “Though he spoke of a ‘mean point’ to which excitations or behaviour strive to return, not mere survival, and certainly not only the ordered equilibrium of a visual field<sup>8</sup>, but the integrity of a biological individual was at stake”.

Humanistic psychology, the third force of American psychology, between psychoanalysis and behaviourism, will draw abundantly from Goldstein’s theoretic repertoire: from self-realization to communion, from sphere of immediacy to that idea of “awareness” upon which I would like to dwell. Goldstein identifies the primary nature of the mental dimension in the experience of “awareness”. As often happens in his writings, a phenomenon which is usually characterized in psychological terms is demoted to the biological category. In *The Organism* he had already focused on the subject of the contrast between *life and mind* [Leben und Geist] (pp. 353-363), and had concluded that the problem of the mind should officially be part of the

<sup>8</sup>A biological conception of the mind is today supported by Gerald Edelman, which Oliver Sacks, in his 1995 *Foreword to The Organism*, considers Goldstein’s true heir. The application of the Darwinian “population thinking” (Edelman, 2004, chapter 4) to the immune system earned Edelman a Nobel Prize in 1972. Since then, the author has focused on the further extension of this line of thought and has elaborated what he himself has defined as the *Theory of the Neural Group Selection* (TNGS), better known as *Neural Darwinism*.

“The global theory that Goldstein and Lashley and the Gestalists sought”, comments Sacks, “may now have emerged in Edelman’s theory of neural Darwinism and his concept of the brain as a sort of society, in which every part is dynamically connected, “in converse”, by a process of re-entrant signaling, with every other” (Sacks, 1995, pp. 13-14). The analogies between the two theories are many and I would like to list just a few. To begin with, like Goldstein, Edelman (1992, chapter 2) claims that the mind should be reintegrated in nature. Secondly, we can see the broadened vision of biology and the corresponding attempt to elevate this sector of knowledge to a major scientific subject and to the main element of comparison for the system of unified knowledge. In this direction, Edelman foresees a progressive integration between biology and psychology to eventually arrive at the foundation of a subject field, which he refers to as sciences of recognition (evolutionism, immunology, neuroscience). Lastly, it is worth mentioning that both authors share a monistic approach to the mind-body issue, and claim that such an approach may be successful only if it is based on biological knowledge.

However, in the place of the organism, seen as a whole, Edelman places the concept of “evolutionary morphology” or “dynamic morphology” as main axis of all his theorization. In order to simplify as much as possible, we may say that, for him, evolutionary morphology alone determines in the human species, by *natural selection* (interorganismic) and *somatic selection* (intraorganismic: initial, experiential and by “re-entry” connections between neuron group maps), the progressive epigenetic appearance of value-category associations, of perceptive categorizations, of a *primary consciousness* and, thanks to the development of language, of a *higher-order consciousness*. There is no room for any Cartesian dualism. The hypothesis of the *res cogitans* is unacceptable for the author. The dynamic morphology is the Mind. Everything else is mere speculation.

field of biology. Based on how he was re-elaborating and expanding the epistemic range of his subject, the apparent dualism would have been recomposed in a unitary manner on the area of biological knowledge<sup>9</sup>.

In his famous article *The Smiling of the Infant*, the author questions himself on the inner experiences of the fetus and hypothesizes that even at such an early stage, experience of psychological nature is present. “The observation of the first smiling”, he writes, “has taught us that even very early ordered behaviour seems to be accompanied by a psychic experience, the experience of well-being which accompanies the condition of ‘adequacy’. We believe that it may not be too far-fetched to attribute even to the *embryonic life some psychic experiences*, something akin to the feeling of well-being in ‘order’ and of anxiety in ‘disorder’. I feel justified in doing this particularly since it renders unnecessary the assumption of conscious experiences in the proper sense of the word, which we certainly cannot assume to exist in the embryo” (1957, pg. 182).

We thus see that, in this manner, conscience is bypassed to re-found psychism as a whole on the terrain of “awareness” of the “inner states, moods, feelings etc., which do not originate in a definite stage of development and are not related to a definite activity of the organism. They are characteristic properties of all organismic life, psychic phenomena belonging to the various ways of the coming-to-terms of the organism with the various demands it is exposed to. In the ordered, adequate form of organismic life, this [coming to terms] is accompanied by the feeling of well-being; in the disordered, by anxiety, whether it occurs in the mature organism or in the fetus” (ibid., pp. 182-183). It is clear that the author here refers to an organismic “awareness”, to a subjective feeling of being, of being present and reactive before the stimulating universe.

His collaborator and disciple, Fritz Pearls (1893-1970) – founder of the Gestalt Therapy – spoke of “awareness” as one of the inherent properties of life which is present even in a cellular protoplasmic stage (Pearls, 1970, chapter 3). And, if all that is vital, claims an ontology and an epistemology that cannot be reduced to the paradigm of physics, then this awareness must contemplate the experience of death as well. In discussing the finality shown by living organisms, Goldstein declares to accept the designation “definite end”, meaning “actualization of one’s own essence” (Goldstein, 1939, pg. 324). The word “end”, which is used to summarize the *innere Zweckmässigkeit* [internal aim] of the third Kantian *Kritik der Urteilschraft*, means both purpose (intention, desired result) and extinction (cessation, death). From the agglutination of these two semantic areas emerges the existentialist character of Goldstein’s approach in thematizing, in the area of biology, the connection between individual freedom and mortal destiny. The only thing left to support the man is a sort of “faith” – an attitude of absolute devotion to life, which allows all human beings to transform the traumatic impact of reality “into admiration for nature and veneration for its benignity” (pg. 393).

## BIOGRAPHY

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## REFERENCES

- Ash, M.G. (1998). *Gestalt Psychology in German Culture, 1890-1967*. Cambridge, England: Cambridge University Press.
- Cimino, G. (2002). *Elementi di storia delle neuroscienze*, Edizioni Psicologia, Roma.
- Ellenberger, H. F. (1970). *The Discovery of the Unconscious*. New York, NY: Basic Books.
- Edelman, G. M. (1992). *Bright Air, Brilliant Fire – On the Matter of the Mind*. New York, NY: Basic Books.
- Edelman, G. M. (2004). *Wider than the Sky: The Phenomenal Gift of Consciousness*. New Haven, CT: Yale University Press.
- Goldstein, K. (1934). *Der Aufbau des Organismus. Einführung in die Biologie unter besonderer Berücksichtigung der Erfahrungen am kranken Menschen*. Haag: Martinus Nijhoff.
- Goldstein, K. (1939). *The Organism: A Holistic Approach to Biology derived from Pathological Data in Man*; with a foreword by K. S. Lashley, New York, NY: American Book Co.
- Goldstein, K. (1940). *Human Nature in the Light of Psychopathology*. Cambridge, Massachusetts: Harvard University Press.
- Goldstein, K. and Scheerer, M. (1941). Abstract and concrete behavior: an experimental study with special tests. *Psychological Monograph*, 53(2).
- Goldstein, K. and Scheerer, M. (1945). *The Goldstein-Scheerer Tests of Abstract and Concrete Thinking*. New York, NY: The Psychological Corporation.
- Goldstein, K. (1951). *Remarques sur le problème épistémologique de la biologie*. Translated by S. e G. Canguilhem. *Actes du congrès international du philosophie scientifique, 1949, Vol. I. Epistémologie*. Paris, 1951, Herman, pp. 141-143.
- Goldstein, K. (1957). The smiling of the infant and the problem of understanding the 'other'. *Journal of Psychology*, 44: 175-191.
- Goldstein, K. (1959). Notes on the development of my concepts. *Journal of Individual Psychology*, 15: 5-14.
- Goldstein, K. (1995). *The Organism: A Holistic Approach to Biology derived from Pathological Data in Man*. New York, NY: Zone Books.
- Harrington, A. (1996). *Reenchanted Science – Holism in German Culture from Wilhelm II to Hitler*. Princeton, NJ: Princeton University Press.
- Klein, G. S. (1976). *Psychoanalytic Theory: An Exploration of Essentials*. New York, NY: International Universities Press.
- Kuhn, T. S. (1962). *The Structure of Scientific Revolutions*. Chicago, IL: The University of Chicago Press.
- Novalis, F. H. (1976). *Fragmente*.
- Pearls, F. (1970). *The Gestalt Approach & Eye Witness to Therapy*. Palo Alto, CA: Science and Behavior Books.
- Sacks, O. (1995). Foreword. In K. Goldstein, *The Organism* (pp. 7-14). New York, NY: Zone Books.
- Simmel, M. L. (1968). *The reach of mind: Essays in memory of Kurt Goldstein*. New York, NY: Springer.

# When the Therapist is Aroused: Sexual Feelings in the Therapy Room

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## Abstract

This article focuses on the therapist's self-regulatory skills as vital to the process of addressing sexual feelings as part of psychotherapeutic interaction. How do we support ourselves as psychotherapists in containing and exploring sexual feelings, impulses and thought patterns while staying within the ethical boundaries of a psychotherapeutic relationship? Psychomotor exercises with precise individual dosing are described to support containment of sexual arousal. Training in gender skills through psychomotor awareness is a pathway to replacing old automatic, defensive strategies with containment and coping anchored in the present.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** sexual feelings, therapist's self regulation, psychomotor skills

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## Sexual feelings in the therapy room

How do we react if our client is sexually attracted to us and we sense a sexual reaction in our own body? What if our client, or we ourselves, romanticize the connection between us with a subconscious sexual subtext? Or if we listen to a story of sexual abuse and our body responds sexually – perhaps with sadistic or masochistic impulses – at the same time as we feel disgusted by the story? In my experience as a psychotherapist all of the above will sooner or later find their way to the therapy room. As I have met them, I have searched for tools to help me handle these situations, while working to establish a system of norms around 'healthy coping' with sexuality. In a culture where the trend is either exaggerated sexualizing of contact or the absence of sexuality in the contact field, I see the above as a substantial collective challenge, which becomes even more important to address as a psychotherapist, as we become role models for 'healthy coping'.

## The ethical boundary

It is my standpoint – in accordance with the ethical rules of The Danish Psychotherapist Association – that any sexual acting out between therapist and client is incompatible with

therapy. Upholding this principle, as well as promptly reacting if we find the necessary boundary disrespected by ourselves or colleagues, is crucial. But how do we manage sexuality within this ethical boundary? One solution is for the therapist to avoid or deny his/her own sexual feelings in the therapy room. This will lead to a lowered, or even a lack of, sensitivity towards sexual feelings as part of interaction with the client. Another more functional solution is for us to sense and contain our own sexual feelings, impulses and thought patterns, and find ways to use this emerging information constructively in the therapeutic process, viewing it as part of the therapist's counter transference.

## Gender skills

Coming from the Bodydynamic tradition some years back, I initiated the development of an approach called 'gender skills'. We were a group of colleagues exploring which psychomotor skills support our sense of gender identity, gender role identity, containment of sexual feelings and manifestation of sexuality.

To me this became an important element of how I personally dealt with sexuality and, consequently, my development as a therapist. Working with basic skills that are represented in the muscle system supports a sense of "healthy coping". No matter what our history is with regard to sexuality, there is a psychomotor potential within our body, and when focusing on precise dosing of muscle activation it becomes possible to use this knowledge to help create new imprints. In my opinion, dealing directly with traumatic imprints accounts for only a small part of the psychotherapeutic healing process. The biggest challenge lies in how we access new neural networks to replace old automated survival strategies with containment and coping anchored in the present. Phenomena that might prove interesting to investigate with regard to sexuality may include concrete body sensations, emotional states, arousal states and thought patterns. Typically, if the ability to contain the energy of sexuality is lowered, either through "giving up" or "controlling" in the muscles<sup>1</sup>, we step into automated coping strategies and lose access to curious exploration. Locked patterns can take different forms – such as overwhelm ("I get overwhelmed and defensive when I feel sexual arousal in the therapy room"), avoidance ("I almost never feel sexually aroused in the therapy room") or over-identification/sexualization ("I get a kick out of sexuality emerging in the therapy room. I want it to continue – for me"). Examining locked patterns is as interesting and meaningful as examining the underlying emotional states, but this examination requires an adequate containment capacity.

## Containing sexual arousal

In my view, containment of increased arousal is the key skill for "healthy coping". If we are able to contain the energy of the arousal – when it is faint and somewhat diffuse, when it is full of life, and when it is characterized by high arousal – it offers the potential to:

- Curiously observe and examine the phenomena
- Either name these phenomena internally or express them in the contact field with the client
- Reflect on them
- And consciously choose how to relate to them

<sup>1</sup> Patterns of "giving up" or "control" in the muscles are called hypo- and hyper-response in the Bodydynamic tradition. Both types of muscle response are seen as defense mechanisms or coping strategies, which help us to manage feelings and impulses that are not available consciously to contain and own - in contact with a given context. Bentzen, Bernhardt & Isaacs 1997 and Brantbjerg, 2005, 2007 and 2008.

The following body exercises can support the ability to contain sexual arousal and are useful in the therapy room, either to support the therapist without the direct involvement of the client, or as part of the exchange between therapist and client.<sup>2</sup>

### Exercise 1

Sit on a chair with both feet connected to the floor. Feel your sitting bones and do small circular movements with them. Feel how the circular movement also activates the area around your physical balance point right in front of the 4th and 5th lumbar vertebrae. Make the circular movements smaller until you simply come to rest on the sitting bones. Feel how your weight meets the chair and the floor and how the chair and floor come up to meet your buttocks and feet. (This exercise helps us contact the skills of centering and grounding). Lightly push your feet into the floor. This push triggers an upward movement through the whole body. You can push with the outside of the feet, the whole foot and the inside of the feet. Try all three versions to explore your personal sensory experience. Pushing with the inside of the feet activates muscles on the inside of your legs, pelvic floor and connective tissue all the way up the front of the spine. This activation will energize areas of the body that are central to the containment of sexual arousal (and other emotions) and supports a body positioning that support sensing your gender. Pushing with the outside of your feet activates muscles on the outside of your legs and further up along your back. This activation will potentially support skills such as boundaries and how you carry and position yourself. Both sets of skills may support the ability to contain sexual arousal. Be aware of dosing when doing these exercises – they can all be done with more or less power, fast or slow, briefly or for longer periods of time. Precise dosing may make the difference between an exercise being effective or not.

### Exercise 2

Sit on a chair with both feet to the floor. Place your palms on the inside of your knees and let your hands/arms offer resistance to your legs pushing inwards. Feel how your inner thigh muscles and pelvic floor and perhaps your lower abdominal muscles are activated. This movement gathers energy in your centre and your genitals. For some people, pushing with the feet works best, while for others pushing with the knees works best. Boundaries can also be supported by placing your hands on the outside of your knees, pushing the knees outward while arms/hands offer resistance.

These simple exercises support me in maintaining a sense of contact with and containment of my sexuality, in my life in general and particularly in my work. My favorite is to lightly push the insides of my feet into the floor. The movement triggers sensory contact with my pelvis and my genitals, supporting a sense of carrying and owning my sexual energy in a centered way. In the therapy room I use the exercises to support my presence. I can do that without bringing attention to it in the explicit contact field, or I can do it while teaching the skill to my client, telling them what helps me manage the sexuality I sense in the room. For me, this muscle activation supports a healthy I-you boundary, while simultaneously acknowledging the presence of sexuality. The inner thigh muscles, pelvis, abdominal and hip muscles, and the iliacus muscle that 'coats' the inside of the pelvis are the primary muscle groups that support containment of sexual arousal. Awareness of this body container may be

<sup>2</sup> Body exercises will always touch upon both a basic psychosocial potential and upon biographical experience associated with the potential. The intention behind the instruction may define whether the exercises will promote a sense of resource or if regressive material is activated.

supported in various ways, yet what feels supportive is very individual depending on which muscles are characterized by control or giving up.

### Exercise 3

Activating the abdomen, pelvic floor and inner thighs supports sensing a muscular container for sexual arousal to be held in. The transversus abdominis plays a key part in establishing a physical container for sexual arousal. To establish awareness of this muscle, kneel on all fours and let your belly relax fully. Activate the muscle by imagining 'sucking in' the navel slowly, or think of contracting horizontal muscle fibers reaching all the way down to the lowest part of the stomach. Repeat this a few of times. Contract/gather your stomach, hold the activation while breathing in and out, and then slowly let it go. Stand or sit and repeat the movement of activating/gathering your stomach muscles. Remember dosing. The activation can be very slight and still be effective. Sometimes it is only effective when done very gently. The pelvic floor and the horizontal abdominal muscles work together and are often activated together. You may enhance the connection to the pelvic floor by slightly pulling your legs together while activating the abdominal muscle. Stay connected to your breath. 'Gathering' your stomach is about strengthening the sense of a physical container. It is not about holding your breath or creating a space you cannot breathe in.

For me, contact with the horizontal abdominal muscle in the lower abdomen in particular has been an important part of establishing a safe physical container for my sexuality. Knowing that I have a muscular container for sexual energy to be built and contained in, provides safety and enables me to be curious and open in my contact with clients about sexuality.

### Exercise 4

The iliacus muscle that 'coats' the inside surface of the pelvic bones directs movement of the pelvis back and forth, making it key for the positioning of the pelvis. With this pelvic tilt we can decide whether to move our genitals forward or pull them back. This is part of regulating visibility and the sensing of sexuality in a contact field. Stand with your feet shoulder width apart and move your ankle joints and knees, slightly bending the knees. Slowly move your pelvis back and forth and experiment with the extent of the movement. Examine how you feel about positioning your pelvis. Do you have a habitual position? Do other positions offer new options for the sensing and containing of sexuality? Do you sense activity in the muscle?

Simultaneously bring your attention to the front surface of your sacrum, which is also part of the internal pelvic space. Start by bringing attention to your tailbone perhaps by touching it to get a sense of location then sense the difference between moving your attention up the back of the sacrum and up the front of your sacrum. Are you able to find a pelvic tilt that supports the sensing and containment of your sexuality?

These exercises can be combined so you sense the abdominal and pelvic floor activation while working with the pelvic tilt. The possibilities for exploration are endless, and individual selection and dosing are crucial as to whether this type of exercise will build personal resources or not. For me, as I described in relation to exercise 3, sensing an internal pelvic space optimizes my sense of safety regarding sexuality. Pelvic movement can also ignite sexuality leading to a heightened arousal level. If my sexual energy is already awake, and it is more about being present with it, sensing the internal muscular space that supports this presence is important. The experience of sexual arousal can simply be there in a contained form, which offers me time and space to include it as part of the phenomena I observe in the contact field with the client. I can include it as part of the explicit therapeutic exploration, or if I

choose, I can merely contain it inside myself, thereby allowing it to be part of the counter transference phenomena I do not verbalize.<sup>3</sup>

### **New skills – new possibilities**

The aforementioned exercises all focus on supporting containment of sexual energy by activating specific muscle groups or muscles. The exercises thereby train the ability to self-regulate in relation to sexual arousal.<sup>4</sup> There are no body exercises that provide access to a resourceful experience for everybody - it takes active selection and precise dosing to seek out what will optimize our unique presence and our ability to contain and self regulate.

Activating psychomotor skills will always directly touch into two layers of consciousness. One is the original potential connected to the muscles being activated. The other is our individual history linked to this potential. Thus, these exercises hold the ability to provide access to both new potential and also call on biographical material. If the exercises are performed with no attention to dosing, they might even prove to be re-traumatizing because of their ability to precisely touch into implicit memory. This is my reason for focusing on individual dosing and selection. The examples above are a small selection from a wide repertoire. My key intention behind this article is to communicate part of my personal experience with containing sexual arousal in the role of therapist and generalize it so it can hopefully become useful to other psychotherapists.

### **Self regulating skills**

Ideally, self-regulation starts in a state in early childhood, when contact with ‘adequate’ caretakers helps us regulate our emotional states and subsequently to develop skills that make self regulation possible. According to attachment theory, seeking out help to regulate emotional states will continue to be triggered in stressful and anxiety provoking situations. This mechanism follows us our whole life. The difference is in how quickly we are able to shift into accessing self regulation skills. From this perspective the therapist’s self regulating skills are vital. If I am able to regulate my own emotional arousal when sexuality is brought up in the therapy room explicitly or implicitly, I am able to offer the client a contact that will help him/her through the transition from care seeking to the ability to self regulate and explore.

### **The challenge of examining our own sexuality**

I know it is sensitive to work with sexuality, and perhaps even more so when the vehicle is sensory awareness in the body. From personal experience I know how much vulnerability and shame can be associated with acknowledging and owning the parts of your relationship to sexuality that are not fully functional and age appropriate, that did not grow into a full-fledged adult sexuality, and that did not find functional boundaries, but are characterized by either trauma or patterns from personality development. Perhaps it is even more shameful when you are a psychotherapist and are supposed to be able to help others regulate their emotional states.

It may be challenging to take a closer look at behavior that covers up, hides or protects low resourced aspects of ourselves, a tendency that can also lead us to remaining isolated and blind to the fact that our struggles are part of a much greater collective issue. It might also cause conscious or subconscious resistance when you are invited to explore patterns in your body related to sexuality

<sup>3</sup> Counter transference is here defined very broadly as all reactions triggered in the therapist when interacting with the client. Bang 2002.

<sup>4</sup> Today *affect regulation* is thoroughly examined within the field of neuropsychology (Schore 2008, Siegel 2006, Hart 2006, McCluskey 2005, Stern 2004 a.o.).

in the context of a workshop— both as a therapist and in general. Another possibility could be that conscious or subconscious resistance is triggered by encounters in our history associated with sexuality that might cause a natural skepticism as to whether the workshop facilitator or therapist is capable of handling the subject and contact in a functional and supportive way.<sup>5</sup>

### The importance of acknowledging patterns

A body oriented approach offers an opportunity to reach behind well established self images, establishing contact with parts of us that may be otherwise difficult to access on a conscious level. It also offers an opportunity to explore patterns we may not have discovered in ourselves. A body oriented approach is one way for us as psychotherapists to look into our patterns related to sexuality. There are others. To me the key is not how we do it but that we do it. I am curious as to how we as professionals can support each other in this challenge.

### BIOGRAPHY

Merete Holm Brantbjerg is a psychomotor therapist trained in Denmark 1975-1978 and a co-creator of Bodydynamic Analysis. She developed Resource Oriented Skill Training as a psychotherapeutic approach to trauma work. Merete leads trainings and workshops in Scandinavia, North America and London, and maintains a private practice for therapy and supervision.

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### REFERENCES

- Bang, S. (2002). Rørt, ramt og rystet. Supervision og den sårede hjælper. Copenhagen: Socialpædagogisk bibliotek Gyldendal.
- Bernhardt, P., Bentzen, M., & Isaacs, J. (2004). Waking the body ego, part 1: Core concepts and principles. In I. Macnaughton (Ed.), *Body, Breath, and Consciousness: A Somatics Anthology* (pp. 131-160). Berkeley, CA: North Atlantic.
- Brantbjerg, M.H. (2007). Resource Oriented Skill Training As a Psychotherapeutic Method. Copenhagen.
- Brantbjerg, M.H. (2008). The Relational Aspect of Resource Oriented Skill Training. Copenhagen.
- Brantbjerg, M.H. & Ollars, L. (2006). Musklernes intelligens. Om 11 Bodydynamic Jeg-funktioner. Copenhagen: Kreativ.
- Hart, S., & Silver, D. (2008). *Brain, attachment, personality: An introduction to neuroaffective development*. London, England: Karnac.
- McCluskey, U. (2005). *To be met as a person: The dynamics of attachment in professional encounters*. London, England: Karnac.
- Frederiksen, D.B. (1996). Stol på mig. Seksuel tiltrækning og seksuelle grænseoverskridelser i den terapeutiske relation. Copenhagen: Dansk Psykologisk Forlag.
- Schore, A. (2008). *Paradigm shift: The right brain and the relational unconscious*. *Psychologist Psychoanalyst*, Summer 2008, p. 20-26.
- Siegel, D. & Hartzell, M. (2006). *Parenting from the inside out*. New York: Guilford Press.
- Stern, D.N. (2004). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton & Company.

<sup>5</sup> Over the years the field of psychotherapy has shown many examples of blurry boundaries on sexuality from therapists to clients or workshop participants. (Frederiksen 1996).

# What Disgust Means for Complex Traumatized / Dissociative Patients: A Pilot Study from an Outpatient Practice

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## Abstract

Although complex traumatized / dissociative patients frequently become traumatized under repelling circumstances, the role of repulsion or disgust has, until now, only been researched sparingly in the field of psychotraumatology. A few exceptions can be found in the field of psychosomatics, but in contrast with its brethren of basic emotions - fear, shame and grief (depression) - disgust does seem, however subconsciously, to be a taboo subject for both patients and trauma therapists. We are therefore happy to report that this pilot study, which was conducted in an outpatient psychotherapy practice with a sample size of 71 patients, was able to raise a number of new hypotheses regarding this hitherto neglected emotion.

Disgust may turn out to be an important diagnostic indicator. Our research showed that patients suffering from complex psychological trauma tended to suffer more from symptoms of disgust. They could also only overcome their disgust with exceedingly more difficulty than other client groups. Memories of disgust, which hark back to sexual abuse and violence inside the patient's own family, acquire special significance, as the patient is unable to digest these repellent experiences. Instead, the disgust they experience in such instances descends into the depths of the unconscious where it dwells for years. Symptoms of disgust, however oblique and concealed, coincide significantly with other psychosomatic symptoms, often exacerbating existing phobias, aggressive behaviour and shame.

Lastly, this article will also briefly look at ways of treating disgust effectively with the aid of interactive and physically oriented settings.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

**Keywords:** complex trauma, dissociative disorders, disgust, psychosomatics, psychological trauma predictor, PTSD

## 1. Introducing the research project

Disgust has been a recurring topic of interest in our practice in recent years based on a number of cases. As neither disgust nor the role of disgust in complex trauma had been the subject of many research studies, we decided to design a pilot study at the Trauma Institute Leipzig that would focus on the issues and questions relevant to us. This pilot disgust questionnaire (PDQ, see below) was designed to answer questions that arose in therapy sessions and was to take account of the invaluable input that was provided by advanced clients. In spring 2009 my wife, Irina Vogt, DP, and I selected a representative cross-section of our patient population and were able to interview a total number of 71 patients. The sample was structured as follows:

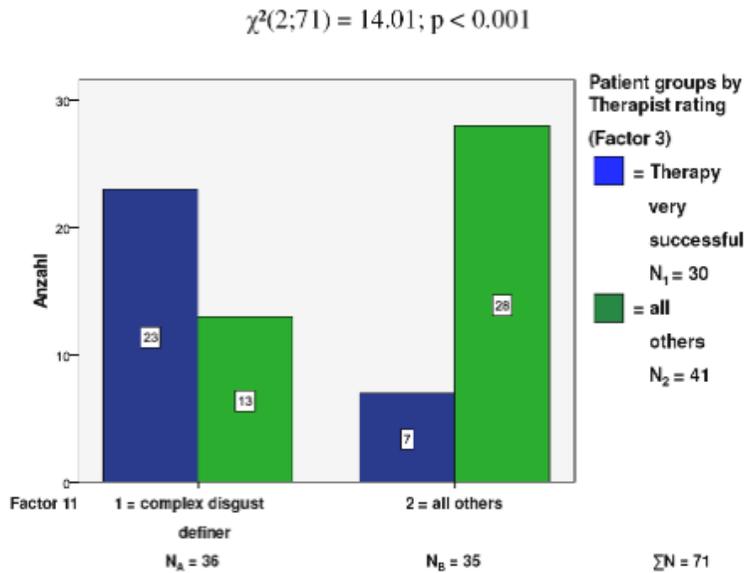
Sample structure		Women	Men	$\Sigma$
Number N		41	30	71
Age	$\emptyset$	38.1	39.2	
	from - to	25 - 71	25 - 51	
Hours	$\emptyset$	74.6	84.0	
	from - to	5 - 170	2 - 180	
Therapy phase in depth psychology/analytic psychology	Start	15	8	23
	Middle	10	10	20
	End	16	12	28
Diagnoses a) Complex and dissociative post-traumatic disorders	DID	6	4	10
	DESNOS/DDNOS	15	13	28
	PTSD	2	1	3
	$\Sigma$ - trauma	23	18	41
b) Other types of disorders	Borderline personality disorders/structural disorders	6	7	13
	Neuroses, complex personality disorders	9	5	14
	Depressive reactions and other diagnoses	3	0	3
	$\Sigma$ - others	18	12	30

**Table 1.**

*Sample structure*

As this table illustrates, approximately 58% (N=41 from 71) of the patients were complex traumatized patients suffering from dissociative identity disorder, chronic complex trauma, a chronic yet unspecified dissociative disorder or a fixated post-traumatic stress disorder. From here on, this particular group will be described as “trauma patients – total sample” in order to be able to adequately compare and contrast it with the other patients (N=30) of the sample. The statistic comparisons and hypotheses discussed in this article follow the same sequence of questions from the pilot disgust questionnaire. The expert rating scales which are cited and the legend of factors this yielded can both be requested from the author.

The objective of the introductory question was to explore to what extent our patients were able to define disgust, as we often observe major mentalization weaknesses in our trauma patients with regard to determining the notion of disgust. A general diagnostic comparison of the level of definition between trauma patients and other diagnostic groups did not yield a statistically significant difference. But a therapy oriented comparison between patients considered above average and highly successful in their therapy progress by two expert raters and patients considered average and comparatively less successful did produce a significant difference in the level of their disgust definitions. The following graph handsomely illustrates how:

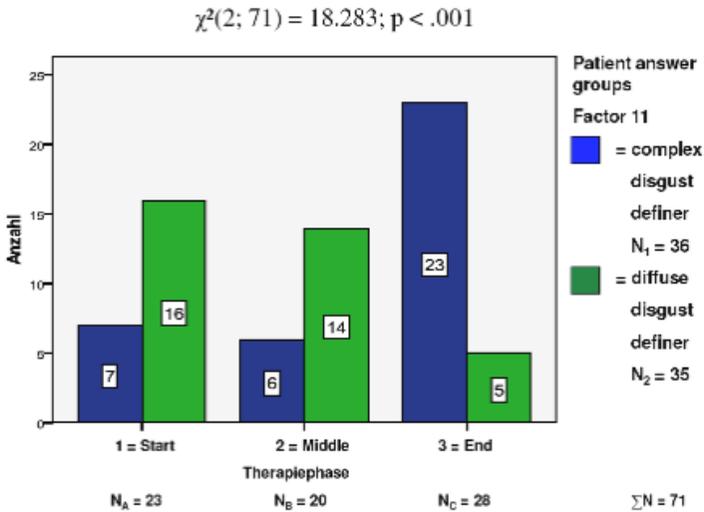


**Graph 1.**

*Definitions of disgust depending on therapy success (Question 1 in PDQ and therapist rating TRUS)*

Patients who included physical impulse reactions to disgust, mental boundary experiences and individual trigger or symptom associations in their subjective definitions of disgust were classified as complex disgust definers. Less competent disgust definers, on the other hand, revealed extensive self-assessment problems with regard to this affect /emotion. This was evidenced by their responses which were limited to associate disgust with particular diseases such as “herpes”, triggers such as “decomposing animals”, or a schematic flight reaction formulated as “I must run away from disgust”.

A further differentiated analysis of complex versus poor disgust defining skills is shown in Graph 2:



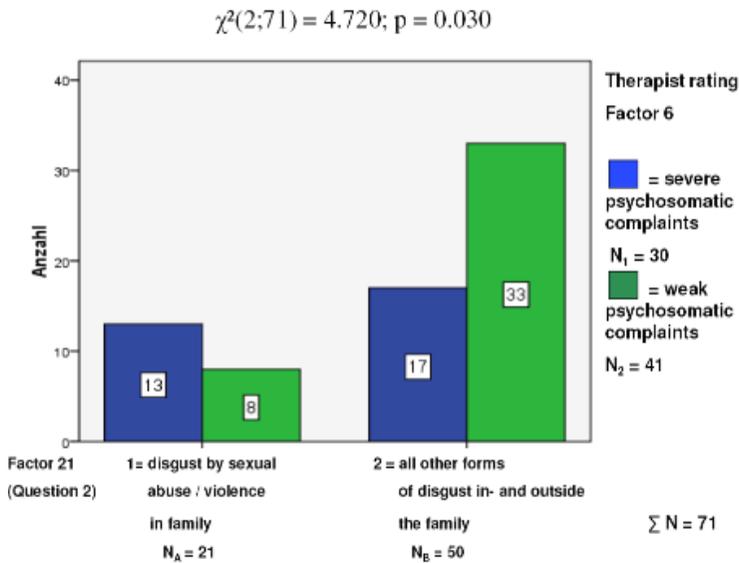
**Graph 2.**

*Disgust definition depending on therapy phase (Question 1 in PDQ and therapist rating TRUS)*

This graph clearly illustrates how the mental-emotional skill of complex disgust definers significantly improves in the third therapy phase, in which differentiation and integration are major themes. We therefore hypothesise that the skill to mentalize disgust is only acquired during the third therapy phase when the trauma exposition has been largely completed and the issue of disgust is overcome, enabling patients to better describe and deduce difficult emotional states.

A further evaluation of the responses to PDQ-Question 1 revealed that a large number of patients experienced tactile triggers, the merest suggestion of touch and/or observations thereof as disgusting. A similarly large number of our pilot group reported that a combination of smells in connection with visual cues or a combination of imagining the smell, sight and touch of something was thought to be extremely disgusting and that they were unable to overcome such sensual impressions over a long period of time.

The second item on the PDQ raised the question of which specific and individual experiences the patients concretely and subjectively remembered as particularly disgusting. Two internal raters then allocated the answers to 10 answer categories, which ranged from sexual violence, abuse and harassment within the family to unhygienic conditions and addicted family members to the same sexual and hygienic experiences of disgust outside the family, the sight of decomposing organisms, disease, wounds and many other experiences. Apart from summarizing these main categories we also conducted various statistical comparisons with other questions from the PDQ and with the therapist rating (TRUS). The most interesting and striking statistically significant result was perhaps the following (comp. Graph 3):



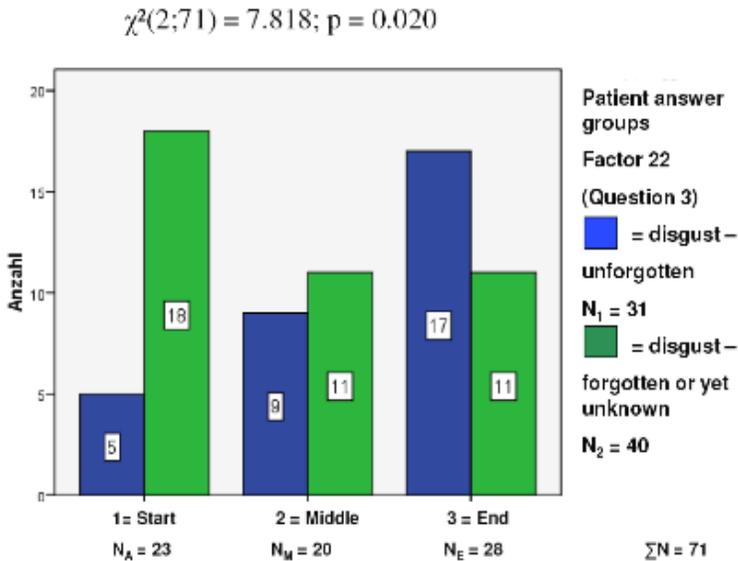
### Graph 3.

*Specific disgust and disgust experience in connection with psychosomatic complaints during treatment (Question 2 of the PDQ and therapist rating – TRUS)*

This illustrates that disgust when experienced as an element of sexual violence and abuse within the family will have a lasting effect on a person. Psychosomatic complaints can therefore be considered a likely consequence: the connection is highly significant and the first physical complaints are reported to have appeared – as far as they can be remembered by those affected – after the abuse.

Another comparison with high statistical significance ( $p = 0.016$  for  $\chi^2(2; 71) = 5.844$ ) confirmed that disgust originating in sexual violence cannot be forgotten if the act in question occurred within the family of origin.

The following calculation for PDQ Question 3 set out to investigate to what extent specific categories of disgust are forgotten over a period of time or cannot be forgotten depending on the phase of the therapy (see Graph 4):



**Graph 4.**

*Forgotten disgust depending on therapy phase (Question 3 in PDQ and therapist rating TRUST)*

Two aspects in particular seem very interesting here. First, the proportion of patients who have forgotten or are unable to consciously remember disgusting experiences at the start of the therapy is noticeably high. Second, and in relation to this, the percentage of those remembering their disgust is higher at the end of therapy than at the beginning. An analysis of the context shows that the highest percentage of remembered or actually unforgotten experiences of disgust concern sexual acts of violence and abuse or other forms of disgusting uncleanliness inside the family. It is my hypothesis that therapy restores fragments of association chains which enable the patient to become aware of memories of incidents *in the form of reemerging disgust*. Such memories are never quite forgotten as patients may uncritically, or as part of an aspect of defensive traumaphobic behavior, like to believe (see also Van der Hart et al, 2008).

In Question 4 of the PDQ we therefore homed in on those experiences of disgust as a subcategory, which could *never* be forgotten in the patient's consciousness, and looked for separate connections between the symptoms.

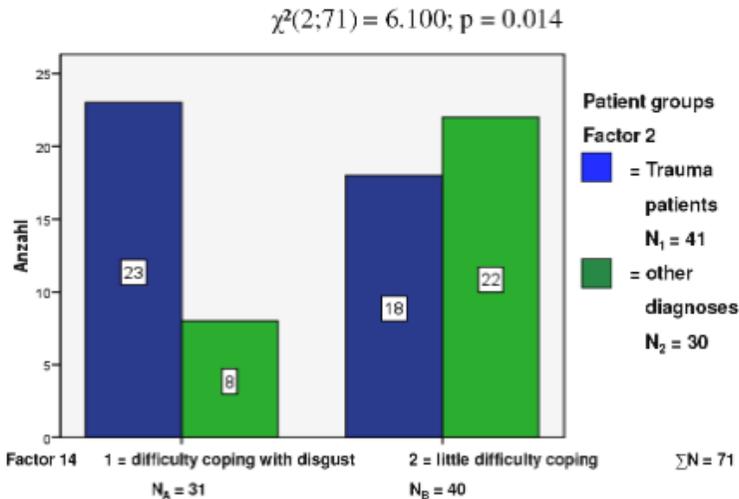
The cross table (graph 4.) makes clear that the patient group which was never quite able to forget the disgust experienced within the family was also the one which showed noticeably strong psychosomatic symptoms ( $p = 0.043$  for  $\chi^2(2; 71) = 4.096$ ).

Using the categorization deployed in our response analysis we reached a conclusion which was remarkably similar to the results in Graph 3 (see above). This means that disgusting experiences of sexual violence and abuse – just as other disgusting experiences – are first and foremost *considered particularly disgusting when occurring inside the family, and, secondly, are least likely to be forgotten*. They also show a statistically significant relationship with psychosomatic complaints, which the therapists are able to diagnose in the course of therapy.

Question 6 of the disgust questionnaire then asked the patients about their separate experiences of disgust, which have only come to light *because of the therapy*. The summarized answers to Questions 5 and 6 of the PDQ imply that approximately half the clients (N=35 for Question 5 and N=49 for Question 6) are unable to rediscover “early experiences”. The majority of “confirming rediscovered experiences” (in Question 5 – N=23 out of 36 “rediscovered experiences”) and completely surprising rediscovered experiences (in Questions 6 N=18 out of 22 “new discoveries”) can be grouped together under the headers sexual violence and abuse. This seems to suggest that, especially with regard to these charged topics, different repression and dissociation processes provide for a more temporary or fragmentary forgetting than with other experiences of disgust.

Question 7 asked something completely different of the patients. They were asked to compare their personal difficulty in coping with six of the most important basic emotions and rank them from 1 to 6.

The rankings provided by the patients were analyzed based on a group which “copes well with disgust” from the rankings 1 to 3 and a group which “doesn’t cope well with disgust” from the rankings 4 to 6 (see attached PDQ). Following this, a great number of statistical possibilities were investigated to see if there were any correlations. I found the following graph the most interesting (see Graph 5 and Table 2):



**Graph 5.**

*Coping with disgust and psychological trauma (Question 7 in PDQ and therapist rating TRUS)*

Graph 5 shows a strikingly high significant correlation between patients suffering from psychological trauma and severe difficulty in coping with feelings of disgust. Repeating this result in larger samples would mean seeing one of our basic clinical experiences confirmed, i.e. that patients suffering from the consequences of trauma do in fact struggle more with their feelings of disgust than do other patients.

From a clinical point of view, a higher deficit in coping with disgust could be compensatory and related to a higher dissociation value. We were only able to statistically confirm this suspicion as a tendency, in which our criterion (cut off  $>/< 3 \times 30$  – i.e. three answer values in FDS-20 are greater than/equal to 30) was used as a clinical experience value. But in the end a certain degree of correlation between dissociation and difficulty coping with these feelings would be expected in our clinical sample.

In relation to the above results we used a detailed analysis to find out whether the ability to cope with disgust was different at the beginning or at the end of the therapy. Corresponding subcategory calculations confirm the general supposition that *those beginning therapy generally believe coping with disgust to be easier* – perhaps because they are at that point unable to remember disgusting experiences, or they perceive the fragments they can remember to be meaningless or not so troubling. Here it is shown clearly that out of 23 therapy beginners only 8 patients report difficulty in coping with disgust, whereas almost double as many – 15 patients – believe that feelings of disgust are no problem at all. However, things tend to look differently for the subcategory of those ending therapy. Out of the 28 patients that form this group a majority of 16 patients actually reports having great difficulty in coping with their feelings of disgust, whereas the rest reportedly has no great difficulty at all. Unfortunately, it was not possible to establish a significant relationship with these small samples, which means that this remains, for now, an open question to be answered in future.

Question 8 was dedicated to the problem of the subjective attribution of emotion. Is the basic emotion under discussion perceived to originate in physical or inner mental factors? As modern psychotherapists we obviously do not lend much credence to the obsolete dichotomy between mind and body. But these are the terms traditionally used by our patients and a great number of psychodynamic discussions we have with clients suffering from psychosomatic complaints often start off by distinguishing them between the physical and the mental. Seeing the difficulties clients had coping with their feelings of disgust, I hypothesised that the subjective determinants of the complaints may actually have been more physical.

I therefore decided to compare the median values of all the basic emotions under evaluation to see which were considered more physical or mental by the 71 patients (see Table 2).

## Perceived disgust determinants in comparison:

	N	Mean	Standard deviation	Minimum	Maximum
disgust	71	3.72	1.845	1	7
fear	71	4.66	1.867	1	7
aggression	71	4.51	1.638	1	7
grief	71	5.18	1.366	2	7
shame	71	5.20	1.499	1	7
joy	71	4.97	1.558	1	7
	fear and disgust	Aggression and disgust	grief and disgust	shame and disgust	joy and disgust
Z	-3.062	-2.714	-4.698	-4.837	-4.118
Asymptotic significance (double-sided)	.002	.007	.000	.000	.000

Table 2.

Comparison between: disgust – fear, aggression, grief, shame, joy relative to physical / mental experience (Question 8 in PDQ – response analysis)

The result is rather astonishing, if only because it is surprisingly crystal-clear. First, disgust is not just physically experienced by the clients, but of all the basic emotions which were investigated, the ranking of median values leave no doubt that in the subjective perception of the clients it is the most physically determined emotion. Second, and perhaps most surprising of all, the difference between the median values of disgust and the other basic emotions proved to be *highly significant* for the 71 patients according to the Wilcoxon test. In other words, the subjective experience of disgust can really be designated a special role. However, the next question that arises is whether this is more relevant to patients suffering from trauma than to other patient groups. We therefore also compared the median values for trauma vs. non-trauma patients. The result was clear enough: our 41 trauma clients in particular experienced a stronger mental/non-random determinant in relation to the feeling of disgust.

Patients suffering from trauma were very clear in assessing disgust as something physical and non-random. The difference with the other 5 basic emotions was significant (p between 0.000 and 0.027).

Non-trauma patients did report that they considered disgust to be the most physically determined and least amenable to influence, but the difference with fear and aggression was not significant, i.e. not meaningful in our sample of 71 patients.

In Question 9 of our disgust survey we intended to record the relationship between motivation and change. We wanted to follow up on our clinical observations to see if it was more difficult for the interviewed patients to change disgust than any of the other basic emotions. Table 3 documents the first result:

**Changing disgust in comparison:**

	N	Mean	Standard deviation	Minimum	Maximum
disgust	71	3.25	1.730	1	7
fear	71	3.94	1.874	1	7
aggression	71	4.75	1.565	1	7
grief	71	4.11	1.661	1	7
shame	71	3.30	1.525	1	7
joy	71	4.45	1.637	1	7
	<b>fear and disgust</b>	<b>aggression and disgust</b>	<b>grief and disgust</b>	<b>shame and disgust</b>	<b>joy and disgust</b>
Z	-2.774	-4.341	-2.687	-0.153	-4.051
Asymptotic Significance (double-sided)	0.006	0.000	0.007	0.878	0.000

**Table 3.**

*Comparison of disgust – fear, aggression, grief, shame, joy in relation to overcoming emotions through will power / effort (Question 9 in PDQ – response analysis)*

Table 3 basically confirms the statements of the previous table: in the experience of the patients disgust is a feeling that is very difficult to change. It is therefore different from the other basic emotions, except for shame. In other words, our clients experience shame to be an emotion that is just as hard to change as disgust. A comparison of the frequency distributions of disgust and shame in PDQ Question 8 (see above) shows that only 26.75% of all patients believe that disgust is mentally determined – whereas a percentage of 73.23% believes this to be the case for shame. This means for Questions 8 and 9 of the PDQ that, although disgust and shame are perceived to have different underlying causes, both are similarly difficult to change. A separate comparison of this question for the subcategories of trauma and non-trauma patients also revealed that especially the trauma patients experienced disgust and shame as very difficult to change, whereas the non-trauma patients could not confirm this, as, apart from shame and disgust, fear and grief were also considered to be similarly changeable or difficult to change, respectively. The changeability of disgust does not therefore prove to be a significant exception for non-trauma patients.

In summation, the hypothesis that disgust in patients suffering from psychological trauma is an unconscious and autonomously organised state of affect that is very hard to change through therapeutic interventions, seems verified, given that the majority of clients feel at the mercy of inner autonomous processes more so than with other basic emotions.

As disgust can combine, dominate or be in the background of any of the other basic emotions we asked the patients in Question 10 to list the combinations in which they were

aware of their feelings of disgust, i.e. which other basic emotion appears with disgust the most frequently.

The answers made clear that fear and shame combined most frequently with disgust on our empirically researched answering scale (fear – absolute 19 out of 71 = 26.8%; shame – absolute 14 out of 71 = 19.7%). By grouping together the three answer possibilities of Question 10, the frequency of fear in combination with disgust rises from approximately  $\frac{1}{4}$  of all answers (26.8 % of 71) to almost  $\frac{1}{3}$  of the total of answer possibilities, if the related concept panic behaviour is added in to overall reactions of fear (31.5 % of 71).

The second most frequent combination, i.e. disgust and shame, amounts to 20% and remains constant throughout.

The third most frequent combination is *anger affect* with 15.5% of 71 patients. If all three answer possibilities are taken into account and the related concept of aggressive feelings is added to the share of overall aggressive reactions, this number rises to almost  $\frac{1}{3}$  (31 % of 71 patients).

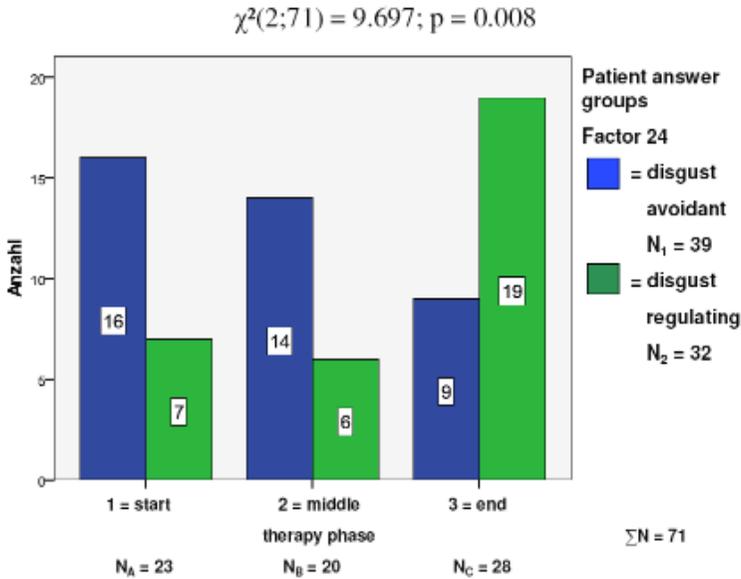
Most patients have at least two very different feelings accompanying disgust. The first and third answers they give differ significantly (Wilcoxon test for 71 patients resulted in a test value of 0.437 a significance of  $p=0.018$ ).

From a different point of view this fear-aggression-shame hierarchy corresponds with the general behavioral organisation in traumatic situations: first, there is a tendency to flee; if that is not possible, the victim tries to fight; and if it that fails, helplessness and shame follow.

In Question 11 the patients were asked about subjective and individually different conscious behavioral reactions and strategies for acute and anticipated experiences of disgust.

More than half the patients (54.93 %) report that their behavioural patterns are very passive for disgust. They avoid disgust by planning ahead, withdrawing and fleeing. Only about  $\frac{1}{4}$  of patients have very proactive and competent coping strategies (23.94 %), in which they (in relatively safe situations) consciously control their feelings and affects and choose the most favorable way of coping with the unpleasant situation. The other 25% react hesitantly, passively, or by soothing themselves – neither by fleeing nor by acting against it. We described these 32 active and passive patients who were able to cope with disgust either way (50%) “disgust regulating” and “disgust avoidant” for the purposes of our crosstabulation.

I then checked if disgust avoidance changed quantitatively during the course of therapy (see Graph 6):

**Graph 6.**

*Disgust avoidance depending on therapy phase (Question 11 in PDQ – response analysis)*

This graph shows relatively well that during therapy the level of disgust avoidance slowly decreases whilst active regulation of disgust increases. The leap in improvement between therapy phase 2 and 3 corresponds with the previously noted improvement in overcoming disgust in Question 7 of the PDQ (see above).

With another hypothesis we sought to find out if there was a possible correlation between disgust avoidance and the number of body-oriented treatment settings recorded by the therapists.

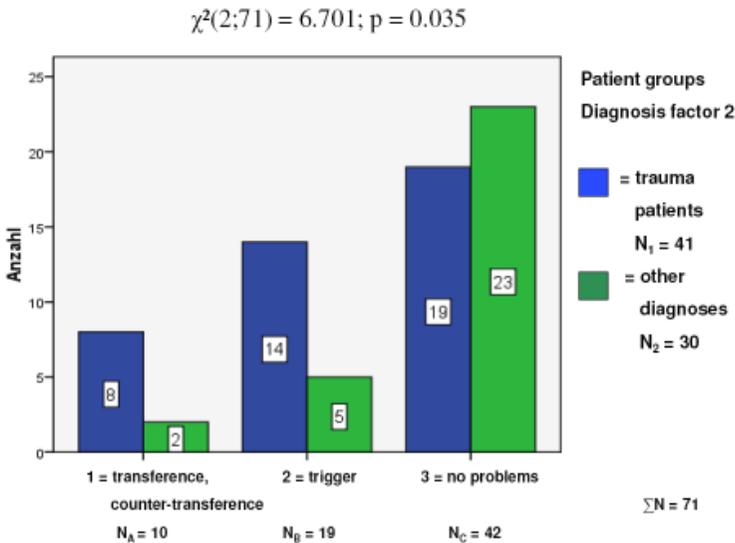
This cross tabulation confirmed our supposition that patients who avoid disgust are also considerably less accepting of physically oriented settings in therapy and that therapists intuitively tend to offer this group of patients fewer such settings ( $p = 0.014$  bei  $\chi^2(2; 71) = 6.053$ ).

The same tendency could be identified by the therapist rating (TRUS) for the dimensions *attachment and relationship blocks* in combination with the assessment dimension *implemented group and/or individual therapy settings*. The first cross tabulation revealed a significance value of  $p=0.033$  ( $\chi^2 2;71$ , value 4.542) and the second a significance value of  $p=0.024$  ( $\chi^2 2;72$ , value 7.477). Hypothetically speaking, the patient's subjective ability to regulate disgust could be indicative of attachment and relationship blocks and the initial reluctance to join in physical and group settings noted by the therapist. Or to put a positive spin on it: body-oriented and group settings foster attachment and relationship skills and allow the patient to overcome their avoidant behaviour as long as such settings are professionally dosed and structurally implemented.

Finally, Question 12 of the PDQ asked the patient to evaluate the experience between patient and therapist, which, admittedly, is a potential minefield.

For almost 60% (N=42, 59.15 %) the perceived disgust towards their psychotherapist does not appear to be a problem. Graph 7 (see below) further explores to what extent the disgust experienced by the patient in the therapeutic relationship could be qualitatively related to the treatment diagnosis. For this purpose I formed three groups in the therapist rating: group 1, which reported that the disgust in question “really” stemmed from the therapist. Analytically speaking, this could be partly caused by impressions of strong feelings of disgust, which constitute a hitherto unnoticeable interactive transference. On the other hand, it could also be caused by unconscious disgust in the behaviour of the therapist, which would be tantamount to a counter transference by the therapist. I therefore decided to call this group of ten patients (N=10 out of 71 = 14.08 % patients) the “transference-counter transference group”.

Nineteen more patients (N=19, 29.57 %) were grouped together in the so-called “trigger group”, as these patients reported that they very clearly experience disgust in their therapeutic relationship, but could trace it back to past transgressions, such as sexual abuse and similar negative experiences. In this case the transference could be consciously felt, even though it could not be turned off. These observations represented a cue or a trigger for a background of disgust or trauma. The third group was a grab-bag of patients without reported disgust in the patient-therapist relationship. Graph 7 differentiates among these three groups in relation to the treatment diagnosis:



### Graph 7.

*Disgust experienced by the behavior of the therapist (Question 12 in PDQ – response analysis)*

It is possible that this composition reflects a significant correlation between the experience of psychological trauma and the disgust experienced by patients during treatment. Due to the low number of patients at N<sub>A</sub>, however, this can only be statistically confirmed as a tendency.

Complex traumatised / dissociative patients thus tend to suffer far more from interactively experienced disgust than other psychotherapy patients. This result is hypothetically valid

for both positive and negative correlations. That means that trauma patients possibly react strongly to disgust while struggling to comprehend the transference background of it. On the other hand, trauma patients are also able to understand their experiences of disgust as triggers and are therefore increasingly less burdened by therapeutic interactions. A calculation of these phenomena in relation to therapy progress (start, middle, end) shows no frequency distribution that can be deemed significant. However, it can be phenomenologically recorded that the perception of interactive disgust is polarized at the start of therapy. The ability to perceive the trigger potential of disgust in oneself slowly grows as therapy progresses. The relatively high percentage of clients who perceived no disgust or similarly negative basic emotions probably means that the patients suppress or try to suppress their contradictory feelings unconsciously or out of a need for harmony at the start of therapy.

In conclusion, the following statistical calculations were obtained by testing the hypotheses between the therapist rating (TRUS), the Dresden Body Image Questionnaire (DKB-35 of Pöhlmann, Thiel, Joraschky, 2008) and the Questionnaire for Dissociative Disorders (FDS-20 by Freyberger, Spitzer, Stieglitz, 2005).

A comparison of the therapy course (start, middle, end) and the attachment and relationship blocks noted by the therapists showed that this interactive rejection continued to decrease as the therapy progressed, whilst the focus on contact, support and personal individual engagement steadily increased.

Other rating comparisons also confirmed this inherent treatment logic as patients were, for example, seen to be more content and better socially integrated (work, family, friends) at the end of therapy. Furthermore, patients who showed the biggest strides in improvement were also those with experiences of long-term group therapy (see also Vogt, 2004, 2007 a).

In a secondary finding we used the Dresden Body Image Questionnaire (DKB-35 by Joraschky and Pöhlmann, 2008) to find out to what extent the rating result for psychosomatic complaints corresponded with the average Dresden body image profile.

A cross tabulation between the Dresden Body Image results, a cut-off value of 3.2 and a therapy rating of very conspicuous vs. unclear psychosomatic patients showed a significant difference between these two conspicuous groups and unclear to inconspicuous groups ( $p = 0.047$  at  $\chi^2(2; 57) = 3.932$ ). This correlation, therefore, validates the rating to some extent. Patients with severe psychosomatic symptoms in therapy generally have a more distorted body image than other people.

A comparison of patients suffering from psychological trauma versus other diagnostic groups in DKB-35 and FDS-20 revealed a significant difference for both diagnostic materials regarding the aforementioned median group values. In the DKB-35, trauma patients were clearly less interested in establishing physical contact on the physical contact scale. On the conversion scale in the FDS-20 there were conspicuously more physical symptoms ( $p = 0.017$  and  $0.003$  for  $N=57$ ).

The FDS-20 revealed a further interesting secondary finding. We were able to identify a differential diagnosis with a meaningful value between trauma patients and other diagnostic groups both for the screening criterion  $> 3 \times 30$  points and the cut-off value of  $\geq 300$  points with the 20 FDS questions. These are useful orientation points for our clinical work, as we basically cannot expect a higher hit quote in dissociation research.

A general problem with all the dissociation questionnaires known to us is that essentially they only become sufficiently effective from the middle phase of therapy onwards, since subjective dissociation perception only increases from that point onwards. After all, the

fear of becoming aware of complex dissociative trauma symptoms (see Van der Hart et. al., 2008) only decreases with increased trust in the psychotherapist, therapy comparisons as part of group therapy and/or personally experienced therapy progress. It is not easy to experience both *the sensitivity for and defense against* dissociative symptoms with such questionnaires.

## 2. Summary of the main results

Using a pilot study with a self-developed questionnaire to further investigate the feeling of disgust (PDQ) in addition to the Dresden Body Image Questionnaire (DKB-35 by Pöhlmann, Thiel, Joraschky, 2008) and the questionnaire for dissociative symptoms (FDS-20 of Freyberger, Spitzer, Stieglitz, 2005) 71 patients of an outpatient psychotherapy practice were interviewed. Their answers revealed interesting new research results in relation to the experience and overcoming disgust.

All patient groups appear to have problems mentalizing their feelings of disgust, which can only be overcome during therapy. The overall patient group describes disgusting touch and assaults, smells and views of repelling sights as particularly disconcerting.

It is striking to note that survival of sexual violence, abuse and harassment inside the family of origin are considered to be especially disgusting and difficult to overcome for the majority of patients suffering from psychological trauma. It is illustrative that these gruesome experiences are frequently completely forgotten due to the stress they exert. They are therefore only recalled within the safe framework of the therapeutic setting. Yet for another smaller group of patients it is impossible to banish their memories of the sexual violence they experienced; they suffer under the continuing duress of these pulsating emotions.

The majority of complex traumatised/dissociative patients who were mostly harmed in early childhood report clear psychosomatic complaints that persist for longer periods of time during the therapy and in the questionnaire responses.

It is shown that in their subjective experience, patients suffering from psychological trauma in particular have more difficulties overcoming disgust than other patient groups. This significant result and its comparative difference from how other basic emotions are overcome indicate that disgust may have a central role in determining and assessing successful treatment of psychological trauma. Even more meaningful is the fact that psychotherapy patients do not tend to reflect adequately on the background to their feelings of disgust at the beginning of therapy. Therapeutically speaking, the issue of disgust only emerges in the therapeutic relationship with the therapist. However indirect and encoded, disgust partly comes to the fore in a generalised defensive mechanism against body-oriented and group settings. Thus, disgust can function as an indicator of a traumatic event in addition to forecasting the possibility or impossibility of experimental body-oriented individual and group settings. Disgust is subjectively seen as highly physiological in origin and – together with shame - considered to be extremely difficult to change according to almost all clients.

According to our research results, the ability to regulate disgust only starts to grow in the final therapy phase, which is after trauma exposition work and voluntary dual settings and group therapy with body-oriented settings that are conducted in our practice.

Significant scale ratings with DBK-35 and the FDS-20 underline the fact that determining psychosomatic and dissociative symptoms and a positive change in body image structures should receive more attention in complex traumatized and dissociative

patients than may have been the case up to now. All three questionnaires generally confirm the close links among disgust, psychological trauma, distorted body images and dissociative symptoms. A continuation of the research approach would be desirable in this case.

### 3. Questionnaire for the pilot study

The Pilot Disgust Questionnaire (PDQ) was designed for the purpose of research. It is shown here so that colleagues can better understand and assess these partly pioneering new insights for themselves. A pilot study always aims to prompt further research on its subject. A scientific research plan, for example, could help to validate items of the questionnaire, objectify raters, and investigate samples in broader and more varied terms.

I am aware of the disadvantages of a pilot study, but together with DP Irina Vogt, I wanted to press ahead with this topic, as the issue of diagnosing and treating disgust in complex traumatised patients became ever more important in our daily work. We also wanted to encourage our colleagues to become involved in this topic. Nevertheless, we hope our results and the questionnaire we hereby make available will be accorded the usual professional respect.

The response analysis as well as the therapist rating of the research sample (TRUS) can be requested without much ado from the author. We only ask any researchers who wish to make use of our material or parts thereof to cite the source with the necessary precision and to briefly request permission via email. Obviously my wife and I would be delighted at any continuation of this practice-oriented investigation and any interest in our approach. Our first objective would therefore be to support you as straightforwardly as possible.

### 3.1 The pilot disgust questionnaire (PDQ)

*Research questionnaire of the Trauma Institute Leipzig on the topic of disgust (PDQ – pilot disgust questionnaire)*

Dear client,

We would hereby like to ask you to answer these questions as openly and truthfully as possible. All your answers will be treated with the strictest confidence and the results will be made available to you anonymously as part of a pilot study.

**1.) How do you personally understand disgust?** Please tell us briefly your own personal definition of the term or a personal description or list us some phenomena, etc. (3-5 lines).

I think disgust is:

.....

**2.) Which experiences were particularly disgusting?** Please describe up to three significant experiences of disgust (individual incident or persistent influences; please, if possible, tell us your age – if there isn't enough space, use an extra page!)

1)

(Age?):.....

**3.) Which feelings of disgust had you forgotten about or repressed for a long period of time?** (please remain brief) – But you always knew that they had taken place or that you had experienced them?

1).....

**4.) Which feelings/experiences of disgust were you never able to forget?** (please remain brief) – because they were never really banished from your consciousness and continued to live on in nightmares, daydreams, thoughts, etc?

1).....

**5.) Which experiences of disgust reemerged only during the process of therapy?** (having been completely forgotten after the incident/events and having been only rediscovered because of the trauma exposition? Aha-effect)

1).....

**6.) Which experiences of disgust had you not known about until you started therapy?** (only discovered thanks to trauma exposition – surprise effect)

1).....

**7.) Please rank these emotions as to how difficult you find it to cope with them.** Please use each ranking only once, even if this is difficult. Now rank the following six emotions: great fear, strong aggression, deep grief, strong disgust, deep shame, great emptiness from 1 to 6.

1. In general still easiest to cope with:.....

2. Slightly more difficult:.....

3. Even more difficult:.....

4. Much more difficult:.....

5. Hardly able to cope with:.....

6. Almost impossible to cope with:.....

**8.) Which feeling is generally more physically and which feeling more mentally fixated?** Please use a 7-point scale to assess each feeling! (1 cross per line)  
(The 7-point scale ranges from -3 to +3 for the basic emotions of fear, aggression, grief, disgust, shame, and joy. The Excel table used in the questionnaire can unfortunately not be shown here for reasons of space.)

**9.) To what extent can you change these feelings by willpower alone?**  
(1 cross per line)  
(The 7-point scale ranges from -3 to +3 for the basic emotions of fear, aggression, grief, disgust, shame, and joy. The Excel table used in the questionnaire can unfortunately not be shown here for reasons of space.)

**10.) In which hierarchical combinations do feelings of disgust appear for you?** (E.g. disgust with fear / panic / shame, aggression / anger / emptiness, grief / depression and other combinations)

Please use 3 situations as an example (different or similar combinations are allowed)

- 1.) Situation: disgust with – ..... eg. when:.....
- 2.) Situation: disgust with – ..... eg. when:.....
- 3.) Situation: disgust with – ..... eg. when:.....

**11.) How do you deal with feelings, memories or situations of disgust on an everyday basis?**

- 1.) I deal with disgusting situations by.....

**12.) Have you ever felt disgust in relation to your therapist? If so, which therapy situations, e.g. a glance, gesture, facial look, language, behavior, etc, did you find especially disgusting?** (By providing this feedback you help your therapist. We are aware that during therapy often contrasting situations arise, etc. Please describe up to 3 situations):

- 1) Situation: .....

Thank you for participating in this difficult subject. These confidential results will be made available anonymously in our pilot research study!

DP Irina Vogt      Dr. Ralf Vogt      Trauma-Institut-Leipzig, 2009

(This pilot disgust questionnaire was revised three times thanks to valuable feedback from clients. For reasons of space the actual answer fields have been minimized)

## BIOGRAPHY

Dr. Ralf Vogt is a psychotraumatologist, psychoanalyst, family therapist, body psychotherapist, individual and group therapist. He has been working in private practice since 1992. For the past 15 years he has been working on his own therapy model SPIM-20-CT together with his wife, DP Irina Vogt. The latest version SPIM-30-CT is in progress. Together they direct the training curricular at the Trauma-Institute-Leipzig which includes workshops and seminars by renowned international clinicians. They organize biannual international conferences regarding the field of complex trauma and dissociation. Dr. Ralf Vogt has published various papers and books on trauma and dissociation in German and English. He is a member of DeGPT, ESTD, ISSTD (Fellow Award) and on the board of directors of the ISSTD.

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**REFERENCES**

- Clauß, G., Ebner, H. (1974). Grundlagen der Statistik. Berlin: Volk und Wissen
- Freyberger, H.J., Spitzer, C., Stieglitz, R.D. (2005). FDS-Fragebogen zu Dissoziativen Symptomen.
- Krause, R. (2006). Der eklige Körper in der Analyse. In Z.: AKJP (Analytische Kinder- und Jugendlichen-Psychotherapie. H 129, Jg. 1/2006, S. 7-23.
- Lienert, G. A. (1969). Testaufbau und Testanalyse. Weinheim: Beltz. 3. Aufl.
- Lohse, H., Ludwig, R., Röhr, M. (1986). Statistische Verfahren für Psychologen, Pädagogen und Soziologen. Berlin: Volk und Wissen, 2. Aufl.
- Pöhlmann, K., Thiel, P., Joraschky, P. (2008): Das Körperbild von Essgestörten Selbstbeschreibungen auf der Basis des Dresdner Körperbildfragebogens. In P. Joraschky, H. Lausberg u. K. Pöhlmann (Hrsg.): Körperorientierte Diagnostik und Psychotherapie bei Essstörungen. Gießen: Psychosozial-Verlag.
- Van der Hart, O., Nijenhuis, E., Steele, K. (2008). Das verfolgte Selbst. Paderborn: Junfermann.
- Vogt, R. (2004). Beseelbare Therapieobjekte. Strukturelle Handlungsinszenierungen in einer körper- und traumaorientierten Psychotherapie. Gießen: Psychosozial-Verlag.
- Vogt, R. (2007). Psychotrauma, State, Setting. Psychoanalytisch-handlungsaktives Modell zur Behandlung von Komplex-Traumatisierten u. a. Störungen (SPIM-20-KT). Gießen: Psychosozial-Verlag .
- Vogt, R. (2007). Handout-Manual SPIM-20-KT. Eigenverlag: Leipzig Trauma- und körperorientiertes Einzel- und Gruppentherapiekonzept mit handlungsaktiver analytischer wie verhaltenstherapeutischer Ausrichtung.
- Vogt, R. (2008). Körperpotenziale in der traumaorientierten Psychotherapie. Aktuelle Trends in körperorientierter Psychotraumatologie, Hirnforschung und Bewegungswissenschaften. Gießen: Psychosozial Verlag.
- Vogt, R. (2008). Praxis einer körper- und traumaorientierten Psychotherapie unter Berücksichtigung besonderer Settings für Anorexia-Nervosa-Patienten. In: Joraschky, P.; Lausberg, H.; Pöhlmann, K. (Hrsg.): Körperorientierte Diagnostik und Psychotherapie bei Essstörungen. Gießen: Psychosozial Verlag.
- Vogt, R. (2010.). Ekel als Folge traumatischer Erfahrungen. Gießen: Psychosozial Verlag.
- Vogt, R. (2012). Täterintrojekte - Diagnostische und therapeutische Handlungsmodelle für dissoziative Strukturen. Kröning: Asanger Verlag.
- Vogt, R. (Ed. In preparation). Perpetrator Introjects – Diagnostic and Therapeutic Treatment Models for Dissociative Structures. Kröning: Asanger Verlag.

**SELECTED BOOKS**

- Vogt, R. (2006). "Beseelbare" Therapeutic Objects. Psychoanalytic interactional approach in a body- and trauma-oriented psychotherapy. Gießen: Psychosozial-Verlag.
- Vogt, R. (2008). Psychotrauma, State, Setting. Psychoanalytical-Action-Related Model for a Treatment of Complexly Traumatized Patients. Gießen: Psychosozial-Verlag.
- Vogt, R. (Ed. In preparation): Perpetrator Introjects – Diagnostic and Therapeutic Treatment Models for Dissociative Structures. Kröning: Asanger Verlag.

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### ***The Science of Body Psychotherapy: From Research to Practice and from Practice to Research***

**Date:** Tuesday, 18th September 2012

**Time:** 09.00 – 15.00 hrs

**Fees:** Congress participants £65.00

External (non-Congress) participants: £75.00

Lunch and morning tea/coffee included

**Place:** Churchill College, Cambridge University, UK

**To register:** <http://www.eabpcongress2012.co.uk/en/programme/presentations.html>

**09.00 - 10.30: Session 1:** *The Science of Body Psychotherapy: relevance, methods and future perspectives*

Opening: Herbert Grassmann (Chair of EABP Scientific Committee)

Sheila Butler (Chair)

Joop Valstar: *What am I doing anyway? A BP clinician's perspective*

Frank Röhricht: *What could I be doing? Research informing practice*

Rae Johnson & Christine Caldwell: *The Research Mind 101*

Sheila Butler: *Bringing the themes together*

*Open facilitated discussion – audience participation*

**11.00 - 12.30: Session 2:** *Evaluating therapeutic processes and outcomes in BP research projects*

Frank Röhricht (Chair)

Courtenay Young: *What are we not doing?*

David Tune: *Process research – pros and cons*

Stefan Priebe: *Are randomised controlled trials the only gold that glitters?*

Elisabeth Sedlmayr-Länger: *The Criteria of Evaluation*

*Open facilitated discussion – audience participation*

**12.30 - 13.30: Lunch**

**13.30 - 15.00: Session 3:** *Other scientific findings, projects and developments relevant for the theory and/or practice of body psychotherapy.*

Siegmar Gerken (Chair)

Helen Payne: *From Practitioner to Practitioner-Researcher*

Maurizio Stupiggia: *Effects on body image*

Sheila Butler: *Building Bridges: What is happening in other fields, considering interrelations and connections between us and our worlds*

Herbert Grassmann + Committee: *The Body Psychotherapy Practitioner Research Network*

*Open facilitated discussion – audience participation*

**15.00 – 15:30: Afternoon Tea & Departure**

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How does material in this manuscript inform the field and add to the body of knowledge? If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto? If it is a case study, is there a balance among the elements, i.e. background information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge? If this is a reflective piece, does it tie together elements in the field to create a new perspective? Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

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