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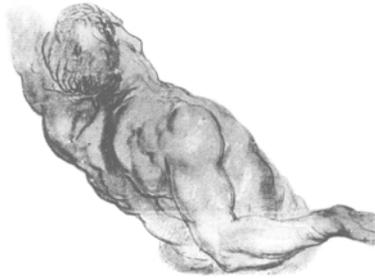


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USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Frozen Transference: Early Traumatization and the Bodypsychotherapeutic Relationship

Robert Lewis, M.D.

Abstract

This paper delineates my clinical construct, cephalic shock, as a specific form of frozen character structure which becomes frozen transference in the therapeutic situation. Cephalic shock is related to A) Winnicott's (1965b) construct: the mind as the locus of the False Self B) current trauma research and literature, especially neuropsychobiology. C) Attachment theory research and literature: the special strengths and limitations of a bodily approach to early and later trauma- when the perpetrator is the primary attachment figure- are discussed. The material is illustrated via a vignette of a mother-infant pair on a video, plus three clinical vignettes from my practice.¹

Keywords

Cephalic – Frozen transference – Nonverbal – Resonance – Shock

INTRODUCTION

In Wilhelm Reich's concept of character, a person's muscular armor can be understood as the embodiment of his (I will use the masculine pronoun for convenience's sake) past experience. It is, in other words, his history engraved or frozen into his body's form and motility. If one defines transference as some form of bringing the past into the present, it is a small step to view character, as we experience it in the therapeutic situation, as frozen transference.

This paper will stress a particular kind of frozenness of character to which I have given the name "cephalic shock". About 25 years ago (Lewis, 1981) I began writing about a group of my patients who were old before they were young, who could not stop thinking, and who thus had no "peace of mind". It was and still is my thesis that these patients had turned to a body-oriented therapy, because they were trapped and tormented by the mind within their head – a mind which ripened too soon in order to protect them from trauma. Now, as part of their post-traumatic shock, this ever-vigilant mind gave them no peace and robbed them of their deeper life experience. So, over these past three decades, I have brought a different orientation to the somatic psychotherapy of Reich and Lowen. They tried to get a patient out of his head and into his body. This never worked for me when I was a bioenergetic patient. I was always watching silently from some place deep within my head. I began to realize that the symptoms of cephalic shock- the rigidly frozen head and neck and incessant mental activity- were cephalic armor against losing one's mind and going insane. Winnicott (1965a) had described something quite similar in the "unthinkable anxieties" (p.58) which resulted from deficient empathic handling: falling forever, going to pieces, having no orientation, having no relationship to the body.

These people could not get out of their heads in order to get into their bodies. Their heads were already in shock. They actually needed to get back into their shocked heads and to begin to thaw them out, so that they could experience their head as part of their body.

So, to summarize my basic assumption, the classical bioenergetic approach, which tries to get the patient out of his physical head, 1) is a bioenergetic impossibility 2) only furthers the patient's dissociation. The underlying terror of insanity, and the compulsive thinking-ego or mind as False Self- (Winnicott, 1965b) with which such patients hold onto a false sanity, can only be dealt with where it is (in the head), not where it is not (in the abdomen or the pelvis).

Actually, as we will see from some clinical vignettes, the shock of being handled by a caregiver who does not recognize/accept the autonomy of a child's psyche/soma, can take many complex forms as that child develops.

CEPHALIC SHOCK

What Does It Look Like in the Adult Patient?

When we say that a person "lives in his head", we mean by this on one level of description that he is unconsciously holding on in a state of traumatic shock with the anatomical structures of his head. His head has become a cerebral fortress: it no longer feels like a part of his alive body. It is barely moved by the wave of breath which expands and contracts the rest of the body. The mind within this shocked head becomes dissociated- divorced from the living process. It is perhaps counterintuitive, but nonetheless true that a patient in this shocked state does not experience his head as a three-dimensional part of his body: it is numb (we might say frozen), so he cannot feel its weight, its warmth, its flesh and blood substance.

¹ This paper was read at a symposium in the psychosomatic division of the Park Hospital in Bad Rothenfelde, Germany. The symposium, entitled "Psychotherapie-mit Leib und Seele"(Psychotherapy with Body and Soul) was held in 2001.

How do I diagnose this muscularly-anchored holding attitude of the head/neck and shoulder girdle, and in the process hopefully get the patient into better contact with his head- as opposed to getting him out of his head? (Lewis, 1984).

The patient presents with some variation of the theme that he cannot stop thinking, that he never or rarely experiences peace of mind, and that he lives in his head. He often points to an area low on his brow, between his eyes as being the locus of this perpetual cerebral motor. Our patient has a frozen or shock-like appearance i.e., his head, neck and shoulders move as one unit- there is very little movement at the joints. The face is mask-like, with no play of expression, the eyes look vacant, or glazed or terrified. The above signs may be grossly present and obvious or subtly and fleetingly present. The presentations of this construct are so varied because no two people experience a given trauma identically, and people hold onto themselves for dear life **with their heads** in infinitely varied ways. For instance, one patient, Ben, had, in addition to a mother who was insecure ground, a father who was brutally physically abusive, and beat him about the head. The “jaws of death” that Ben saw when energy moved strongly into his head, make his cephalic shock unlike any that I have ever or will ever again work with. In general, however, I look for any lack of harmony or unity between the head and the rest of the body, such as a head that looks like a cerebral fortress sitting on top of a more vulnerable, alive looking torso and limbs.

How Do I Further Explore Whether My Patient is Trapped in this Unnatural Fight Against Gravity, Which I Call Cephalic Shock?

I have the patient lie on his back, so that there is very little real need to fight with gravity. **I gently support his neck with my hand, and observe the degree to which a subtle movement with each breath in and out is transmitted through the neck, physically unifying the head with the rest of the body.** It is a basic tenet of bioenergetic analysis (Lowen, 1970) that “Breathing is the basic pulsation (expansion and contraction) of the whole body” (p. 43). In other words breathing is a total body movement. Therefore this simple diagnostic test reveals a great deal about your patient’s psyche and soma. To repeat: to the extent that the respiratory wave subjectively and/or objectively, does not move up in inspiration past the chest through the neck to the head, and then down again in expiration, to that extent, the unity of mind and body, psyche and soma is split. Of course, in the clinical encounter, nothing is all that simple. A person has to trust me and my hands on a deep level before they will really let me have the weight of their head. Furthermore, the wave of respiration can be trapped, broken, smothered or otherwise distorted by the tissues of a person’s head and neck in infinitely varied ways.

Moving now back to my patient in consultation, I have already begun to assess the degree to which he can let me support the weight of his head. Typically, the patient, caught in the cephalic attitude of self-holding, will lift his own head automatically without being told to do so, the moment I touch the back of his head. When I call this to his attention, he still is unable to give over to me more than a small fraction of the weight of his head and this only with difficulty. When I hold my patient’s head firmly between my hands, he is stunned that I am actually supporting his head in a predictable, reliable manner, and says, “At last I can let go. I’ve been holding me all this time.” His words are a verbal response to the nonverbal dialogue between his head and my hands. This nonverbal dialogue is the language of the body and may also include the quality of eye contact between us and the resonance of our voices. As my patient, let us call him John, gradually lets go of his head, he has very little sense of how heavy it actually is, and he is very afraid that it is much too heavy for me. After a minute or so he has a sense of peace, of being deeply understood. Soon, however, comes a sense of profound mistrust, isolation, and feeling that he has never been understood. This sequence can be helpfully seen as the emerging of John’s frozen past traumatic lack of attunement, to be reworked via the transference/countertransference between us. This frozen transference emerges as the shocked body tissues thaw in response to my attuned touch in the here and now. This approach is specifically for trauma which is not encoded in words or images.

John is a composite of the many people I have worked with in this way over the years. Let me share a little more of his story. When I first rock his head from side to side, John is unable to relinquish control. When I make my movement less predictable, he feels terrified. We stop. (We always agree on a stop signal, and a safe place if necessary.) John says, “It felt like I could lose my head, go crazy”. Over a period of some months, this work continues amidst the other issues he brings to therapy. Slowly, he is able to explore his fear of insanity, his underlying not knowing and unintegration. The head- rocking becomes a mutual kind of playing, sometimes frightening, sometimes sweet. “I’ve never been able to play”, he says. He takes over the movement himself at times- at his own rhythm and intensity. As he slowly lets me hold that part of his being which he entrusts to no one, the threat is that his mind will fall to pieces before the support of my hands delivers the peace of mind which comes from surrendering to someone outside of himself.

Throughout this process I am offering John in the quality of contact in my hands, my eyes, voice, etc., an invitation to give over to me some of the self-holding of his false, caretaker self; on a body level, to relax the muscles of the skull, face, jaw, shoulder girdle and thoracic diaphragm. To the extent that he relaxes this bracing which cut off his going-on-being, he risks the unthinkable anxieties but finds his spontaneous gesture.

What Causes Cephalic Shock?

In the mid-seventies I described (Lewis, 1981) what happens to an infant who is raised by parents with significant borderline/narcissistic pathology. Such a parent, typically, is so poorly attuned to their infant that they fail to provide a

crucial function: they fail to help the infant modulate and organize its emerging and core bodily self; the infant's rhythms, states and energy are not met and mirrored adequately. So the infant is thrown back on its immature nervous system, a system that simply is not ready to maintain homeostasis—**there is no deeper issue than this**; this is the first and deepest life and death issue once the umbilical cord is cut.

Our shocked infant will have to find a way to hold on, hold together and hold against the parent who cannot provide it with auxiliary ego, a parent who is missing big pieces of its own ego. I refer you to the films by Brody and Axelrod (Brody, S. and Axelrod, S. *Mother-Infant Interaction Series: Forms of Feeding at Six Weeks*. 1962) on mother-infant interaction: one is stunned and barely able to sit through these films in which the infant is chaotically assaulted by dysrhythmic, gross mishandling at the hands of mothers who love their children and are consciously trying to do their best by them.

Let me describe a part of one of the feedings by a dysfunctional (rated low in empathy, control and economy of time and movement) mother in this film (video):

This mother took three hours to feed her infant boy. She told the interviewer that each feeding took about three hours and that she found feeding was a burden. For a six-week old infant that would work out to a minimum of fifteen hours spent in feeding each day! In the film portion presented, this infant was clearly hungry and wanted the bottle. In this six and one half-minute segment of the video the mother allowed her hungry infant to suck for eighty seconds, never more than three seconds at a time. During the same period she tried to burp him between one and two thousand times!! Trying her best, this mother simply could not hold still for more than a few seconds. She would offer her infant the nipple which he would seize with wild enthusiasm, only to have her pull it away a second or two later in a motion she appeared unaware of. Her infant would tense up his body and scream. She would then immediately try burping him in numerous different ways. She would wildly pat his back and/or jiggle it up and down while looking at him with puzzlement. She appeared to want him to stop crying before she would offer the bottle again, oblivious to the fact that he was crying because he was hungry. After several moments of this tense, jarring, jiggling and patting, this infant's head, neck and arms would become tensed in a startled position and his eyes would reflect shock. At that point he would stop breathing and crying. His mother then laid him back, offered the bottle and after a few seconds the whole sequence was repeated.

An infant will startle, i.e., exhibit a Moro (startle) reflex, whenever a subtle change in its equilibrium occurs. The reflex will be triggered, for example, by sudden movement, noise or temperature change or even its own energetic crying. The handling to which a borderline/narcissistic parent inadvertently subjects an infant, creates a chronic state of disequilibrium or shock, if you will, that is way beyond the shock that the infant can discharge in the Moro (startle) reflex. This is the unique shock of mis-attuned, unempathic handling, a daily occurrence, repeated perhaps hundreds of times a day in the course of feedings, diaper changes, etc. The infant is having the ultimately crazy-making experience of being held by someone who is out of touch with it.

There is now a great deal of neuropsychophysiological research data that begins to document what happens to an infant that experiences traumatically high, that is, overwhelming levels of arousal, which are not adequately soothed or as a current infant researcher puts it, "interactively repaired" (Tronick, 1989) Patterns are being laid down in the infant's immature nervous system which become part of its hard wiring (Schore, 1996). **Structure which is both neural and at the same time psychic is being imprinted into the circuits of the infant's cortex and limbic system.** When an infant is at the limit of what he can tolerate biologically, I would say, when he is being cephalically shocked, the danger registers at brain stem, midbrain and thalamic levels, and apparently engraves long lasting damage (Perry, 1997).

TRAUMA AND A BODY-ORIENTED APPROACH

Frozen Transference-The Body Does Not Lie

I will begin this section by focusing on the special strengths and limitations of a bodily approach to trauma. The implication of the phrase "frozen transference" is that with the above outlined approach, which operates on a core body level, one can by thawing the frozen transference out, recover the perfectly preserved record of the traumatic past. The stories we tell in spoken language about our past, whether they concern trauma or ordinary events, have been shown by current trauma research to be fallible, even if they are substantially correct. But when an experience has been traumatic, it has, by definition, overwhelmed our psychosomatic unity. It leaves us with disoriented and fragmented bodily sensations, feelings, and movements. These may be exact imprints of what happened to us at the time of the trauma. If so, they would be a more reliable record of the past than verbal memories have proven to be. My clinical experience convinces me that an approach that works directly on a core bodily level gives us access to the sensory-motor language, which **is the only available memory of the trauma.** My patient, Claire, for instance, was not involved in a legal battle with her parents when during our session she began to wheeze asthmatically as her frozen, rigid chest softened. Therefore, we did not have to concern ourselves with the absolute historical truth of her recovered bronchial contractions- they were very convincing to both of us and they reminded her of the many times from six years on up when she had been locked in the cellar after having been beaten by her mother. In addition to her cephalic shock, some of Claire's trauma was frozen in the bronchial tree of her lungs. Modern trauma theory suggests that we were desensitizing Claire's state-dependent memories so that they could be put in a time and place as part of a verbal narrative. Brain imaging techniques might have shown Claire's Hippocampus and Broca's

area light up as she found (Herman, 1992) “a language to speak of the unspeakable” (p.175). Ultimately however, a story told that restores a sense of dignity and affiliation, may be more precious, more healing, than the historical truth.

An Ideal Approach

Bioenergetic therapy is ideally suited to the challenge of helping the fragmented, frozen body tell a healing story. Pierre Janet (1925) taught us that trauma was laid down in the body, and that traumatic memories were state-dependent. Work on a core bodily level gives us access to these shock states. **It allows us to explore in nuanced detail, in sensori-motor slow motion, the trapped fragments of the past.** If we are not too countertransferentially threatened by this chaotic, nonverbal material, the patient will slowly find the inner and then the spoken words to fit his experience. This is not only true of cephalic shock, that is, early trauma. **IT IS TRUE OF TRAUMA OCCURRING ACROSS THE LIFE CYCLE.** In cephalic shock the trauma occurs when the infant’s young mind cannot grasp what his organism is experiencing. There are no words or images to adequately encode his body sensation. This is preverbal trauma. But, as we have already said, trauma at any age is largely a nonverbal experience. It breaks us, shatters us, overwhelms our psychosomatic unity. It leaves us with a sensory-motor language that is divorced/dissociated from a story placed in time and space and told in words.

Early and Later Trauma

You will never see an adult patient walk into your office with a pure case of cephalic shock. No two people have the same life experience, and a given trauma and everything that comes after it affect each other reciprocally. Recent research (Schore, 1996) is documenting how the experience of being attuned to (for instance, effectively comforted and soothed at times of stress) in infancy hard-wires the basic bodily trust into the nervous system, into neurobiological patterns of coping with stress. We used to say the infant internalized the attuned care as an ability to regulate and soothe itself; it treats itself the way it was treated. We are beginning to measure the neurochemistry of how this gets built into babies by their experience. Their levels of cortisol, for instance, and the balance of their sympathetic and parasympathetic nervous systems reflect their ability to modulate their energy and feelings and to recover smoothly from adversity. The babies in the video internalized a chaotic experience many times a day. Unfortunately, each traumatic feeding is likely to have made them less able to cope with the next. This is how their daily developmental trauma makes them more vulnerable to the next “shock” trauma that life has in store for them.

Furthermore, the same caretaker who cannot respond to his infant in a well-attuned, emotionally responsive way in the earliest months of life, will tend to have long term difficulties with the child as he matures. The child will not be well-attuned to on a core bodily level, or genuinely engaged with on an intersubjective level. Additionally, any actual patient may come from a family of origin in which his unempathic handling was embedded in a chaotic, neglectful and violent environment. In such families of origin, his daily bread, so to speak, may consist of physical abuse, sexual abuse, spousal abuse, substance abuse, and extreme neglect, which leaves him and such children unattended and therefore additionally at high risk for accidents and further abuse from predators outside of the families.

Betrayal and Attachment Theory

My construct, cephalic shock, is enriched when it is informed by attachment theory and research. The biological purpose of the attachment system, you will remember, is to maintain physical closeness between the young child and the mother, as a protection against predators. But how are we to understand what happens to the psyche/soma of a child whose body’s flight response propels it back to the traumatic danger? Because this is exactly what happens to the cephalically shocked infant: his primary attachment figure is also the perpetrator. The infant’s scream, his cry of distress, is the biological signal by which he maintains proximity to an attuned caregiver. What is terrible about the feedings in the Brody-Axelrad video is that the babies’ signals of distress do not bring them relief, but only increase their abusive handling. When the danger comes from your secure base, your deepest neurobiological survival mechanisms fail you. Your body and mind go into shock.

Attachment researchers have recently described a most disturbed category of insecurely attached children who seem quite similar to those I describe as cephalically shocked: they call them “disorganized/disoriented” (Main, M., & Solomon, J. 1986). When such a one-year old child is reunited with its parent after Mary Ainsworth’s (1969) naturalistic “Strange Situation” test, it may typically go toward the parent, then go away, spin around, bang its head on the wall, kick the floor. Instead of comfort, the return of the parent leads to a state of disorganization in the child. The researchers have found this kind of behavior in the presence of abusive, frightening, and disorienting parental behavior. The researchers also described “prolonged freezing, stilling or slowed, underwater movements” in these disturbed children

(In the stunned six-week old infant in the video, one can see him protesting his poorly attuned care. One can see his repeated Moro or startle reflex easily enough, and one sees him becoming overwhelmed, glassy-eyed and limp. One can reasonably describe both these six-week old infants and Main’s disorganized one-year olds as more or less frozen stiff in the

combined state of chronic hyperarousal and numbed immobility which Herman (1992), van der Kolk (1996) and most trauma researchers have identified. On yet another level of description one can reasonably hypothesize that brain stem catecholamines and endogenous opioids are mediating these states, and that the more time the infant/young child is at their mercy, the more deeply they are etched into his maturing neuropsychobiological circuitry.

THERAPEUTIC PROCESS AND RELATIONSHIP

First Vignette

I am thinking of Charles, a man whom I worked with whose neuromuscular system was locked in such somatic terror and confusion. His core body feeling about his bond with his mother was that her touch felt like that of the water leeches that suck your blood. But leeches need your blood to live, so if he moved, she would die...and as noxious as she was to him, she was also his life source. So he froze...his spastic muscles rather than his skin became his containing membrane. As he put it, "You need a mother to learn how to use your muscles properly." As an adult he moved mechanically and without pleasure and felt that he had been able to organize a false neuromuscular self with his left brain. In a poignant attempt to hold himself, he had substituted his musculature, a part of himself, for the too dangerous significant other. He had done the same thing with his mind, literally splitting his thought process into a speaker and a listener. It was not easy to change this in therapy because beneath his control lay chaos. He sensed his flexor and extensor muscles contracting simultaneously instead of alternately; and beneath this paralysis, was the fear that he would go out of control, move violently in opposite directions and, in so doing, tear himself apart or destroy others. Charles slowly learned in our therapy how to reorganize himself in his body by internalizing how he could bodily be with me- that is, how he could touch, move and breathe with me. He learned, for instance, that he could move for himself and still be in contact with me. Charles' path to a vital connection with his core bodily self was via a somatic and emotional attunement and engagement with me.

Second Vignette

My second vignette illustrates how Freud's fundamental rule of psychoanalysis has in my approach been broadened. In addition to the spoken word, the patient is invited to share without conscious censorship his pre-symbolic sounds or vocalizations, bodily sensations and movements. My patient Anne, a fifty-year-old woman, was one of two surviving children of parents whose own parents had been either incarcerated or murdered by the Nazis. Lying on my somatic psychotherapy couch, she put her hand over her solar plexus, where she said she was experiencing a burning, pressured sensation/feeling. Anne and I attempted to explore what her bodily sensation was expressing about her inner state. I watched her breathing. Her respiratory wave, as it moved along the front of her body, was shallow. She was pursing her lips, and swallowing frequently. I encouraged her to breathe into and sense with her hand the area of her body to which she had called our attention. Over some five or ten minutes, the burning sensation moved up into her throat, as her breathing deepened. I asked Anne if she heard an inner sound or words or sensed any tone in her burning throat. She was uncertain. I suggested that she give sound to her exhalation, allowing anything to come out that wanted to. She then emitted a very high-pitched, far away sound...it cut off after several seconds. She then described it as "weird", and said it made her feel "inhabited" as if by some kind of "poltergeist". We waited. I was sitting next to her. She felt both frightened and intensely curious. After several minutes, the burning over her solar plexus became more intense, and another wave of feeling moved up the front of her body, culminating in another high-pitched, extremely difficult for me to listen to, wail, for which Anne, moments after, used the word "horror". She then said, in a horrified tone, "it's an old woman...it's my father's mother's voice...he carried it, and now it's in my body". The history was that her father alone had survived. His entire family had been shot by the Nazis. Let me note that while it did not happen in this particular session, Anne would often appear initially or at moments when she was threatened by her material, quite frozen and unable to feel anything at all. At these times I might physically hold and mobilize her muscularly braced head and neck in the manner described earlier in this paper.

Anne saw that I absorbed and contained her scream or wail with difficulty. We were communicating intersubjectively, but on a core bodily level (Stern, 1985). With my explicit support Anne was directly experiencing the not yet verbally encoded and/or highly charged material in her own body. She and I were communicating in a split-second, mostly out-of-awareness fashion. The elements of this non-verbal dialogue included our level of arousal and energy, motor activity, the size of our pupils, the tone and pitch of our voices and lots more.

Actually, the above vignette with Anne, in which we were both surprised by her grandmother's voice, was not really representative of the work-a-day somatic, nonverbal work that we did. In our initial session, Anne had explained her reason for entering therapy with me: she wanted to explore her youthful manner and appearance...which belied her almost fifty years of age. She said this to me in the tone of voice of a young girl. Anne had been in psychoanalysis for close to fifteen years before she got to me. She had grown immeasurably during this time, but still feared to more fully assert her creativity, independence and authority. In this phase of her therapy with me, sessions often began with the burning or other physical sensation over her solar plexus or throat. When I encouraged her to be with the sensation and see what happened, Anne's bodily state would change. Sounds and movements came out of her and moved through her; not those of a murdered grandmother, but rather those of a hitherto hidden, private self. At times the room would fill with a level of energy, arousal, vitality and sound many times that of the fifty-year-old woman with the little girl's voice. At other times Anne would tell me she felt a band of tension cutting off her voice and breath at her solar plexus and/or throat. She would ask for help and I might

put a hand on her body where she felt the tension. Whether and where and how I touched Anne on a given occasion is difficult to convey in a paper, in part because it is largely determined by implicit, nonverbal process. It is difficult to convey because there is such a multi-layered mix of things moving between Anne and myself. Consciously, I hear Anne's voice catch in her throat, and I know from experience that a firm, but light massage of her thyrohyoid membrane just above the cartilage that houses her larynx will likely reduce her choking and help to open her fuller vocal resonance. But I am also affected by the largely unconscious, nonverbal projective identifications that move in a split-second time interval between us. Let me elaborate briefly. Anne has a strong ego and functions at a high level in the world. She does not hallucinate. But when she connects with the primal sensation and movement of her dissociated self, things get...very primal. There is, for instance, a sudden, terrified body memory of sexual abuse by an uncle. Or a sense of her abdomen being inhabited by snakes or worms. Or a frantic sense of being trapped inside her thorax. As I sit next to Anne, I am aware that this material makes me uncomfortable- I don't like snakes, I hate being trapped and I really hate being sexually abused. But I believe two things are helping me to stay appropriately present to Anne. First, since I am trained to work with a person on a direct bodily level, Anne is having an opportunity to embody and renegotiate this primitive material. Consequently, my burden of having to receive and contain via projective identification is not so heavy. Secondly, Anne does not leave me floundering too long in her speechless terror or guttural (visceral) rage: Her observing ego finds the inner and then the spoken words that make her chaos more comprehensible. Nevertheless, how much overwhelming, chaotic material can I tolerate without subliminally showing Anne my dilated pupils, or pressing too hard on her thyrohyoid membrane in order to tone down her self-expression. Additionally, let me note that, although it is beyond the focus of this paper, never to be forgotten is the issue of whatever countertransference feelings I may be having about working at close range with Anne who, in spite of her childish voice, is an attractive adult woman (Lewis, 2000).

But let me return to the question of how I responded to Anne's request that I help her reduce the band of tension that was cutting off her voice. At times my physical touch seemed to reduce a physical restriction and/or support an inner resonance which then came close enough to the surface of Anne's being to enter her consciousness as a sound she could hear and a movement she could think about. She felt exuberant and terrified, ferocious and loathsome as she came to more fully embody the fifty-year-old woman that she was. It is difficult to do justice to the explicit transference issues that are imbedded in the implicit somatic material I am emphasizing. Having said this, let me note that at times I was Anne's lethally narcissistic mother in the transference, as Anne was overcome with shame and barely able to believe that I could tolerate eye contact with her after she had delivered herself so vitally into the room with me.

Third Vignette

My final vignette concerns Ben. His clinical picture was very much that of cephalic shock as I have outlined it earlier. Ben, if you remember, was the man I mentioned earlier who saw what he called "the jaws of death" when his head relaxed enough to let a lot of feeling into it. His mother was insecure ground and his father beat him about the head as part of being brutally physically abusive. Let me share some of the heart of our encounter:

For close to two years, we met twice weekly. The bedrock from which our work emerged was my constant physical presence and warmth. Over a period of months, Ben's center of gravity slowly dropped from his head and seemed to embrace his heart, his solar plexus and his pelvis. Throughout our work, this movement downward and toward the core was catalyzed both by my releasing Ben's deep head and neck tensions with my hands, and even more often, by his own spontaneous brow and head movements

Each crack in Ben's cerebral fortress reverberated in the rest of his body. Once it was not all anchored in his head, his guts and his heart began literally to spew out in pulsatile waves the trauma and toxicity he had lived with. He erupted many, many times in energy/movement/sensation/pre-emotion as his shocked organism struggled to come down from his head into his heartland and into a new way of being with another human being. For example,

Ben sits up (he has been lying on the bed). "You're repulsive- I want to puke everybody out- get out!" he screams. He pulls at his solar plexus and groans, "I want to reach in and turn my insides out--shake everyone out and start over again." (Later, he says this was about "bad love."): He jumps up onto his feet, as though choking on all that he has taken in and swallowed down. He is overcome by deep, racking sobs, crying out that he feels he is dying. Later he says he felt "suffocated" in the throat and "poisoned" in the solar plexus.

Before I tell you how it was for me to accompany Ben on this wild journey to places that neither of us had been to, I want to offer a limited explanation as to how it could be that in the middle of this awful process Ben began to report that his sex life with his wife had become fuller and more exciting: when you work deeply with the head, the thoracic diaphragm is activated. A partial explanation for this is that the phrenic nerve, which supplies the diaphragm, originates in cervical nerves 4 and 5 in the neck. The diaphragm in turn seems to be a major gateway to the rest of the body: the medial lumbo arch of the diaphragmatic muscle with the upper part of the psoas major contributes to the ilio-psoas muscle which descends to the pelvis and thigh. This anatomy sketch is offered in the spirit of a very limited explanation as to why Ben reported that his chest was glowing and his legs were flowing.

But let us return to my relationship with Ben. In my own Reichian-based bioenergetic therapy (Reich, 1973) the idea had been to dissolve my armoring. Once we got down to the core level of my biopathy, the goal was to reorganize a truer, more spontaneous bioenergetic self. While to some extent this happened during my own therapy, I think it took a decade or two of living with myself, my good wife and children, before I began to exist in a truer, more unified way from somewhere closer to my center. So how was it for me to help Ben to go where I had never been? At times I was envious of, at times thrilled by, and at times terrified of the depths to which he let his process take him (us!). Often, as in the above session where Ben fought on a core bodily level to free himself of toxic introjects, or when he demanded my warmth and presence, the action was so gripping and palpable, that my excitement won out over my fear, and our attunement was “good enough”.

Ben taught me about *Leib und Seele* (body and soul): at times his words seemed like echoes from the depths...like utterances from a man buried deep below the earth's surface. I found myself intuitively holding onto his words as if they were precious vessels from a place where spirit and matter are one. One can only approach, never hope to touch directly this inner flame. Ben said:

There is a box, a place in me that I never let anyone into... I can't trust...could be too hurt.. To get what I want, it feels like I must show some part of myself that was meant to remain private...in this private place in me – energy and matter are mixed in a really delicate way- it's a shimmery thing...I'm very fragile there... like the flame of a candle in gunky protoplasm...I'm terribly shy...I need hope, bravery ...the light mingles, resonates with an essential part of my self...I want to shine-glow out of that vulnerable place. I remember as a child running naked in the woods...I think I made a sound ...which kept something in me from being broken.

I believe that in Bioenergetic therapy we sometimes have mistakenly equated physically touching our patients with truly touching and being touched by them. I mean by the latter, a touch that is well-attuned to the patient's inner state or being. Ben had bravely compensated for a profound lack of early attunement with a mind and a language that wrapped themselves around people and held them in his head. Now, using metaphor and analogy, his spoken language increasingly touched me from the deepest recesses of his being. His words cried out from a place of cosmic isolation. They were the vessels for the hope that his inner being could be known, held and embraced, even when our bodies were not in direct physical contact.

As a child, Ben had stared for hours at the back of his father's head, wondering how he might make contact with and be taken in by him. He had given up on being seen directly, and mentally/visually tried to bore his way into being held (known, apprehended) in his father's mind. Now Ben's poignant metaphor and analogy allowed me to attune to what no one may touch directly in another human. The pain of his isolation emboldened him to risk losing his private self. I rarely found words in the moments when Ben's nascent psyche-soma touched the nascent (shy, fragile) hidden parts of my being. But I believe these shared moments brought both of us a fuller sense that we really were “insiders” in the community of humans.

CONCLUSION

This paper has delineated my clinical construct, cephalic shock. Cephalic shock has been related to Winnicott's construct: the mind as the locus of the False Self. An attempt has been made to integrate these early shock states with the neuropsychobiology of modern trauma research. Additionally attention has been drawn to the similarity between my construct and the recently described disorganized/disoriented one-year olds in the attachment literature. My clinical vignettes have described how in a somatic psychotherapy Freud's fundamental rule of psychoanalysis has been broadened and deepened. Somatic and emotional attunement occur in split-second time – intersubjectively, but on an implicit, core-bodily level.

As I reflect on my work with John, Anne and Ben, it is only when things are going perfectly that my countertransference gives me a rest. And as you can imagine, this rarely happens. When there is not quite enough happening, I am at risk of failing at my chosen ego identity: that of being a therapist...a failed therapist is a wounded healer. But when almost too much is happening, I am still shaken: once again the wounded healer in me is stirred, the self that was broken by my own early and ongoing traumas and never fully healed.

In summary, when you have no words for your feeling, for what happened to you, for what is missing in you, we listen to the inner resonance- of your inchoate secrets- as it lives in your body. We help you to sense and amplify this inner resonance until its movement comes close enough to the surface of your being to enter your consciousness.

But we also listen carefully to your words and we are touched by them when they come from a depth of your being that no one can put a hand on. We invite you to surrender to the spirit of your body and the body of your spirit- and in so doing, to embrace your true self.

Bibliography

- Ainsworth, MDS, Wittig BA. (1969). Attachment and exploratory behavior of one-year olds in a strange situation. In: Foss BM, ed. Determinants of infant behavior, vol.4. London: Methuen.
- Brody, S. & Axelrad, S. (1966). Mother-infant interaction film series: Forms of feeding at six weeks. 1965. University of Cal. Extension Media Center, Berkeley, CA 94704 (tel. (510) 642-0460.
- Herman, J. (1992). Remembrance and Mourning. Trauma and recovery (pp. 175-195). New York: Basic Books.
- Janet, P. (1925). Psychological Healing vols. 1-2. New York: Macmillan. (Original publication, Janet, P. (1919). Les médications psychologiques. (vols. 1-3). Paris: Alcan.)

- Lewis, R. (1981). The Psychosomatic basis of premature ego-developmnet. *Comprehensive Psychotherapy*, vol.3, Gordon & Breach, New York.,91-102.
- Lewis, R.(1984). Cephalic shock as a somatic link to the false self personality. *Comprehensive Psychotherapy*, Vol .4, Gordon & Breach, New York,101-114.
- Lewis, R. (2000). Vignetten zu Fragen der erotischen Übertragung und Gegenübertragung in der bioenergetischen Analyse. *Körper und Seele*, Band 6, Schwabe & Co., Basel, 51-61.
- Lowen, A. (1970). The Pleasure of being fully alive. *Pleasure*(pp.35-61).New York: Coward-McCann.
- Main, M.and Solomon, J. (1986). Discovery of a new insecure-disorganized/disoriented attachment pattern. In: Brazelton TB, Yogman MW, eds. *Affective development in infancy*(pp.95-124). Norwood NJ:Ablex.
- Perry,B.D. (1997). Memories of fear, in J.Goodwin and R. Attias (eds.). *Images of theBody in Trauma*. New York: Basic Books, 9-38.
- Reich,W. (1973). *The function of the orgasm*, vol.1. New York: Farrar, Straus and Giroux (Noonday Press).
- Schore, A.N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Developmentand Psychopathology*, vol.8. Cambridge University Press, 59-87.
- Stern, D. (1985). The sense of a core self. In: *The interpersonal world of the infant*(pp.69-123). New York: Basic Books, Inc.
- Tronick, E.Z. (1989). Emotions and emotional communication in infants. *American Psychologist*,vol. 44, 112-.119.
- Van der Kolk, B. (1996). *Traumatic Stress*. New York: Guilford Press.
- Winnicot, D. (1965a). Ego integration in child development. The maturational processand the facilitating environment. (pp.56-63). New York: Int. Univ. Press, Inc.
- Winnicott, C. (1965b). Ego distortion in terms of True and False Self. The maturational process andthe facilitating environment. (pp.140-152). New York: Int. Univ. Press, Inc.

Biography

Robert Lewis, M.D., in private practice in New York, is a senior trainer on the IIBA faculty, and a member of the clinical faculty of the NYU/Mount Sinai Medical Center. He has published extensively on the integration of early developmental and relational issues into the basic bioenergetic approach. Bob has long been interested in the sensory-motor story which trauma engraves in our bodies. He coined the term “cephalic shock” to capture the psychosomatic experience of what Winnicott called the mind as the locus of the false self. His elucidation of Cephalic Shock and way of working with the head, voice, and diaphragmatic connections to the pelvis, are beyond words. He has found the Attachment paradigm deeply confirming of the centrality of relationship in his clinical approach. Bob aims for and is touched by the moments of encounter in which implicit mystery becomes almost palpable. He leads workshops in Europe and the Americas, and residential intensives on Long Island, New York. He can be reached at boblewis@inch.com

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