

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume fifteen • number two • spring 2016



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International Body Psychotherapy Journal*The Art and Science of Somatic Praxis**(formerly US Association for Body Psychotherapy Journal)**volume fifteen · number two · spring 2016*

The *International Body Psychotherapy Journal* (IBPJ) is a peer-reviewed, online journal, published twice a year in spring and fall. It is a collaborative 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 can be ordered through the website <http://www.ibpj.org/subscribe.php>. 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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The IBPJ is available free online.

Print subscriptions: <http://www.ibpj.org/subscribe.php>

Printed single issue Members €17.50, Non-members €20

Yearly subscription: Members €30, Non-members €35

Two-year subscription: Members €55.00, Non-members €60.

Payment through bank transfer, American Express or PayPal.

Changes of address: secretariat@eabp.org

Advertising: jill.vanderaa@eabp.org

Translation The online Journal is published in the English language. Abstracts of articles are to be found on the IBPJ website in Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian and Spanish.
<http://www.ibpj.org/archive.php>

If an article originally written in another language has been accepted for publication in English, the full article may also be found in the original language.

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ISSN 2169-4745 Printing, ISSN 2168-1279 Online

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Cover image The Messenger by Ofra Sivilya

Spring Issue – Editorial

In Chinese medicine Spring is the season of the wood element. The power of wood is said to be filled with creative potential, to contain the power of both being true to your own nature and becoming more yourself by expressing your inner needs and desires. Spring invites us to break through the moist suspense of winter and say ‘yes’ to life in all its totality and ‘no’ to obstructions blocking us from living. What if we consider character armour in terms of wood? Can we think of the defences we have adopted over the years in our attitudes and our muscular holding, in our beliefs and our ability to act as our attempts to say yes to life and no to that which obstructs us from being alive? Perhaps the human character structure is the best we could come up with; the most elaborate personality organisation we believed would enable us to engage with life and with others. Therapy then can serve the space when our character armour no longer serves us the way we needed—to stop the spillage of symptoms or rigid ways of being, to contain unregulated emotions, to lessen difficulties in forming or sustaining relationships. However, alongside our wish to transcend our character, to liberate ourselves from the things that prevent us from living life more fully, perhaps we can also extend some gratitude to this wood element. We tried our best; it has to account for something.

Thus, to view pathology and pain through this lens is to honour our past subjective organisations as genuine attempts, if not always successful, at life. Like the tree that entwines itself around the obstruction to reach for light, it makes something unique and of beauty, as well as the shape of dysfunction. As such, our symptoms and pathology are also victories of our emancipated spirit – representing the depth of sacrifice we were willing to make, for our life and for the people who we love.

In this issue, Noa Oster and Renana Reiss discuss their work with Benny, a child on the autistic spectrum. They offer a synthesis between the work of Frances Tustin’s pioneering role with children with autism in the 1950s and Will Davis’s Functional Analysis, and examine somatic and motoric aspects of work alongside relational transference dynamics. It might be interesting to read this piece while keeping the thought about wood. While working on this issue, we asked Roy Desjarlais, a bodyworker and craniosacral therapist who specialised in working with children on the autistic spectrum, to respond to Oster and Reiss’s paper. We were shocked and saddened to learn that Roy recently and quite unexpectedly passed away. We wish to express our condolences to Roy’s wife, family and friends. Roy commented on Oster/Reiss paper and shared his wealth of experience within a different approach to work with children on the autistic spectrum.

Matthias Wenke presents a fascinating comparison between Wilhelm Reich and Alfred Adler, particularly through resonance and intersubjectivity as they manifest in the relationship, in the body and in movement.

Our next paper, by Margit Koemeda-Lutz, Aureliano Crameri, Volker Tschuschke, Peter Schulthess and Agnes von Wyl, compares a myriad of therapeutic approaches and interventions. The paper explores how ‘committed’ we are to our own modality, and how much flexibility we exercise in our work with our clients. Their findings make a strong case both for the centrality of the client-therapist relationship, as well as for improvisation and responsiveness outside of prescribed responses.

Shinar Pinkas brings a poetic piece about processes of sleep and awakening in psychotherapy. She examines liminal states of consciousness and introduces a novel body psychotherapeutic technique that utilises theoretic and clinical material from Wilfred Bion, a British psychoanalyst. Pinkas illustrates her arguments with a group work vignette.

Last, Luisa Barbato and Nitamo Federico Montecucco discuss how recent discoveries and insights in neuroscience, particularly from psycho-neuro-endocrine-immunology (PNEI), confirm and support the “psychosomatic unity paradigm,” and therefore body psychotherapy.

We are hoping you will find the papers in this issue inspiring and provoking at times. If you were stirred or touched by a paper, please let us and/or the author(s) know. Feedback makes a tremendous difference for our authors and it enables a healthy dialogue which makes space for the advancement of our profession. In view of the current political situations, death and hatred so widely spreading in our world, we will dedicate the next IBPJ issue to the themes of hope and faith. We invite you to send us relevant contributions.

Wishing you a happy Spring,

IBPJ Editorial Team
Asaf Rolef Ben-Shahar
Nancy Eichhorn
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Whitewater healing

By Dorothy Oger

Between the client and the therapist
There is a space that can be shared
If both are willing to breathe together,
Both willing to touch their own pain.

Will you help me build my selfhood,
Asks the child of his therapist,
To become real? To learn to ride the surf,
Pulsating home and pulsating to you?

Will you help me remember myself,
Asks the therapist of the child,
To sustain and support the wave of relating?
To invite you through my real self?

In the in-between movements
Of gathering and of connecting,
Of engaging and of retiring,
A new coherence emerges.

Therapist and client enter a new space
When they relate honestly, body-to-body,
Moving from contraction to selfhood,
From separation to community.

They enter the safe space
Of a wider mind that contains them both,
That reclaims them both as humans,
A powerful dimension for change.

BIOGRAPHY

Dorothy Oger holds a Master of Arts in Germanic Philology (English and Dutch Literature and Linguistics). She is a certified NLP Trainer & Coach and she holds certificates in systemic constellation work and in Emotional Freedom Technique. She is a trainer and coach, practicing both within corporations and privately. A poet since the age of eleven, Dorothy offers individuals, groups and organizations a unique way to reflect back and deepen an experience. Her poem “I shall stand for love”, written in the aftermath of the terrorist attacks on Brussels, has inspired people to regain trust and to step out of the stuck state of powerlessness. Translating the poem in their language and sharing it through the Facebook page has been healing for them:

<https://www.facebook.com/weshallstandforlove>.

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Whitewater Surfing

Relational body psychotherapy with children on the autistic spectrum

Noa Oster and Renana Reiss¹

Abstract

This paper offers a theoretical and clinical outlook on working with children on the autistic spectrum from a relational body psychotherapy perspective. Pulsation (Davis, 1984, 1999, 1999a; Reich, 1973) is positioned as a central axis of the therapeutic encounter, which is illustrated with a clinical case. Through this lens, the authors explore autism both as a personal matrix and as a transference pattern within the therapeutic and autistic relationship. The authors examine therapeutic positioning (based on a synthesis of Davis, 1984, 1999, 1999a; Tustin, 1986, 1990; Winnicott, 1958, 1965, 1971, 1987), which supports fluctuation between states of consciousness and gradual establishment of a dyadic state of consciousness (Tronick, 1998) with the client. The authors suggest that shared presence in a dyadic state of consciousness has an integrating quality, which contrasts against the repeated enactment pattern of the autistic relationship that tends to take place within the therapeutic relationship.

Keywords: autism, relational body psychotherapy, pulsation, instroke, autistic relationships.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 15, Number 2 Spring 2016 pp 7 - 20. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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A. Introduction

Benny has soft golden curls, almond shaped eyes, fair skin and angelic beauty. Something in all this and in what lies beyond, that the eye cannot fully translate, made me fall in love with him at first sight. Benny is diagnosed with low functioning autism. I started working with him when he was two-and-a-half years of age as part of a therapeutic team working within the Developmental Individual Relationship (DIR)² model. He doesn't speak at all and mostly avoids eye contact. Benny remains in his own inner world most of the time. He has great difficulty initiating connection and relating to existing relationships. When one does establish interaction with Benny, he is usually unable to remain in connection for long periods; it is as if he loses interest and retreats back into his own world. Benny experiences frequent states of emotional and physical dysregulation; when he is flooded, his breathing becomes quick and shallow and his hands (and when he is sitting, also his legs) fly everywhere like flags in stormy weather.

¹ The case vignette presented in this paper is from Noa Oster's work. It has been anonymized and printed with permission. The two authors equally contributed to the conceptualizations and writing of this paper.

² Developmental Individual Relationship, a therapeutic model for children with varied developmental and emotional difficulties, particularly on the autistic spectrum. The model is based on encouraging the child's innate potential for communicating, and cultivating meaningful relationships, developing logical and creative thinking (Greenspan & Wieder, 2006).

When I met Benny for the first time, it was only his eyes that hinted there was something different, something out of the ordinary about him. His eyes were somehow de-focused and foggy. I wondered what he saw. I was unsure how much they saw the world; but it felt certain to me that he saw the world in a different way than me.

When paying closer attention to his movements, I noticed that although Benny walks and runs, his legs seem as if they are not truly connected to the ground, floating—disconnected from weight and roots—as if his upper body rather than his lower body carries his weight. His upper body, however, seemed particularly solid, and I could notice high muscular tonus in this area - a rigid posture which lacked flexibility.

On the whole, one cannot remain indifferent to Benny. There is something charming about him. There is something one can sense even when you pass by him on the street, combined with his autistic “hard to get” attitude that touches you deeply.

B. I want more: From contraction to joint movement

During one of the team meetings we decided upon and agreed on a hand gesture to indicate ‘more’ (more banana, more singing, more playing . . .).

One of Benny’s favourite games is jumping on a physioball. Benny is placed on the ball in a sitting position, held under his armpits or by the hips as the therapist bounces him on the ball. One day I decided that I would sit together with Benny on the ball. I positioned Benny between my legs so his back could feel the front of my body as my arms were wrapped around him, touching his stomach. And so we bounced up and down. Benny was very enthusiastic about the new game. He never experienced this type of bouncing before. I was also excited about our jumping and about the prospect for our relational orientation the game enables us to establish.

Choosing to position myself in such an embodied interpersonal manner, where my body served as an enveloping container (Shahar-Levy, 2005), provided Benny with a bodily-connecting experience, both sensorial and emotional, which was appropriate for his infantile developmental stage. Such a positioning allowed us to create a nonverbal dialogue through movement and touch, required for both Benny and I, allowing for greater attunement between us. “When we are attentive to our own bodies we can feel ‘the other’ alive and moving through us” (Rolef Ben-Shahar, 2014, p.153). Our touching bodies opened a channel for a vital and unmediated connection.

We met four times during the week and spent considerable time bouncing together on the physioball. Every time I stopped and Benny wanted to continue, I asked him “more?” alongside the agreed sign. At first Benny took my hands and used them to sign. After a week, while we were sitting on the ball, when pausing between the bounces, Benny entered his own world, and I allowed him this inward movement.

I breathed deeply, so Benny could feel my stomach emptying and inflating against his back, feeling my physical presence. From my own breathing I moved to his breathing; I placed my hands on his stomach and with each exhalation I gently pressed on his stomach. It might have seemed as two people sitting on a physioball, each in their own different world (my hands’ movement, and breathing were almost unnoticeable), but our shared field was alive and pulsating through body-to-body communication and deep attention to breathing, whereas I physically affirmed his breathing.

After a quarter of an hour, Benny ‘snapped out’ of our shared unique bubble, took my hands and signed “more”. This time I did not satisfy his wish immediately, and before continuing I took

his hands and signed “more” a few more times while saying it aloud. We kept bouncing until Benny lost interest and left the ball.

When working with autistic children, we find it useful to pay close attention to pulsation. Reich (1973) argued that life energy has a pulsatory quality. He noticed that all organismic processes are characterised by natural biological rhythms of expansion from the core to the periphery and contraction from the periphery to the core. This is relevant on all levels, from a single cell in our body to complex processes such as heartbeat, breathing, orgasm, crying and more.

The founder of Functional Analysis, Will Davis (2001), expanded on the concept of pulsation and differentiated between the direction of the pulsation and the quality of its movement. To describe its direction, he used the terms *outstroke* (from the centre to the periphery) and *instroke* (from the periphery to the centre). In both directions, according to Davis, qualities of expansion and contraction could occur.

In its essence, pulsation describes a movement toward something. The instroke movement aspires to connect with the self, and has qualities of gathering, connecting with inner resources and self-organisation. The outstroke is an outbound movement aspiring to connect with the other. Both movements are cyclic and are intertwined with one another, so that the gathering pulsation of the instroke allows the outbound movement, and the outstroke requires re-gathering in order to process and reorganise.

Looking at autism as body psychotherapists, as we use the lens of pulsation, we can consider it a contracted state, lacking the movement toward something³. It seems that the very pulsatory organismic nature is wounded. The injury is clearly visible when it comes to connecting with the other, but at the same time it manifests also in the difficulty to connect with oneself. In a state of contraction, unlike the instroke, there is a withdrawal from something or an attempt to prevent something from happening (Davis, 1984). In fact, contraction is a chronic bodymind holding, an attempt to protect the person from (real or perceived) threats – a holding that prevents the person from experiencing life pulsating through oneself.

This kind of contraction, which is expressed in an inward withdrawal from the periphery of the body toward the core, has been thoroughly studied by Davis (1999), who describes it as a response to early developmental traumas. Davis describes how, during these early stages, the body of the foetus/baby is, in many ways, a system that has not yet been properly differentiated into different segments and therefore cannot rely on neurological defence mechanisms such as “fight or flight.” These defences are reliant on the muscular and neural systems that are insufficiently developed for self-protection. The only strategy available for the young organism is an inward withdrawal, reaching a “plasmatic contraction.” In Davis’s (ibid) terminology – an inclusive chronic contraction, based on plasma and connecting tissues that envelope the muscles. The withdrawal may seem like an amoebic contraction in the face of danger. The connective tissues “create a body” as they give the body structure and inner cavity. The structure they create are connected to their function as providers of stability, support, space, containment, differentiation and protection to all organs and muscles. The plasma and connective tissue are characterised by exceptional qualities of adaptation and flexibility, reconstruction and spontaneity. The plasmatic contraction creates a rigid structure that deeply compromises the capacity to adaptively function – both somatically and

³ Naturally, there are also organic aspects to autism. We are not claiming otherwise; we only wish to illuminate another facet of working with people on the autistic spectrum.

emotionally. It makes the person highly vulnerable resulting in a greater need for control. The far reaching consequences of plasmatic contraction concern crucial developmental aspects such as metabolism and the ability to be physically and emotionally nourished.

One of our therapeutic goals is to allow, through the dyad, a transition from contraction to instroke. At the early stages of its life, the dyad is symbiotic. Within it, sensory interactions like sucking, eye-contact, games and caresses are the primary communication form between a mother and her baby, creating a space of sharing (Tustin, 1986). Within this shared space, the mother helps the baby regain his selfhood thus assisting him in the transition from existing to real: "Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation" (Winnicott, 1971, p. 65). For us, the meaning of transition from existence to being relates to our embodied nature, a process that in its earlier stages cannot fully take place except in a dyad.

Winnicott (1958) and Tustin (1986) wrote about autistic injury in relation to the infant's premature consciousness regarding his bodily separateness from the mother. This sudden realisation occurs at a stage in which the baby's psychic organisation was insufficiently developed to tolerate it, since he or she has yet to develop a sense of continuous-being and of the mother's continuous existence. Psychologist and perinatal researcher Daniel Stern (1985) related to this initial developmental stage, the emergent-self stage, as a process in which, through learning about the relations between the infant's sensory experiences, a primal sense of self begins to form. In his discussion on primitive emotional development, Winnicott (1987), mentions three main challenges: self-cohesion, object-relations, and indwelling the psyche in the soma. According to Winnicott, during the first developmental stage maturation is mostly a matter of integration. The trauma of becoming prematurely aware of one's bodily and psychic separateness, compromises the maturation of this initial developmental processes. Since the self has merely begun to form, the experience of separation is directly experienced (instead of being perceived) (Stern, 1985), destabilising the very being of the baby. Generally speaking, we can argue that the baby is wounded in the depth of the establishing foundations of self-organisation within a pulsating living body, a body which is a home, in which one can safely indwell.

During the first stages of life, life's pulsation is primarily inward bound. We regard this instroke as a life-giving movement, making the body real and alive, a process that gradually becomes an entirely different existential experience than the first experience of the newborn. It means that a space to be inside and to move within is created, a medium between me and the other is built upright, the sense of human belonging is created allowing the baby to be nourished at all levels. These processes serve as fertile ground for later developmental stages. In encountering autistic children, it sometimes seems as if they have no real need to shift from their contracted state.

This is also connected to the tragic process whereby autism recreates and perpetuates itself. In our work as body psychotherapists, we are attentive also to the nonverbal communication from which completely different voices unconsciously arise, wishing to become part of the pulsating human nature. We can work with these aspects without bringing them into consciousness.

The repeating transition from the chronic plasmatic contraction (Davis, 1999) to an instroke-supporting dyad is a central axis in our therapeutic work with children on the autistic spectrum. Just like a mother maintains connection with her newborn while breastfeeding, as the baby drifts into a dreamlike state while the warm nourishing milk enters his or her body,

so can the therapist hold a similar space with the client – an instroke-supporting space. This is a space where the therapist allows the client to be supported by the therapist’s holding, touch, and eye contact in order to go inward-bound to self and without having to reciprocate the connection. Bodymind markers can clearly indicate that the client is in a shared space rather than a withdrawn encapsulation. The therapeutic positioning that supports such a process relies on two parallel axes: the beckoning and the movement. We may look at this beckoning as the long-term calling of which Winnicott (1971) spoke. The mother gives back the baby his own self, which reflects in her eyes thus assisting him in becoming real. In turn, the movement, as an ongoing process, re-familiarises the bodymind with the potential of moving from aloneness to a dyad, back and forth, opening a possibility of choice, even if this choice is unconscious. Such a choice is of great developmental importance as it indicates a mutual willingness to remain in the contraction while knowing it is possible to move from it to a nourishing and benevolent dyadic space; thus, it is a countermovement to the autistic cyclical lock.

During our next session we spent our time on the physioball in the same manner – when Benny wanted more and signed with my hands, I took his hands and signed, and when he pulled inwardly we remained in physical connection, paying attention to breathing. On the following day, again on the ball, when I stopped bouncing, I let go of Benny and I hid my hands behind my back. First, Benny tried looking for my hands but when I refused to help him he made a small but clear sign with his hands. I was so excited that I gave him a big hug. Benny got upset, held my hands and made the ‘more’ sign. Three days later (when the entire team continued to encourage Benny to use the sign) I met him again and was happy to see that Benny had internalised the sign and he can now say ‘more!’

While we can understand Benny’s remarked achievement of learning the sign from various angles, we would like to offer a relational body psychotherapy perspective. The entire process allowed Benny to pulsate. He moved inwardly and outwardly in his own personal rhythms and the movement itself had a clear quality of expansion. This is but a small part of the picture, since the pulsation was not individual but dyadic. I (Noa) beckoned Benny with my own bodymind to join me into an intimate, dyadic space, and I waited for him to come. This positioning demanded that I made sure I was present in my own body, that I could be attuned to my own pulsation. It is a positioning that is first and foremost human, and it carries an invitation for unmediated connection. In other words, I tuned myself as if an instrument for Benny to play his own tune, in his own language – one of bodily sensations.

The willingness to reside in a space of shared pulsation opened a channel of mutuality, of nonverbal communication, which seeks not to translate itself into words - a dyadic state of consciousness. Dyadic states of consciousness (unlike individual states of consciousness) are created within a relationship where both parties influence one another and are influenced by the other. “Mother and infant actually do co-create each other through subtle but powerful processes of reciprocal influence” (Mitchell, 2000, p. 21). During individual states of consciousness, our consciousness remains in our own personal space, but when we are in contact with the other – affectively influencing and influenced by them, creating the relationship and created afresh by it, a new space is opened between us. In this place our individual consciousness meets and creates a new one, shared and unique to us alone. This novel consciousness is a whole bigger than the sum of its parts. We pulsate together, sharing a deep mutual being, where experience is possible without words since “I feel that you feel that I feel” (Stern, 2004, p.75). Edward Tronick, whose research was based on extensive

infant and infant-mother observation, believed that dyadic states of consciousness formed a rich source for growth and change. He argued that: “Dyadic expansion of consciousness is a powerful force for change. The infant’s mind becomes more coherent and incorporates more information. And when a dyadic state of consciousness is achieved there is a restructuring and change of the infant’s present and past mental organization” (Tronick, 1998, p.298). The transition from individual to dyadic state of consciousness requires active involvement of both parties and is not necessarily conscious.

Within the therapeutic process, the transition into a dyadic state of consciousness forms a transformative movement toward something, where in the bodily experience this movement manifests in moving from contraction to instroke. This is a movement that is in fact choosing life, resulting in the ability to make contact with self and with the other. The autistic injury occurred during early infancy (and possibly earlier) in symbiotic fields that were meant to first and foremost ensure the possibility of instroke, an inward movement that embodies the reality of being and is safely held in the hands of the infant’s attachment figure. “The loss might be that of certain aspects of the mouth which disappear from the infant’s point of view along with the mother and the breast when there is a separation at a date earlier than that at which the infant had reached a stage of emotional development which would provide the infant with the equipment for dealing with loss. The same loss of the mother a few months later would be a loss of object without this added element of a loss of part of the subject” (Winnicott, 1965, p. 221). In light of such loss, the movement of choosing life has healing qualities in itself.

We believe that the relational body psychotherapy perspective is of value as it can “speak” the autistic language, which may develop from an early injury during the physical-sensory shared space both as means of communication and as a developmental axis. Benny was able to hear the beckoning to join into connection thanks to the language in which it was uttered, the same language that defined the spaces in which he resided and in which he had lost himself, and thanks to the significant relationship that already established itself. Anne Alvarez, a consultant, child and adolescent psychotherapist and author, writes with great acuity about the intention of this beckoning: “It seemed to me that my function was to reclaim him as a member of the human family because he no longer knew how to make his own claims” (Alvarez, 1992, P. 54). The transition from avoidance, withdrawal and chronic contraction into a shared dyadic pulsation arguably allowed for the retrieval of those “lost parts” within a living system, which validated an experience of going on being. Noa beckoned and Benny accepted her invitation to “come home” to a relationship that was a fertile ground for two embodied psyches to recreate one another, to touch and be touched.

In our therapeutic work with autistic children, touch can also serve as a therapeutic tool, but it is much more than this – it holds within it the very call of inviting the autistic child to experience himself as “a member of the human family” (Alvarez, 1992, p. 54). Body psychotherapy can offer touch as an additional language seeking to “speak” the sensory world of those who “swung out of human care and ‘holding’” (Tustin, 1986 p. 165), and help them transition more easily between different states of consciousness. Looking at it from a wider perspective: “A body is not a thing (object), it is a person” (Rolf Ben-Shahar, 2013, p.40), and thus contacting the body allows for development and opening non-concrete spaces within a concrete body. Human touch can create unmediated connection between people, encompassing all levels of our being – physical, emotional and spiritual. “Touch in psychotherapy is a stance rather than a technique – a declaration of connection. It is not just something we do, it is a way for us to become” (ibid, p.41).

C. We want more: Autism as a relationship

To say that “I called Benny using my own bodymind”, “ensuring I felt myself pulsating,” and to say that “transitioning to a dyadic state of consciousness demands active participation of both parties,” may sound completely detached from the reality of encountering such a lost autistic little boy. Such a meeting brings up great complexities for the therapist, which makes it harder for her to remain in connection with the other as well as with herself. We would like to draw your attention to the complexities we have encountered in order to understand its effect on the therapeutic relationship.

A meeting with an autistic child confronts us as people with our basic need to relate. We need connection with the other in order to validate ourselves and to be in physical contact with the other in order to feel real. In fact, this mutual process is scarcely met when encountering an autistic child. This lack of mutuality may evoke in us, as therapists, familiar and painful childhood tunes from our own past. Our choice in psychotherapy as a vocation oftentimes arises from injuries during the developmental stage where our deepest yearning as children was to deserve closeness and love for who we are, and our ability to authentically and independently express ourselves. “An injury to the right for assertiveness expression of will (or unwillingness) oppresses the child’s necessary separation-individuation rebellion... the child understands that in order to attain love and connection he is required to sacrifice his own wishes and independence... and masochistic character structure is created. Every therapist carries within her a pronounced masochistic personality – the mere willingness to endure long hours of another person’s suffering and gain one’s worth through listening and helping (being at service) has masochistic qualities” (Rolef Ben-Shahar, 2013b, p.183).

The mutual bouncing game with Benny on the physioball stemmed from me almost instinctively; I was driven by an inner force to find a game that would work for us that would allow Benny to remain engaged with me, which would allow me to feel a good-enough therapist, a meaningful therapist. When my body came in contact with his, when my hands could speak with the body they met, then I felt together, in connection, then Benny cannot ignore my presence with him, he cannot ignore the fact that I, too, exist. During the first bouncing sessions I did everything I could to adapt myself to him, to keep him and us on the same wave, so that we continued to enjoy the surfing without falling from the board into the endless ocean. At the time I could not feel my effort, the deep internal tension that kept me alert and attuned to him, unable to slow down. I was unable to allow the spaces that beckoned him to become more active. I became full, and the price I paid didn’t matter. And as a gift, Benny forced me to slow down when, after a few rounds of an exciting and vitalising game, he slowly turned inwardly.

In this unique encounter, there is a significant fundamental difference between the child’s “endless ocean” and ours as psychotherapists, with the terrors and dreads these hold and the defences we both have for facing such dread. The autistic child’s terror of falling into the ocean is a fear of complete annihilation, where he would become “a no-body” and “a non-entity” as Jean, Tustin’s client (1986), poetically expressed. Autism, a powerful and chronic defence mechanism, points out the real danger that is constantly present in the body and mind of the child. Therefore, this ongoing dread is also present and activating the therapeutic encounter with powerful undercurrents. Our own endless ocean includes, among other things, the dread of helplessness when faced with failure of our masochistic mechanisms to make ourselves worthy of love, of closeness, of validation. While the autistic child is terrified of becoming a “no-body”, we dread of becoming “nobody”, remaining insignificant within the relationship and feeling worthless as people.

Our habitual position as therapists is being “outside”, in the outstroke, available for connection with the other, even in the price of self-abandonment. The more threatening our inner substances, the more this pattern tends to become stuck, and we make an even greater effort staying “outside” with the other, thus avoiding really touching those painful substances. In fact, the quality of the outstroke becomes more contracted and there is less pulsating movement. Bodily speaking, we might find frequent leaning toward the other while losing our capacity to sense ourselves, to feel our own centre. Our own resources and the capacity to tolerate more and more may actually be of disservice to us. We willingly agree that the child will use us as an autistic object (Tustin, 1980); we justify him or her in myriad ways and in fact contribute, unconsciously of course, to the prevention of real meeting between us, a meeting that would confront both parties with their personal dreads and terrors.

A relational-embodied look at this special dyad may demonstrate the likelihood of the therapeutic relationship to become contracted, a relationship in which the therapist and child are autistic to one another. The movement toward something, within each of them as well in the dyad, decreases and may even become blocked. A contracted dyadic state is created – the therapist tends to be stuck in a contracted outstroke and the autistic child is contracted “in nowhere.” The great willingness to meet fails, creating pain when the meeting is unsuccessful. It is then that the shared wound is embodied – a wound connected with the ability to move from contracted space into the instroke. While the autistic child needs to build his selfhood through the instroke, the therapist is called to remember her selfhood and her having a real body using the instroke, thus restoring the expandable pulsation to herself and the dyad. The relationship perpetuates its own autistic nature when both parties unconsciously avoid moving, due to their inner resistances.

When our pleasurable bouncing game stops for a few moments and we are sitting together on the physioball, Benny on my lap, although there is no eye contact, I remember myself, naturally and simply. My body reminds me to breathe, to breathe deeply. I breathe and sense my body. I breathe and sense my stomach meeting Benny’s back. I manage to expand into the separate reality of myself as well as to our joint reality. My body feels lighter, more present, a new consciousness streams within me, I can lean backward and rest. My inner work during this state of consciousness is directed at permission to be myself and allowing Benny to be himself. Then a new feeling of unity emerges, a feeling that connects us, holding me and him in a wider container, in a synchronised dyadic pulsation. Our surf board is no longer too narrow to contain us both in this stormy water; we both bathe in a moment of grace, which allows us to float safely, calmly.

We believe that in order to move from the contracted dyadic state into an instroke and dyadic pulsation, a third party is required. Just as the mother-baby dyad requires the support of the father (or another person) to face the big challenges of infancy and to provide her a wider container into which the dyad can lean on and later open to, so does our dyad requires support of similar qualities. Faith in our capacities and abilities to face the world outside, a sense of identity, a feeling that we belong to something bigger than us (“a family”), a sense there is a wider ground holding us, supporting us and our growth, and ability to sense the dyadic here and now – we need this to have an ongoing dyadic development. These are some of the meaningful characteristics for this dyadic relationship. The more wounded and autistic this relationship, the more it tends to be isolated within itself and lacks the capacity to lean, which makes it even more vulnerable.

Within the space of this indrawn and vulnerable relationship, different psychotherapists seek and find different sources of support. For us, the most meaningful third to lean on is

the “Wider Mind” (Bateson, 1979). Bateson described the wider mind as, “The glue holding together the starfishes and sea anemones and redwood forests and human committees” (ibid, p.5). The wider mind allows us to partake in an inclusive system of belonging, where we are both a part of the other but also separate from it. “The wider mind... is a space that connects us; a field that requires us to surrender into it and then allows deep connections to interpersonal, collective, and spiritual resources” (Rolef Ben-Shahar, 2014, p.99). When we are able to re-embodiment ourselves and lean on the wider mind we, in fact, validate its existence as a body, as a real entity that provides our contracted dyad a wider context of being, in which it is held. This body of the wider mind is the space within which a novel movement can take part –both of the individual and of the dyad, a movement of opening the closed space to a third party, which embodies the connection to our organic nature, sharing the wider pulsation of life.

When we are deeply immersed in our contraction, it is easy to forget that we are held by a wider mind. We remain in an experience that is lacking a dimension; such an experience makes it difficult to sense in a wider context. Our willingness as psychotherapist to remain in the isolated autistic dyad, and even more so to be in touch with these lurking threatening substances in the endless ocean, is potentially endangering our capacity to remain present with ourselves and the other. This is the ground we walk on as we come to work with autistic children. It is, inevitably, a walk on an earth full of thorns, seeds and unique textures, but our ability to sense them at their fullest viciousness and tenderness is of a completely different quality when we are able to tread it barefoot. Willingness to touch the pain enables the beginning of a healing process. It is a positioning that refuses to demand of the other what we are unwilling to go through ourselves – staying with a deep pain held enveloped in loving hands. From this opening into a wider perspective, pain can signal us where we are. This signal provides bodily grounding, emotional and spiritual presence as well as the ability to expand and move from the pain outwardly, into a meeting with the other. Opening up to a multidimensional being and a renewed movement toward something requires great internal resources from the therapist. The psychotherapist may as well use internalised objects, embodiment techniques, images or symbols that hold meaning for herself, and attending to her own countertransference, to better change her positioning in the relationship. Changing the way she is positioned attempts to ignite a parallel internal process to the client’s process – a process of continuous self-reclaiming, of coming home. In this process the therapist reclaims her wholeness, the subject that she is, her reality as present in a human body. Therefore, a new dimension opens inside her, one which is wider than her separate physical body, that can bring movement into the shared field of the relationship and opens a new space to move in.

D. About emergence and straightening up

One repeating image chosen by clinicians working with autistic children is the spine. Tammy Polack (2003) wrote about a ‘frontal spine’, mental in its essence (differing from the physical posterior spine), which spontaneously emerged in her countertransference, and she used it as a model for an organising image within the therapy. Polack saw, in her mind, a frontal spine that was organised around soft and elastic string that would hopefully thicken during the therapeutic process, when solid “experience beads” would accumulate to make spinal vertebrae, allowing for a sense of “mental straightening up.” Polack suggested that psychotherapy with autistic children requires the therapist’s attendance to “pre-spinal” states, primary states, states that are difficult to locate since they have a liquid or gaseous quality. Therefore, the first therapeutic task is to solidify them in the therapist’s mind.

Anne Alvarez (1992) wrote on her experience with Robbie, an autistic boy with whom she worked for over a decade, that his slack or sagging always made it difficult for her to believe that he had any self of his own. Alvarez describes how, during the therapeutic process, she felt the unbearable absence of weight and a gluey kind of contact. At a certain stage her positioning toward Robbie changed. “I believe that I, with my misguided pseudo-psychoanalytic ‘understanding’, provided for much longer than I should have, an all-too-watery medium, in which he thrived but failed to develop” (ibid, p.43). Consequently, she started to grow her own backbone, to insist with him and with herself on a different kind of contact, less gluey. It seems that her own backbone affected Robbie, that he experienced it as an attempt to bring him closer to her. He gradually became vertebrate – discovering that he had bones and musculature, which allowed him to move and act via his emotions, thoughts and words: “He was beginning to have backbone and substance of his own” (ibid, p.49).

We concur with Polack that images can sometimes organise and validate experiences of primary states, states that are hard to perceive. The spine is a wonderful image that occurred to us as well; an image that emerges out of a concrete body. A body that, during its development transition from embryonic, shell-like posture, gradually opens up to lying down, to a horizontal position (held in a bosom-envelope) until it reaches a vertical position of standing up on two feet – facing the other and the world. This process takes place while making a dramatic transition from a liquid environment to a gassy one, where gravity impacts the baby more, demanding the spine to reorganise as part of the baby’s straightening up process. But the human spine holds another potential, related to our embodiment as psyches who have bodies. The structure of the spine indicates its function as a horizontal neural agent, as “enabling” the core and periphery of our somatic presence. Straightening-up potentially enables a transition from a two-dimensional to a three-dimensional experience, but the extent of its potential rests upon the realising of another potential – the transition from an infantile body, almost lacking volume and in that respect two dimensional, to a nourished and present body with volume and mass, a three dimensional body.

We have been meeting autistic children in primary emotional and in many ways in primary bodily states, but even there we can recognise the potential of the human spine. These children need their autistic defence system to serve as a “second skin” (Bick, 1968). Our intuitive tendency is to provide them a liquid-like environment, or as Alvarez (1992) phrased it to be their “human second-skin” as a replacement to their autism. This position, however, perpetuates the symbiotic quality of the therapeutic relationship in a watery environment where we attempt to protect an amoeba or a shellfish since it is so vulnerable. To provide such a protection in our non-liquid world, we find ourselves in a relationship characterised by sticky holding, where we both become part-object and our spine is experienced as one.

Can you picture this situation and us, as psychotherapists, in it? How can we move when we are so indiscernible? How can we separate within the relationship if we are part-objects? As we deepen the supportive environment experience we provide, the more we inadvertently inhibit the client’s ability to be nourished by external materials that can be absorbed and foster development. This clinical picture inevitably becomes flesh and blood during the therapeutic process, as it was experienced in the client’s infancy, becoming a living transference system in therapy. This is the substrate of our relationship’s dynamics from which we can hopefully begin a new movement when the pre-conditions are met.

This novel movement asks of us as psychotherapists to alter our positioning. It is a gentle instroke movement carrying with it immense meaning. We use all the many resources we

were blessed with to retrieve and reclaim our lost parts and become whole again, to embody the boundaries of our body, to remember we have a separate spine. Then a new path opens before us where we can walk barefoot on our ground. It is then that we can meet the child in his own playground, and it is then that we can hold him with firm and reassured hands, hands that can bestow a different quality of holding, one that is also differentiated. Then we can sense in ourselves the immense threat of his fragility on the one hand while seeing the full potential of his spine.

We shift from the frontal-enveloping and protective position where we remained and begin to straighten-up – practicing our innate capacity to curve and straighten and hence to feel part of a relationship where unity and differentiation are both possible, pulled in and opened to the world. We ask to go through, as the client witness, a process that realises the potential that lays within us, inasmuch as having a spine. This process begins with us, resonates within him, and changes our wider mind.

This inner straightening-up as therapists touches the core of our willingness to touch our own whole and imperfect humanity, to touch the huge pain therein, pain that both opened our deep wounds but also contributed to the construction of our greatest strengths. This upright position dares to vibrate the depth of our spine and resonate in the client's own depth, his whole and imperfect humanity. We believe that beyond the marking of human horizons, this process is also humble enough not to pretend to know what would be our client's own unique way of realising his potential and opening a field that allows for joint movement.

“In order to help another become a subject and appreciate themselves as a subject, I needed to do the same, that while many aspects of psychotherapy may remain asymmetrical, the human acknowledgement of another is not one of these” (Rolef Ben-Shahar, 2013a, p.42).

E. Summary and looking into the horizon

In this paper we hope to have opened a window to observing a relational-embodied therapeutic work with autistic children. We suggested that attending to the pulsation – its rhythms, directions, and quality—was a central axis of attention in the therapeutic encounter. This axis allowed us to perceive autism as a contracted state where the pulsation of life was wounded, withdrawn, and lacking the essence of movement toward something. Thus, we argued that the movement from contraction to instroke was a transformative therapeutic and healing movement for the client, the therapist, and the dyad.

We based our paper on Davis's (1999) understanding of the structure and somatic functioning of plasma and Winnicott's (1971) differentiation between infantile existence and being real, to describe the meaning of the instroke that characterise the beginning of life. Through this synthesis we suggested that this baby's primal movement, which exists only in a dyad, embodies the potential to realise the three tasks of primitive emotional development, as conceptualised by Winnicott (1987): self-cohesion, object relations and indwelling the psyche in the body. This integrative movement is a movement that transforms the human experience from existence to reality by arousing life in the body and creating an internal space to live, to move and to develop therein.

During therapy with an autistic child it is possible that the therapeutic relationship itself will become a contracted autistic relationship, where the movement toward – both separately and in the shared dyad—decreases and may even get blocked. In this case, the relationship might perpetuate its own autism through transference dynamics, where both therapist and

client avoid movement, unconsciously, due to inner resistances. We emphasised that the more “wounded” and autistic the therapeutic relationship, the more it tends to pull back into itself, lacking the capacity to lean onto support. We related this also as an almost inevitable therapeutic stage given the meeting of wounds – between the client’s autistic wound and the therapist’s masochistic wound. However, as we recognise the potential for relational autistic patterns, it is important to note that these do not only exist with people on the spectrum. We can recognise, and therefore work with relational autistic patterns in many therapeutic relationships.

We offer a therapeutic positioning for supporting the dyad in the transition from contraction to instroke and, in fact, to a shared pulsation, which is supported by two crucial axes, which we termed the beckoning axis and movement axis. The beckoning axis is based on Winnicott’s retrieval process and the movement axis relates to the cyclical process of movement from aloneness to a dyad. We argue that from within the contracted state the therapist is called to act in two parallel retrieval channels: both re-embodying herself in her own body, thus remembering her separate self, and at the same time retrieve for the child his own self as it reflects in his eyes (in his hands, body, spirit). This process assists both parties in becoming real, guiding us toward a possibility of movement, back and forth, between aloneness (and later separation, individuation) and a shared, dyadic being.

The back and forth movement between different states of consciousness rest on Tustin’s (1990) understanding that fluctuating states of consciousness take place from early infancy forming the base for states of mind throughout life. Tustin claims that states of alert awareness are experienced from the beginning of life when infants are aware of the outside world in a differentiated way. These differentiated states change when the sense of bodily separateness is diminished. Tustin believes that in the autistic injury the infantile consciousness is unavoidably diminished due to the trauma of premature awareness of the infant to its separateness. Alert states of consciousness, which every baby experiences, become intolerable for a baby who experienced trauma of this kind, which does not allow him, in himself, to rely on the dyad in order to regulate and retrieve his sense of security. We suggest that the narrowing of consciousness manifests clearly as injury to the fluctuation between states of consciousness in general, and particularly between individual and dyadic states of consciousness.

We emphasised that a dyadic state of consciousness gradually establishes a novel consciousness that was not previously present – a two-person consciousness. This novel emergent consciousness allows deep integration and reconstruction of processes both in the present and in the past, including retrieval of lost part-objects and subject from the early trauma, and reconnection with resources. The transition from alone-consciousness to dyadic-consciousness is a transformative movement of the autistic child as part of a dyad, it is a movement of choosing a shared journey of life, somatically expressed in the transition from contraction to instroke. A repeated experience of a dyadic state of consciousness provides the cornerstone of an embodied self, which is created from a relationship: “I become through my relation to the Thou; as I become I, I say *Thou*” (Buber, 1958, p. 11).

In our willingness to look directly at the depth of the eyes of an autistic child we also discover our own reflection. Loneliness, not belonging, difficulty in communication, and chronic contraction are the wounds of modern Western society and seeing these reflected through the eyes of a small child is unbearable. Autism as an expanding phenomenon in the Western world marks a pain that leaves us restless. When we gently listen to the pain of this

small boy we might begin to ask: Whose pain is this? We might realise it is far bigger than the pain of the child and his family. This pain can become a compass for us, as it signals how distant and split we have moved from the old and ancient story, a story about our human nature, where each self is also a dyad and each dyad is a microcosm of a wider mind.

BIOGRAPHY

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Whitewater Surfing

Relational body psychotherapy with children on the autistic spectrum

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Review by Roy Desjarlais, LMT, CST-D

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 15, Number 2 Spring 2016 pp 21 - 23. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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I began my exploration into treating infants and children with neurological disorders early in my professional life. My intense interest began after the birth of my first child, who was eventually diagnosed with Tourette syndrome. Some of the most humbling lessons I learned had to do with my personal agendas, expectations, and general lack of understanding of what a child with a neurological disorder is living through. I've spent countless hours exploring Sensory Integration therapy, HANDLE therapy (Holistic Approach to Neuro-Development and Learning Efficiency) and many other forms of non-invasive applications for nervous system issues. My most practiced form of therapeutic technique has been CranioSacral Therapy (CST).

With over twenty-eight years of experience in applying CST and other neurologically focused manual therapies, I was keen to read this article describing the application of body psychotherapy (and all of its permutations) with children on the autistic spectrum.

Within *Whitewater Surfing*, the authors created a wonderful understanding of how two people in a therapeutic relationship can experience something far greater than the individuals. What makes this article so interesting is the delving into the inner interactions between the autistic child and the therapist.

The beginning of the article spends time laying the groundwork for understanding the original wound as a probable cause of autistic behaviours and its ramifications on the psycho/social development of the infant and/or child. My takeaway from the article, in many ways, dovetails my own experience treating this population for over twenty six years...and that is: there tends to be an "insult" to the developing being that manifests in a compromised/compensated nervous system. The authors' contend that this happens prior to the "fight or flight" mechanism being developed (as we know it). The authors' view that this wound causes a contracted state that can be worked with and encourage greater movement to an "instroke" is quite apt in my clinical experience.

My only thought to suggest further consideration regarding the "wound", would be the gestational order of cellular specialisation that happens after conception. It is my understanding that the first system to specialise and form is the precursor to the central nervous system. Cells specialise and create folds that become the rudimentary parts of the brain and then spinal cord. With this being the first order of business in cellular specialisation in the developing foetus, then it makes sense to me that the fight or flight/survival mechanism can get imprinted and/or stimulated very early in our cellular development (Upledger & Quaid, 1996). Oster and Reiss contend it can happen prior to this specialisation which would then effect the cells prior to specialisation and thus imprint even more systemically.

I have experienced this deep/core imprint as being well protected by many of the autistic behaviours. A heavy therapeutic approach will only meet great and overwhelming resistance from the client.

Treating people on the autistic spectrum puts the premium on having an extremely calm interior as well as exterior. The intention to calm and gently address the survival mechanism that got triggered so intensely transcends technique and supports the authors' experiences.

I most resonated with the concept of pulsations and pulsation qualities from my CST background. At the heart of CST is the understanding of rhythmic motions and qualities emanating from the core of the human body, the central nervous system. In the CST paradigm, the words "flexion" and "extension" are used to describe the motions of this core system and relating tissues. This is quite similar to the authors' use of "instroke" and "outstroke". Again, my takeaway from this article is the importance of recognizing and working with the inherent, deep motions of the client in a non-threatening, supportive, and patient way.

What I found vitally important in this article's message is the need for the therapist to self-monitor their positioning both physically and internally to achieve the most therapeutically effective positioning for the child to feel free (safe) to move and change. The need for clarity of purpose and application when working with a person on the autistic spectrum is paramount for successful therapeutic outcomes. My experience with teaching other therapists how to maintain personal balance, while entering the sublimely challenging world of an autistic child, centres on working definitions of three words: Sympathy, Empathy and Compassion.

For application purposes, we can define these three concepts as follows:

Sympathy: I feel bad for you.

Empathy: I feel your pain.

Compassion: I can sit with you while you go through your pain (dysfunction, fear, etc.).

In the first two postures, the therapist is personally involved in the client's pain and/or dysfunction in the attempt to facilitate progress. In the state of compassion, a therapist can be connected to a client's process in a way that is just as supportive, but allows for the free expression of their process. If the client feels sympathy and/or empathy from the therapist, it can cause a reaction (resistance on one end, and attempts to please on the other). Neither is truly neutral for the individual needs of each child. The compassion posture is particularly helpful when the child is experiencing things that might be beyond scope of the practitioner. This can be a helpful tool when confronted with the phenomena of the therapist's processes being triggered and potentially causing what the authors' refer to as an "autistic relationship" between the two. At the very least, compassion posture can help the therapist identify clearer boundaries within this intimate, therapeutic relationship.

Additionally, I look forward to a follow-up article further describing the role of "outstroke" within the paradigm of this article. How does the facilitation of instroke effect the autistic child's ability to organise and express the outstroke? To me, this would bring the concept full circle in its relationship to all organisms that strive for homeostasis.

And finally, I applaud Oster and Reiss for their foray into the complex world of autism. Any avenue that allows the therapist greater understanding, insight and compassion for this

particular life-state is of great benefit. The more we can identify the nuances that allow and autistic child to be accepting of therapies is always an evolution to helping these amazing human beings to thrive and become independent.



Roy Donald Desjarlais, (1960-2016),

“There will always be good in the world.”

Roy Donald Desjarlais, (1960-2016), frequently posted his favourite quote on Facebook to express his philosophy of life, a life that recently, suddenly ended far too soon. Survived by his wife, Dr Shelley Lynch, Roy dedicated his professional life to body psychotherapy pursuits including craniosacral therapy to treat acute, chronic, paediatric and neurological disorders. He spent 15 years at the Upledger clinic as a clinician, instructor, curriculum developer, instructor ombudsman, certification developer and examiner, and finally Vice President of Clinical Services. He developed CST classes and taught nationally and internationally for 20 years. Passionate about dolphin research, Roy frequently volunteered for programs in the Florida Keys and together with his wife, Shelley, co-founded Float for Life using ocean float experiences to help participants connect to the water personally, inspiring care for oceans, rivers and lakes.

His energy and dedication to our field and his clients will be missed.

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Alfred Adler and Wilhelm Reich

Irreconcilable differences or the same basic truth?

Matthias Wenke

Translated by Elizabeth Marshall¹

Abstract

This article compares the radical, holistic understanding of body and mind in the individual psychology of Alfred Adler with Wilhelm Reich's functional identity of psyche and soma. Both start with the immediate, subjective experience of the individual and as such this makes their approaches in principle to phenomenologies of the body in the sense of Husserl and Merleau-Ponty. The author develops the view that from two different starting points Adler and Reich came to almost identical conclusions about body and mind. He demonstrates the discrepancies in Reich's criticism of Adler's concept of *finality* in organics, which arise through his insistence on physical *causality*. He shows that the fundamental pioneering work of both Adler and Reich lies in the fact that they each established independently of one another that the basic state of the human being is primarily unneurotic, consistent, autonomous and social. Today this assumption forms the basis for all humanistic therapies.

Keywords: individual psychology, Alfred Adler, Wilhelm Reich, phenomenology, body psychotherapy, causality, finality, social interest, sense of community, vegetotherapy, sexual economy, character analysis, life style, holism, psyche and soma, functional identity.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 15, Number 2 Spring 2016 pp 24 - 36. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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“As you move, so is the meaning of your life.” Alfred Adler

Reich on Adler

Wilhelm Reich writes about the theory of his contemporary, Alfred Adler: “Any reference to Adler in discussing the sex-economic theory of structure is indicative of a deep misunderstanding” (Reich, 1942/1972, p. 150).

I disagree with this and I'd like to show why.

Science as a protection against reality: phenomenology

Let us look first at the epistemological basis of Adler and Reich, at their understanding of science. Reich writes: “Viewed from the standpoint of unarmoured life, scientific theory is a contrived foothold in the chaos of living phenomena. Hence it serves the purpose of a psychic protection” (Reich, 1942/1972, p.39).

Now compare Adler's view on this: “Authors who are afraid of losing their bearings or of being criticized, only value such facts as can be measured physically in laboratories and are expressed in and reduced to numbers” (Adler, 1938a, p.154). But: “An idea, a view of a fact,

¹ Translations of Wilhelm Reich are by Vincent R. Carfagno. Translations of Alfred Adler are by Elizabeth Marshall, as are those of all other authors except as indicated in the reference section.

should never be identified with the fact itself“ (Adler, 1930a, p.7). So according to Adler too, science serves to defend against the unarmoured life.

Both authors recognize that scientific ideas about reality are defensive instruments of psychic security and in doing so they point to a primary level of directly experienced reality, which is the original source of secondary theorizing. This immediate reality is the subject of phenomenology, the science of incarnated consciousness and its relation to the world, being-in-the-world, which was developed by Husserl (1913) and Merleau-Ponty (1966).

The psychoanalysis that Reich practices is a clinical empirical science in the phenomenological sense: he observes and describes with his senses and his empathy the phenomena, which appear between him and his patients, while remaining impartial and open for the actual present. His use of a biological-medical language doesn't alter this basic subjective attitude of trying to understand symptoms through identification and empathy: "I merely attempted to establish a relation between what is experienced as self and what is experienced as world" (Reich, 1942/1972, p.42).

At the core of such an approach lies phenomenological experience and the search for patients' fundamental being-in-the world as whole body-subjects and the hermeneutic understanding of their situation: "We (...) made evaluations on the basis of the manner in which a person dealt with his conflicts and the motives which prompted his actions" (Reich, 1942/1973, p.92).

Adler points exactly in the same direction: "Individual psychology is research of the personality; that means we consider patients' reaction, their relationship to life's tasks" (Adler, 1935j, p.1). Both authors are concerned with the response of the patient as a whole person to life, to themselves, to their fellow human beings – their *being-in-the-world* (Merleau-Ponty).

Reich emphasizes the holistic aspect of his philosophy: "My present theory of the identity and unity of psycho-physical functioning originated in Bergsonian thinking, and has become a new theory of the functional relationship between body and mind" (Reich, 1942/1973, pp. 23-24).

And listen to Adler on psychophysical unity: "The findings of individual psychology point to the fact that a persons' behavioral forms all fall into a whole and that they are an expression of the lifestyle of that individual. The so-called conscious and the unconscious are not contradictory but form a single entity" (Adler, 1929d, p.87).

The unconscious is therefore not a sealed area in the dark depths of a biological instinct machine. It is the living body-subject, that doesn't convey itself in words but is immediately present in all aspects of expression. Adler differentiates between non-conceptual knowledge (experienced knowledge and body-knowledge) and conceptual understanding, "(...) for those things can also be conscious, which can't be expressed in words and concepts" (Adler, 1937i, p.66). An example is the deep background sensation of being alive. Neuroscientists speak of *explicit* and *implicit memory*, Gilligan (1999) of the *cognitive* and the *somatic self*.

In Adler's understanding there exists only an integrated self, which can conceal itself in its parts. This holistic self is the *seeing body* (Merleau-Ponty, 1986, p.181), which can be its own environment: "The raw material, with which individual psychology works, is the relationship of the individual to the problems of the outside world. (...) This outside world includes the individual's own body and his own soul functions" (Adler, 1935e). Thus the relationship to yourself encompasses all others (Davis, 2014).

This concept of the body as experienced body-space lies at the heart of phenomenology, namely "that the body is the congealed Gestalt of existence itself" (Merleau-Ponty, 1966, p.273).

The unity of psyche and soma: organ dialect

One of Reich's fundamental achievements was to overcome the separation of psyche and soma and show the unity of all expressions of life: "Psychic tension and alleviation cannot be without a somatic representation, for tension and relaxation are biophysical conditions. Until now, apparently, we have merely carried over these concepts into the psychic sphere. (...) But it would be wrong to speak of the 'transfer' of physiological concepts to the psychic sphere, for what we have in mind is not an analogy but a real identity: the unity of psychic and somatic function." (Reich, 1933/1945, p. 340). This process is open in both directions, as psyche and soma penetrate each other completely. So we can state that every idea, every intention, every feeling is the nucleus for a movement.

Adler too recognized this inseparable unity and showed that psyche and body mirror one another: "In rage, fear, grief or any other emotion the body always speaks, and the body of every individual speaks its own language" (Adler, 1931b, p.42f). "We shouldn't forget that the organism is a unity and that if there is an impulse at one point the organism will vibrate as a whole." (1934h, p.66). "We have to learn to understand the dialect of the organs" (1934h, p.70f). "As you move, so is the meaning of your life" (1933b, p.77): one could hardly express the core of body psychotherapy more astutely.

Reich has a similar view: "For character-analytic therapy, the muscular attitudes take on another importance also. They offer the possibility of avoiding when necessary, the complicated detour via the psychic structure and of breaking through to the affects directly from the somatic attitude. (...) The muscular attitude is identical with what we call 'body expression'" (Reich, 1942/1973, p.301). And here the circle comes around to Adler's organ dialect.

Some variations of body psychotherapy take the position that we are completely our bodies and that we embody, express and position ourselves completely therein. But still we all have the experience that we have our bodies and that they are our medium for achieving our goals. How to bring these two attitudes together?

Here we must differentiate between the body (German: *Koerper*) and the *living-body* (German: *Leib*). The living-body is not identical to the body in a biological sense. We see objective bodies when we look at others and also when we see our own bodies partially as objects (for example when we look at our arm), but it is the living-body that we feel and inhabit. The biological body is an abstraction, a collective construct from the external *third-person* perspective; the living-body is the energetically streaming life body of the primordial sphere (Husserl) of each person, from the *first-person* perspective. Living-body means therefore the only really experienced phenomenal body, the experienced interior horizon of the subject, which simultaneously includes the world in always flowing, open horizons. The experiencing, embodied consciousness, which can constitute its own environment, is at the center and simultaneously contains everything. Adler expresses this in an unparalleled metaphor: "The individual is consequently both the picture and the artist. He is the artist of his own personality" (Adler, 1930a, p.7).

The dialectics of *being a body* and having a body are described by Rolef Ben Shahr (2014, p.158): "(...) as functionally identical systems (*bodymind*), and as two systems, which (...) complement one another (*body - mind*)."

In the final analysis a holistic phenomenology of the living body cannot be biological in a materialistic sense, because as I have shown the crux of the matter is the immediate reality of our experience: *consciousness is not in the body, but rather the body is in consciousness*. In this

context Adler clarifies a widespread misunderstanding: “The brain is an instrument of the mind, not its source” (Adler, 1931b, p.136; Wenke, 2011).

Thus the living body and consciousness are not separate. “One cannot ascribe certain movements to body mechanics and others to consciousness” (Merleau-Ponty, 1966, p.151). This touches on fundamental decisions with regard to cause and effect.

Causality or finality of the living?

Adler questions the validity of classic, physical causality in the realm of mobile life. Rather he sees a universal *finality*, a goal-orientation: “All life forms capable of movement (...) are also capable of foresight and can assess the direction in which they should be moving. (...) This anticipation of the direction of movement is the central principle of the mind. Once we have grasped this we can understand how the mind rules the body – it gives the body the goals for its movements” (Adler, 1931b, p.30ff).

Without intention there can be no movement. Intention is an aiming for something, anticipation (Husserl: *protention*). “*We are not capable of thinking, feeling or willing without having a goal.* All causalities are inadequate for living organisms trying to cope with the chaos of all possible future developments and to neutralize the aimlessness, whose victims we would otherwise be” (Adler, 1930q, p.21). What we call motives or reasons for our actions are goals and not causes. Adler points out that often basic goals are “secret” and therefore operational; they lead us without understanding (but not without knowing). Full presence (by meditation for instance) allows us to leave this intentional circle.

With the help of the reflexive function of the bladder Reich does attempt to show that there can be no principle of finality in biology at all (1942/1973, p. 282): “The urinary bladder does not contract ‘in order to fulfil the function of micturition’ by virtue of divine will or supernatural biological powers. It contracts in response to a simple causal principle which is anything but divine. It contracts because its mechanical filling induces a contraction. This principle can be applied to any other function at will.”

Is Reich describing here a causal chain of stimulus and response despite the fact that he rejects mechanistic explanations? What he is describing only becomes clear as a *metaphor* for his functional approach, whereby life functions out of itself and is not bothered about goals subsequently attributed to it. Nevertheless, living function cannot ever be meaningless (mechanical) functioning.

But what is this functioning-out-of-itself? In contemporary vocabulary we could speak of *autopoietic* and *self-referential systems* (Maturana & Varela 1987). “Living systems react to stimuli as to a sign: a stimulus means something against the background of the particular life-style. (...). A creature is always to be found on the horizon of interpretation. It generates meaning out of the pragmatics of its existence. A biology which allows for this can’t be formulated as a theory of mechanistic causality, but must assume a biological subject-theory as its starting point” (Weber, 2003, p.13).

Already on the elementary level of protozoans there is context and meaning: “Even a simple organism doesn’t react to its environment in a causal way, but rather according to the meaning this has for its inner state as a closed system. (...). Thus there is no reason to presume that there are two different processes – psychic and physical - involved in behaviour” (Weber, 2003, p.117).

Adler had already formulated something similar in the thirties: “The individual-

psychological theory is based on the experiential fact of the primordially of the gamete as a self, a whole, a personality. (...). Outside this self of the gamete there is neither an "id" nor "instincts" (...). In the experience of all these realities lies the compulsion to conform or to resolve" (Adler, 1931n, p. 59). *Mobile life and phenomenological experience are one and the same.*

Artificially isolated organs such as Reich's bladder may react unconsciously to pressure or electrical stimulus by contracting, but they do not represent the living reality. Here it is always whole organ systems that interact with the whole living-body in specific *situations*. We can understand that partially autonomic subsystems, as so-called *complexes*, are used by the whole organism as instruments through universal contextuality. There is no action without a situation, no organ function without an environment. "No content without context" (Will Davis, personal communication).

This corresponds exactly to Adler's understanding: "It is a question of considering the life of the soul in context" (Adler, 1927a, p.82). "Where there is a goal, the feelings adjust so as to promote its achievement. Therefore, we are no longer in the realm of physiology or biology: the development of feelings can't be explained through chemical theories or predicted by chemical experiments" (Adler, 1931b, p.33f).

Therefore, even reflexes (such as a bladder contraction) are not a question of mechanics, but are "congealed" *responses, responses of the living body* of the organism in context, automated attitudes to the world. Thus the bladder is a part of the intentional field of its owner. The body is the *incarnated* person and expresses him/her fully. "With the unconscious we want to indicate something which is not said with words. But the human being "speaks" with her body too, (...) and so expresses a kind of consciousness. Someone who wets the bed speaks as it were with his bladder" (Adler, 1937i, p.56).

Reich speaks of a purpose-means relationship, or of *finality*: "Muscular rigidity and psychic rigidity are a unit, the sign of a disturbance of the vegetative motility of the biological system as a whole. (...) The difference between the mechanistic-anatomical and the functional view can easily be demonstrated here: sex economy conceives of the nerves only as the transmitters of general vegetative excitation" (Reich, 1933/1945, p. 341).

And he emphasizes: "A psychic idea has to have a function and has to have an origin" (Reich, 1942/1973, pp. 255-256).

With that both directions are open: on the one hand the idea is a function of the whole personality or of their whole life-style, this means it serves a purpose (*finality*), on the other it is the cognitive surface of an emotional or energetic experience (*functional identity*). Here we have again the dialectic of *body-mind* and *bodymind*.

Reich's functional approach matches Adler's final life-style theory if we read his *general function* as the energy of *being-in-the-world*. Merleau-Ponty (1966, p.297) speaks of an *intentional arc* emanating from the body, directing the life-energy.

This is incomprehensible without a goal in the sense of finality. If this bodily alignment is shaken or ceases then symptoms appear, which are similar to those of losing the ground beneath one's feet: dizziness, hallucinations and so on. Adler writes: "If the striving for success is interrupted, there are shock symptoms throughout the body. Then fear of madness ensues, (...) and thoughts of death and other symptoms appear" (Adler, 1937i, p.203).

Reich understands, as does Adler, the development of character as a *finality*, a method of self-protection, even if he does want to re-interpret it *causally*: "The process we have in mind, though we are talking about it in absolute terms, is definitely of a causal nature. The ego, i.e. that part of the person that is exposed to danger, becomes rigid (...). It acquires in this process a chronic, automatically functioning mode of reaction, i.e. its 'character'" (Reich, 1933, p.338).

As I already demonstrated *every* reaction is a response of the living-body of a feeling subject and not causal mechanics – this includes the self-rigidification of the ego described here as self-protection. It *acts*. It *relates* spontaneously. Self-protection is a fundamental goal. Reich (1942/1973, p.27) himself emphasizes universal intentionality: “Life was characterized by a remarkable rationality and purposefulness of instinctive, involuntary action.”

Reich’s idea of the automatized reaction of character development is described by Adler as a *mechanized life-style* (in Datler et al., 2009, p.160): “Right from the beginning in the life of a child it is subject to a training (...). After a while this becomes mechanized, so that it finds its way according to these mechanized movements and forms of expression.” Thus character means the loss of freedom through the fixation of certain behavioral schemata, once self-created in a dangerous position.

Reich (1942/1973, pp.148-150.) criticises Adler’s concept of character: “He had contended that character, ‘not sexuality’, was the cause of psychic illness. (...) For I had not the least doubt that Freud’s and not Adler’s theory of neurosis was the correct one. (...) Character traits such as ‘inferiority complex’ or ‘will to power’ are merely surface manifestations in the process of armouring in the biological sense of the vegetative inhibition of vital functioning.”

This criticism is based on a misunderstanding. Adler understood character, as did Reich, as an energetic-affective means of protection for the whole individual, a *result* of their development, but not its *cause*: “Character traits are therefore only the external manifestation of a person’s line of movement. (...) They aren’t the primary factor, but the secondary, which has been forced to develop through the person’s secret goal and must therefore be seen teleologically” (Adler, 1927a, p.146).

Thus we can establish here that Adler’s concept of finality isn’t affected by Reich’s criticism. Intentionality, finality and *being-in-the-world* are universals in the understanding of psychophysical dynamics.

With a scientific, bio-medical assumption of universal causality everything becomes a mechanism and there is no-body who experiences and chooses. The subject of all experiences is *eliminated* and therewith freedom and responsibility.

Intersubjectivity, resonance and sense of community

The universal intentionality of *being-in-the-world* reveals us as beings who are always in relationship, at least with ourselves. Just as there are no isolated organs, there cannot be isolated human beings.

Adler recognized the search for contact, relationship, community as the fundamental driving power of human existence: “The oldest instinct of humanity is concerned with the connection of human beings to their fellow humans” (Adler, 1931b, p.198). “That the first act of the new-born child, drinking at its mother’s breast, is cooperation – and not as Freud (...) believed cannibalism and therefore proof of an inborn sadistic instinct – and that this act is as good for the mother as for the child is thus easy to understand” (Adler, 1933b, p.150).

Although we can’t look into other people’s minds, we are always in profound psychophysical connection with them. We share the same space. Let us think about the surprising synchronisation of thoughts, sensations and bodies in systemic family constellations. This means for body psychotherapy especially: “I understand the others through my living body, just as I perceive things through it” (Merleau-Ponty, 1966, p.220).

For Adler empathy, identification is the therapeutic method of choice: “Understanding is really an act of identifying. (...). If I was in their position, in their shoes, then I’d act just

as they do (...). If I can feel myself at one with them then I can understand them” (Adler in Datler et al., 2009, p.169f).

Only what we have first understood in ourselves can we recognize and understand in others. Adler formulates it thus: “I can only heal you with the truth into which I have expanded myself” (Adler, 1928j, p.698).

The feeling of unity with another is a profound interpersonal *resonance* in a free space of trust. How is this resonance possible? Adler sees it as a universal human skill. “We can only find the explanation in the in-born sense of community. This is really a cosmic feeling, a reflection of the interrelationship of all things cosmic, which lives in us (...) and which gives us the ability to feel our way into things, which lie outside our own bodies” (Adler, 1927a, p.65). This ability to expand the ostensible physical borders of the self and to decentralize is remarkable, revealing as it does that these borders are only concepts and that our nature is the open space itself, receptive for whatever comes along.

In Reich (1942/1973, p.277) we find the model of a community of moving ‘electric bladders’, with which he sketches his understanding of non-neurotic human relationships, both to oneself and to other people. “In these movements the charged organic bladder would display a unity. If it were capable of self-perception it would experience the rhythmic alternation of extension, expansion and contraction in a pleasurable way. (...) Such a bladder would feel at one with its surroundings just like a small child. There would be direct contact with other organic spheres, for they would identify with one another on the basis of the sensations of movement and rhythm.”

All those qualities which Adler summarizes as a sense of community are included here. Also both Reich and Adler regard it as natural to live in relationship and resonance: also an experience of oneness seems healthy to both of them.

So we are living continuously in an *intersubjective space*, which Rolef Ben Shahr (2014) calls ‘*wider mind*’ and Gilligan (1999) ‘*relational self*’, in which reciprocity and *co-mobility* are possible (Heisterkamp, 1993, p.77f.). As therapists we put our bodies into the interpersonal field, allow ourselves to be touched, moved, and open ourselves up for bodily resonance with the involuntary expressive aspects of our patients: “We might describe resonance as the sensory and bodily apparatus of the wider mind” (Rolef Ben-Shahar, 2014, p.310). Why else is it possible that I can touch the experience of a client by one of my spontaneously emerging inner images or body sensations? Used in this context, metaphoric words can function as “little energy particles” (Lilly Davis).

For our freedom as humans in general this means that we are always connected to the conditions of the field in which we move. We never exist as isolated egos above things and we can’t act arbitrarily. We swim like fish in common water. In each situation there is something like a coherent, suprapersonal necessity, which we can usually sense immediately. Above all we can sense when we fall short of this logic and *behave inappropriately*. Or to quote Adler: “If the inexorable demands of the ideal community didn’t exist and if everyone could just satisfy their own mistaken laws of movement – one could just as well say, with more phantasy, their instincts, their acquired reflexes – then there would be no conflicts” (Adler, 1933b, p.123). We can conceive of this as the *self-organization of the phenomenal field*.

According to Adler (1931b, p.16) health means confidence into that field, a fundamental sense of community, neuroticism the absence of it, i.e. antisociality.

The qualities of Reich’s *genital character* as the healthy pole of human possibilities correspond to Adler’s sense of community.

As well as a sense of community Reich's patients develop spontaneous activities in those fields which Adler (1931b, p.16) understands as universal *tasks of life*: "Individual psychology knows of no vital issues which aren't related to one of these three main questions – the work issue, the social issue and the sexual issue."

The new kind of social orientation which Reich (1942/1973, pp. 179-180) describes occurs naturally out of the change in the patient's *being-in-the-world* (their life-style), which is the root of all behaviour. "The picture (...) corresponded to a *different form of sociality*. (...). This other form of morality was not governed by a 'Thou shalt' or 'Thou shalt not'; (...). It was replaced by something which might almost be called *vegetative consideration*. (...). Actions were carried out in accordance with a *self-regulating principle*."

Adler's method also emphasizes the dissolving of the neurosis by self-referential in-depth change and not through manipulation (Adler, 1930 q, p.62). "The indestructible fate of humankind is the sense of community. (...). Thus individual psychology asserts that by virtue of their physicalness, a biological factor, human beings tend towards a sense of community, towards the good" (Adler, 1931n, p.90f).

The ground-breaking point here is that Adler and Reich have discovered something which most human sciences including academic psychology could not even imagine: *the primal existence of a good, social, lucid, autonomic, basic condition of all human beings, of which character and neurosis are but self-concealing deformations*. The unrestricted and competent protagonist with complete self-responsibility.

In his theory of the *endo-self Will* Davis (2014) has described exactly this phenomenon. Buddhism refers to it as the universal *Buddha nature* in all sentient beings (Wenke, 2014).

Form, being and flow: neurosis as self-obstruction

A faculty that is connected to psycho-physical health is that of *surrender*. Adler (1912a, p.192) starts with trust in other people: "A deficit in the sense of community impedes the capacity for surrender and for comradeship, which create the only secure anchorage for love and marriage." Surrender has here an explicitly sexual character. "Without a feeling of surrender, love is not possible. (...) Behind psychic impotence we find a deficit in the capacity for surrender, for co-operation" (Adler, 1930q, p.196). "If sexual feelings of love, respect or surrender are dissociated, they freeze up into perversion or neurosis" (Adler, 1937i, p.166).

Reich starts with the sexual side and establishes similar correlations between love, surrender and sociality: "Psychic health depends upon orgasmic potency (...). The essential requirement to cure psychic disturbances is the re-establishment of the natural capacity for love" (Reich, 1942/1973, p.6). "Orgasmic potency is the capacity to surrender to the flow of biological energy" (...) (Reich 1942/1973, p. 102). "The intensity of asocial actions is dependent upon the disturbance of the genital function" (Reich, 1942/1973, p. 81).

As psychic and sexual love are functionally identical, these approaches are equivalent, regardless of where you begin. Sexuality is deepest intersubjective communication whereby not only bodies but also psychic perspectives interweave openly.

Reich describes *orgasmic potency* and the capacity to experience energetic *streaming* as the results of a deep loosening of the character armoring. "I categorized as 'vegetative currents' all somatic phenomena which in contrast to rigid muscular armorings, are characterized by movement" (Reich, 1942/1973, p. 271). This "stream" or "current" is the phenomenological description of what is very obviously a first-hand experience of the living body, an indicator of psychophysical health.

Adler too recognised the dialectics of form and movement and the streaming quality of life. But he emphasizes “that the right characterization of a soul process in words, in a concept of language, can only fail through its own poverty, because it isn’t possible to give a fixed name to this ceaseless flow” (Adler, 1933b, p.172). “The human mind is all too accustomed to putting all flow into a fixed form and not to consider the movement but the frozen movement, movement which has become form. We individual psychologists have always tried to dissolve into movement what we grasp as form” (ibid, p.185). This is the dialectic of *form* and *flow*.

Phenomenologically it’s not about measurable classical physical energy. What is meant is one’s own experience, one’s own direct perception of the phenomenon of life energy as flowing current or as blocked in pain. This energy permeates all experience and feeds all somato-physical processes such as digestion, heartbeat, feelings, all expressive movements and actions.

Energy in movement is vitality which pushes forward, aggression. Reich and Adler see this in the same way: “The designation “aggressive drive” appears (in Adler) from the start in two senses (...). The first sense is the need for activity of the healthy voluntary organs of the musculoskeletal system, affectively neutral to cheerful. The second sense is the response to an obstruction of some other endeavour (...)” (Metzger in Adler, 1907a, p.12).

As for Reich (1942/1973, p. 156): “Every positive manifestation of life is aggressive. (...) Aggression is the life expression of the musculature, of the system of movement. (...) Much of the inhibition of aggression which our children have to endure, to their own detriment, is the result of equating ‘aggressive’ with ‘wicked’ or ‘sexual’. Aggression is always an attempt to provide the means for the gratification of a vital need.”

If parents, siblings or other early attachment figures make a taboo of primary healthy aggression and punish it with scorn or some form of violence, then the child is forced to disconnect both from its anger as well as from its vital energy. It can no longer cope with joy and begins to experience the world as *enemy territory* (Adler, 1927a, p.245f.), where free and spontaneous life will be hated and destroyed. “Fear is a phase of the aggressive drive which is directed against one’s own person (...)” (Adler, 1928n, p.61). Through the experience of powerlessness in the face of its tormentor healthy, innocent aggression is perverted to anger against one’s own life flow. The tormentor is transformed into a part of the self, into an omnipresent and automated introject. As soon as an impulse of the life energy flow appears, fear is mobilized.

This very movement pattern is meant in Adler’s neurosis formula: “Yes, but’ is the best definition of neurosis. Everyone knows that numerous people are stuck in this situation” (Adler, 1937i, p.109). Life becomes difficult, danger lurks everywhere and the neurotic can only freeze up with fear. “Neurotics don’t solve the problems they are faced with. When confronted with them, they react with shock (...)” (Adler, 1930q, p.129). Shock means *too much* energy, whether from aggression, pleasure or joy, which triggers fear.

Such vegetative survival patterns become according to Adler *intelligent reflexes*. “I often found neurosis, (...) in psychic situations in which one could have expected a fit of rage” (Adler, 1912a, p.157). “A number of neurotic symptoms such as erythrophobia, neurotic constipation and colic, asthma, probably dizziness, vomiting, headaches and migraines too, are related (...) to the voluntary, but unconscious interaction of anus contraction (...) and the action of the abdominal press. These are symbolic acts, a language of the belly” (ibid, p.67).

Reich (1942/1973, p. 300) observed the same things: “All our patients report that they went through periods in childhood in which, by means of certain practices in vegetative

behaviour (holding the breath, tensing the abdominal muscular pressure, etc.) they learned to suppress their impulses of hate, anxiety and love. Until now analytical psychology has merely concerned itself with *what* the child suppresses and what the motives are (...). It did not inquire into the way in which children habitually fight against impulses. It is precisely the physiological process of repression which deserves our keenest attention.”

Current research on neuroplasticity confirms Adler and Reich in their assumption, that our experiences train and form the body also on the level of our central, peripheral and vegetative nervous systems. Through exercise (even imagined) we can ‘channel’ neuronal connections (Bauer, 2006; Fuchs 2008). *We become what we do*. Adler: “We tend to ascribe inherited deficits to what is in reality the result of self-training in childhood” (1929d, p.140).

Reich too (1942/1973, p.300-301) understands individual development as a kind of *vegetative training*: “There can be no doubt that most of what people are in the habit of describing as ‘disposition’ or ‘instinctual constitution’ will prove to be acquired vegetative behavior.” Thus creative responses of the living body under acute threat become chronic automated symptoms, under which the later patient, who is also their producer, suffers deeply.

Adler’s neurosis formula ‘Yes, but..’ is the psychic expression of Reich’s self-blocking of the somatic life energy: “The neurosis is nothing other than the sum of all chronically automatic inhibitions of natural sexual excitation. Everything else is the result of this original disturbance” (Reich, 1942/1973, pp. 258-259). “This idea (...) led step by step directly to my present view that *sexuality and anxiety are manifestations of two antithetical vegetative sensations of excitation*” (Reich, 1942/1973, p. 134).

In one of Reich’s (1942/1973, p. 312-313) patients it becomes clear that the neurotic blocking is a particular form of self-relationship, in which we are subject and object simultaneously: “Fortunately it occurred to me that not only the warded off affect but also the defense was represented in his muscular attitude. The smallness and cramped attitude of his mouth could, of course, be nothing other than the expression of its opposite, the protruding, twitching, crying mouth.” This is not the result of biological mechanics. We are so to speak standing in our own way for reasons which are understandable but which have long disappeared.

Many protective mechanisms serve to create a subjective sense of being in control, which is quite obvious in the case of compulsive disorders. The more neurotic a person is, the more they will cling to systems, rules or dogmas and the more they will try to prevent any loss of control. Thus they will withdraw from spontaneous, natural life, which is always opening up new horizons in a permanent flowing present.

Therefore, expansiveness is freedom. And life is movement. Fear – as shocked, constricted energy – prevents connection with others. If we have access to life and spontaneously do what is right in the moment, then there is life expressing itself through our bodies and we are freely part of the situation. That is the intersubjective field of the *sense of community* (Adler), of the *relational self* (Gilligan 1999) or of the *wider mind* (Rolef Ben-Shahar, 2014, p.96).

Therapy as resonance

Heisterkamp (1993, p.14) understands neurosis as “*self-handicapping born of necessity* and the basic principal of treatment as empathic resonance.”

Here resonance is meant as empathy with the bodily sensations of the client which appear via the body of the therapist in the *intersubjective body* (Rolef Ben-Shahar, 2014, p.61). Adler:

“I always feel a coldness in my back (...) whenever I'm in the same room as a psychotic person” (in Bottome, 2013, p.101).

Therefore, Adler recommends for therapists: “It is perfectly natural for human beings to express themselves with their whole bodies and therefore it's often more enlightening to observe someone's movements – how they walk, sit, smile or fidget – than to listen to what they say. Furthermore, we can utilize this in our evaluation of their symptoms” (1929c, p.80).

Reich expresses it thus: “Alongside the ‘what’ of the old Freudian technique I placed the ‘how’. I already knew that the ‘how’, i.e. the form of the behaviour and of the communications, was far more important than what the patient told the analyst. Words can lie. The expression never lies. (...) Character attitudes had to be understood spontaneously. The intellectual understanding of the unconscious was superseded by the patient's immediate perception of his own expression” (Reich, 1942/1973, p.171).

The individual subjective world, all perceptions and memories, originate from internal and external experiences of the body. The basic structure of this internal world is therefore corporeal and without speech. This is due to the fact “that the child structures its life, what I call life-style, at a time when both speech and concepts are inadequately developed. If it continues to grow in its own way then it develops a movement structure, which was never expressed in words and is therefore invulnerable to criticism (.). We can't speak here of a repressed unconscious, but rather of something which was never understood, which defies understanding” (Adler, 1933b, p.30).

Trying to recognize this uncomprehended movement structure, Adler inquires into the *earliest childhood memories*. But he warns: “This schematic fiction should never be interpreted other than as an allegory, however concrete it may appear to be” (Adler, 1912a, p.44). “These are allegories for deep energetic, intentional patterns in the living body, for all memories are connected (...) to the external organs of perception and action, which are related to the environment. (...). Thus we can argue that each organ has as a function of this psychic context its own recollection, its own memory, in the central psychomotor superstructure” (Adler, 1907a, p.99).

If we approach this from the body perspective then images and affects appear as reported by Reich (1942/1973, p. 300): “It never ceases to be surprising how the loosening of a muscular spasm not only releases the vegetative energy, but over and above this, reproduces a memory of that situation in infancy in which the repression of the instinct occurred. It can be said that every muscular rigidity contains the history and the meaning of its origin.”

Thus Adler and Reich have found from complementary perspectives the same truth:

“As you move, so is the meaning of your life” (Adler, 1933b, p.77).

BIOGRAPHY

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Therapists' Interventions in Different Psychotherapy Approaches: Category and Temporal Aspects

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Abstract

This study describes and compares the in-session interventional behaviour of therapists who were clearly affiliated with five different types of psychotherapy: psychoanalysis, Gestalt, transactional analysis, bioenergetic analysis and systemic therapy. To determine the relative occurrence of elements specific to therapists' own, specific to other or common to all types of psychotherapy under investigation, audio-recorded psychotherapy sessions were analysed. A second aim was to investigate if the duration of interactional units were related to certain types of intervention, hypothesizing that longer durations of intervals between therapeutic interventions might indicate higher complexities of processing in patients. Time-lined verbatim transcripts of 11 therapists' verbal interventions from 137 (complete) psychotherapy sessions with 41 patients were coded according to a specially developed multi-method rating manual with 100 different intervention categories. Therapists used a fairly wide spectrum of different interventions, i.e., they worked eclectically. On average they used rather few techniques from their own type of psychotherapy (9.9%), about twice as many from other types of psychotherapy (18.9%), and mostly non-specific, common techniques (67.3%). Certain types of interventions were indeed followed by time intervals whose duration significantly exceeded that of others. More than two-thirds of psychotherapists' interventions – under naturalistic conditions – were common techniques. About 30% of the interventions, however, were techniques specific to different types of psychotherapy. Among these, we found some interventions to engage patients in activities of a longer duration, which may indicate higher complexities of processing.

Keywords: Psychotherapy process, audio-recorded sessions, verbal therapist behaviour, temporal features, categorical features, common factors, specific factors.

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

Volume 15, Number 2 Spring 2016 pp 37 - 65. ISSN 2169-4745 Printing, ISSN 2168-1279 Online

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A multitude of psychotherapeutic approaches have emerged and been propagated since the 1960s (see e.g., Lambert 2013a). Eysenck (1952) raised the fundamental question of the effectiveness of psychotherapy and sparked many psychotherapy outcome studies (for meta-analyses see Grawe, Donati, & Bernauer, 1994; Orlinsky, Rønnestad, & Willutzki, 2004; Smith, Glass, & Miller 1980); all concluded that psychotherapy is highly beneficial. Reviews

of comparative outcome studies have demonstrated that different treatment approaches do not differ in effectiveness (Lambert, 2013b; Lambert, Garfield, & Bergin, 2004; Luborsky, et al., 2002; Wampold, 2001). Some researchers doubted these results (Beutler, 1991, 2002; Strauss, 2001) and suggested that the research strategies and methods for finding differences had been inadequate (Budd & Hughes, 2009). Division 12 of the American Psychological Association created criteria for the empirical validation of treatments (Chambless & Hollon, 1998). But as Lambert (2013a) states, the results of research and practice are always tentative, and “reliance on the prevailing research paradigm (randomized clinical trials) has had the organizational effect of distancing some therapies ... from being considered as ‘evidence based’” (p. 7). Body psychotherapeutic approaches, we think, are still among them.

If the hypothesis of poor methodology were discarded, the general finding of no or very little difference in the outcome of diverse therapies could be due to common curative factors, such as the therapeutic alliance, exploration, support, empathy, and advice, which are used in several or all types of psychotherapy but not emphasized in their theory of change. This possibility was first hypothesized by Rosenzweig (1936) (for common factors, see also Ablon & Jones, 2002; Castonguay, 1993). *Common factors* refer to elements that are shared across most if not all therapeutic modalities. *Specific factors* are theory-specified techniques that proponents of a particular type of psychotherapy have declared as central to their theory of change. According to Lambert (2013b), there is growing evidence to support the hypothesis that there are some specific technique effects and many common interventions across treatments (see also Orlinsky et al., 2004) and that the vast majority of therapists have become eclectic in their orientation. The actual activities therapists engage in overlap to a large degree across theoretically diverse types of psychotherapy. Having reviewed empirical research, Lambert (1992) summarized that 30% of the outcome variation was due to common and 15% to specific factors (see also Lambert, 2013b, p. 200; and for specific factors, see DeRubeis, Brotman & Gibbons, 2005). Researchers have reported on and discussed the relative contribution of common and specific factors (e.g., Weinberger, 1995), Castonguay, Goldfried, Wisner, Raue, and Hayes (1996), Boswell, Castonguay, and Wasserman (2010), Pfammatter & Tschacher (2010) and Pfammatter, Junghan, and Tschacher (2012)). Ulvenes, Berggraf, Hoffart, Stiles, Svartberg, McCullough, ... & Wampold (2012) found that the same type of intervention has different effects when comparing the context of one treatment with the context of another.

There have been several attempts to collect active, curative factors in psychotherapy by looking beyond the boundaries of schools (Crits-Christoph, Connolly, Gibbons, & Mukherjee, 2013; Grawe et al., 1994; Orlinsky et al., 2004;). Orlinsky et al. (2004) proposed a “generic model of psychotherapy”. Grawe (1995) advocated a general theory of psychotherapeutic change (*Allgemeine Psychotherapie*) on the basis of empirically validated active factors. If it is true that psychotherapy is effective and that diverse approaches are equally effective, we still don’t know why. At present, three types of psychotherapy are officially recognized in Germany, 22 in Austria, and 60 in Switzerland. These examples demonstrate that researchers and politicians are far from unanimous with respect to what is worthwhile both in regards to financial reimbursement or inclusion in academic psychotherapy curriculums.

Castonguay, Barkham, Lutz, and McAleavy (2013) underlined the “need to build stronger links between research and practice” (p. 86), because the use of empirical information in the conduct of clinical work is clearly imperfect. In Switzerland, following an initiative

by the Swiss Charta for Psychotherapy – the umbrella organization for institutes offering training in psychotherapy – ten institutes agreed to invite their certified practising therapists to have their therapeutic behaviour and effectiveness examined. With this objective— a naturalistic process-outcome study of treatments in outpatient settings— the Practice Outpatient Psychotherapy Study Switzerland (PAP-S), was carried out. Systemic and cognitive behaviour therapists from several Swiss institutes were invited but declined to get involved. Participating therapists were clearly affiliated with specific types of psychotherapy, but treatments were not manualized. The results of the PAP-S have been and will be published in several reports (Cramer, von Wyl, Koemeda-Lutz, Schulthess, & Tschuschke, 2015; Staczan, Schmuecker, Koehler, Berglar, Cramer, von Wyl, & Tschuschke, 2015; Tschuschke, Cramer, Koehler, Berglar, Muth, Staczan, . . . & Koemeda-Lutz, 2014a; and others). All types of psychotherapy examined in the PAP-S, namely Analytical Psychology (C.G. Jung), Psychoanalysis (S. Freud), Bioenergetic Analysis (A. Lowen), Existential Analysis and Logotherapy (V. Frankl), Gestalt Therapy (F. Perls et al.), Integrative Body Psychotherapy (J.L. Rosenberg et al.), Arts and Expression Oriented Psychotherapy (P.J. Knill, et al.), Process-Oriented Psychotherapy (A. Mindell) and Transactional Analysis (E. Berne), on average resulted in positive treatment outcome as measured by the Brief Symptom Inventory (BSI) (Franke, 2000), the Outcome Questionnaire (OQ-45) (Lambert, Morton, et al. 2004), the Global Assessment Functioning Scale (GAF) (American Psychiatric Association, 1989), and Beck's Depression Inventory (BDI) (Hautzinger, Keller, & Kühne, 2006). Effect sizes were moderate to large, $0.78 \leq d \leq 0.99$, following Cohen (1988). No significant differences between types of psychotherapy were found.

The training curricula of all approaches investigated in our study are based on well-elaborated theoretical concepts (Schlegel, 2002; Schlegel, Meier, & Schulthess, 2011), although some of them are not widely known.

The value of using treatment manuals to train therapists and verify their adherence has been strongly advocated by Perepletchikova, Treat, and Kazdin (2007) and Perepletchikova (2009), advocated and questioned by Orlinsky et al. (2004), and questioned by Miller and Binder (2002) and Castonguay et al. (2013), who coined the term “empirical imperialism”. *Adherence* means the degree to which therapists deliver the theory-specified techniques. Our study reported here used a “bottom-up-approach” of practice-oriented research, with mutual collaboration between clinicians and researchers. We wanted to examine the interventional behaviour of therapists who had finished their training in a given modality and who worked as clinicians in outpatient settings with as little interference or directives from the research team as possible.

Before data collection started, we asked proponents from different theoretical orientations to name and define their specific intervention techniques and to name and define what they believed to share with other orientations. We were interested in exploring therapists' naturally occurring adherence to their own types of psychotherapy as compared to the amount of eclecticism. In a recent meta-analytic review of 32 studies, Webb, De Rubeis, and Barber (2010) found no overall significant relationship between adherence and outcome.

Early on, during data collection, we found the intervals between audible interventions to vary considerably within sessions. In some parts of sessions, turn-taking between therapists and patients followed faster rhythms, whereas in other parts, time lags between verbal interventions increased. We therefore included the measurement and analysis of time intervals between the onsets of verbal therapeutic interventions, assuming that their

duration was indicative of the complexity of cognitive, affective and somatic processing that each audible intervention triggered. Our question was: Are there types of intervention that systematically engage patients in more complex processing? And if so, what are they? From studies of memory (Sternberg, 1966, 1975) we know that reaction latencies increase with increasing complexities of the task. According to Elliott, Greenberg, Watson, Timulak, and Freire (2013): “depth of experiential self-exploration is seen as one of the pillars of psychotherapy process and change” (p. 515), and has been consistently related to positive outcome.

Objectives and explorative questions of the present study

- 1) Investigate the natural occurrence of different types of interventions (no prescriptions by treatment manuals or research design)
- 2) Delineate the amount of specificity (adherence to own concept) by therapists in the five types of psychotherapy under examination (according to a Rating Manual, Tschuschke et al., 2014b, see method, Rating Manual)
- 3) Explore if what therapists retrospectively considered to have been “significant” sessions differed from randomly selected sessions concerning specificity (adherence)
- 4) Test if there were differences in adherence between sessions from successful and unsuccessful treatments (based on the differences between pre- and post-OQ-45 scores (Lambert et al., 2004)
- 5) Investigate if the variability of time lags between audible interventions was related to different intervention categories or if their duration varied independently, i.e., if some types of interventions typically slowed down the pace of verbal therapeutic activity and increased the processing demands on patients, this possibly being a crucial prerequisite for therapeutic change (see Roth, 1994; Stern, 2004).

Method

Context: Practice Outpatient Psychotherapy Study – Switzerland (PAP-S)

Data were collected from 2007 – 2012 as part of a larger process-outcome study, the Practice Outpatient Psychotherapy Study Switzerland (PAP-S) (Tschuschke et al., 2010, 2013; von Wyl et al., 2013), with the participation of 362 patients, 81 therapists, 10 training institutes / types of psychotherapy. Starting in March 2007 cooperating therapists invited new patients to participate. Patients were informed that they would receive therapy whether or not they participated in the study. All patients participating signed an informed consent form, agreeing to have their sessions audio-recorded. Audio-recordings were the maximum of intrusion therapists would tolerate. Although video-recordings would have allowed to additionally observe aspects of nonverbal behaviour and increase the complexity of our observational data, it would have cost losing a considerable number of participating therapists. Our choice was to include a sufficient number of therapists from different types of psychotherapy sufficient for satisfying statistical needs. Patients were told that they would be free to drop out of the study at any time and/or to have audio-recordings of their sessions deleted if they wished. Prior to data collection, the ethical committees in all Swiss cantons in which therapists participated approved the study design and proceedings. The project was funded by the participating institutes and, to a larger part, by an anonymous donor through the Department of Health of the Canton of Zurich, Switzerland. The training institutes signed a contract agreeing to refrain from influencing the scientific evaluation of the data.

To validate therapists' diagnoses and make them comparable within our total sample, patients agreed to participate in additional diagnostic interviews conducted by specially trained clinicians: these included the following: *The Structured Clinical Interview for DSM-IV* (SCID I and II) (First et al., 2003); *Operationalized Psychodynamic Diagnostics* (OPD; task force, 2001); and the *Global Assessment of Functioning Scale* (GAF; American Psychiatric Association, 1989). Interviews were conducted at assessment centres in nine cities in Switzerland at the beginning, at the end and one year after termination of therapy. At each of these assessments, patients filled in a number of self-report questionnaires on depression (BDI), overall symptoms (BSI, OQ-45), and other variables relevant to outcome (see Cramer et al., 2014; von Wyl et al., 2013).

Subsample for this partial study: sessions, patients and therapists

Therapists were asked to routinely audio-record all sessions with patients who participated in the study. The rationale for session selection was to cover types of psychotherapy from different main streams: psychodynamic, humanistic, body oriented, and systemic (see Table 1). After termination of therapy, three sessions out of each treatment were randomly selected by the study group, so that neither patients nor therapists knew in advance which sessions would be selected. Tschuschke et al. (2014a) report on an investigation of exclusively randomly selected sessions from therapists following eight different types of psychotherapy and their relationship to outcome.

From preceding analysis (Tschuschke et al., 2014a) we knew that the number of interventions specific to therapists' own approach was surprisingly low ($4,3 \% \leq \bar{x}_{\text{specific}} \leq 27,6 \%$). We wanted to check if this was different for sessions that therapists, on the basis of their personal notes, retrospectively, qualified as significant for the course of that specific treatment. So, in addition to the 85 randomly selected sessions, we asked therapists to contribute more recordings. Since this was on an uncontracted optional basis, we received additional sessions which were unequally distributed across the factors *types of psychotherapy and therapist* (see Table 2, bold numbers). Four therapists contributed 52 additional sessions from nine patients, which they retrospectively judged to have been significant for the course of treatment.

In the present study, the therapists were all Caucasian: 54.5 % women, 45.5 % men; their average age was 54.8 years (sd = 5.9). Patients were also Caucasian: 58.5 % women, 41.5 % men; their average age was 37.6 years (sd = 10.1).

Patients' DSM-IV diagnoses assessed by external experts in this sample can be taken as representative of our total sample ($\text{Chi}^2_{\text{SKID I}}(4) = 4.62$; $p = 0.33$; $\text{Chi}^2_{\text{SKID II}}(3) = 1.82$; $p = 0.61$)(see table 2a).

Table 2 a Patients' DSM-IV diagnoses assessed by external experts		
	this sample (%)	total sample (%)
axis I		
affective disorders	38.6	38.8
anxiety disorders	12.9	25.1
adjustment disorders	19.4	16.0
other disorders	9.7	8.8
no axis I disorder	19.4	11.3
axis II		
cluster A	0.0	3.2
cluster B	13.0	14.5
cluster C	34.8	26.4
no axis II disorder	52.2	55.9

Rating manual

For the categorization of therapists' interventions by external raters, a rating manual was constructed (Tschuschke et al., 2014b). Proponents of 13 different theoretical orientations, (cognitive behaviourists, systemic therapists and Rogerians included), were asked (prior to the beginning of data collection) to each name and define up to 10 categories of interventions they believed were specific to their type of psychotherapy (specific interventions). We asked these same people to name and define additional intervention categories they believed were also important but not specific to their type of psychotherapy (common interventions). For common intervention techniques we also queried the existing literature (Castonguay, 1993; Grawe, 1995; Orlinsky et al., 2004). Each category was operationally defined. Distinctions from similar categories were included as well as a list of prototypes of therapists' interventions representing that category (for an example, see appendix 1). Some types of psychotherapy share specific techniques (specific, but not unique). We therefore ended up with 100 intervention categories; twenty-five were common to all types of psychotherapy participating, and 75 were specific.

Transcripts

Eight students collaborated to prepare time-lined verbatim transcripts of therapists' interventions from audio-recordings (total sessions, N = 137). Three additional students, not familiar with any type of psychotherapy, were then trained to code these transcripts following our rating manual. Units of analysis were therapists' verbal interventions and the time intervals between onsets of therapists' interventions. The raters neither knew the type of psychotherapy the therapists were affiliated with nor the attribution of intervention categories to types of psychotherapy. Frequency counts for each intervention category and percentages of the total number of interventions in each session were computed. The

percentages of common interventions, interventions *specific to therapist's type of psychotherapy*, and interventions *specific to other types of psychotherapy* were added to yield sum scores for these three types of categories.

Interrater reliability

Observer agreement

Eighty out of 137 sessions were coded independently by two different raters. The average interrater-reliability on a single intervention basis was Cohen's Kappa = 0.68. According to Landis & Koch (1977) this can be qualified as "substantial strength of agreement" (p. 165).

Therapists' global and detailed self-ratings in comparison with external ratings

After each session, therapists estimated the extent to which they believed the session to have been specific to their type of psychotherapy (global rating on a scale from 1 to 10) and to what extent they thought they had applied interventions from each of the specific and common intervention categories. Therapists' global ratings as to the specificity of their interventions in a single session (adherence to their type of psychotherapy) varied greatly (range: 0 – 100 %; $X = 67.5$ %; $SD = 26.8$ %). The external raters' judgments also varied considerably (range: 0 – 61.4 %; $X = 9.9$ %; $SD = 9.3$ %). Overall, therapists believed the adherence to their own type of therapy to have been greater than external raters detected. Nevertheless, there was a correlation of $r = 0.31$ ($p < 0.1$; medium effect size according to Cohen, 1988) between therapists' and external raters' global ratings concerning the specificity of interventions in each session. Concerning single (specific and common intervention) categories, therapists' self-ratings and external ratings on average correlated 0.22; $p < 0.01$ (small effect size according to Cohen, 1988).

Category types and interval duration

Early during data collection we found considerable variation in interval duration between therapists' verbal interventions. We defined four classes of time intervals (int < 10 sec.; 10 sec. ≤ int < 30 sec.; 30 sec. ≤ int < 60 sec.; int ≥ 60 sec.). To uncover whether all types of interventions were equally distributed across these four interval classes, or if certain types of intervention tended to cumulate in interval classes of longer duration, a cross tabulation of time intervals, and the percent frequencies of each type of intervention in these four classes was set up. Positive (more frequent) and negative (less frequent) deviations from the

expected values were computed by
$$\frac{f_{\text{observed}} - f_{\text{expected}}}{\sqrt{f_{\text{expected}}}}$$

Results

Natural occurrence of different types of intervention (Question 1)

External raters identified, on average, 21 different categories of interventions per session (range: 11 – 34; $SD = 4.4$); only 9.9% of all interventions were specific to therapists' type of psychotherapy (range: 0.4 – 61.4; $SD = 9.3$), 67.3% were common interventions (range: 18 – 86.9; $SD = 13.5$), 18.9% were interventions specific to other types of psychotherapy (range: 6.1 – 59.8; $SD = 10.6$), and 3.9% of therapists' interventions could not be coded using our rating manual.

In all five types of psychotherapy, three categories of interventions played a dominant role (see Table 3; rating manual category numbers in brackets): *support* (46), *clarifying inquiry* (55), *advice/information* (52). These three categories added up to 61.6% of all interventions. All three are common interventions shared by a variety of types of psychotherapy. An additional 5.7% of interventions were other common interventions, such as *exploring and discussing dysfunctional patterns* (21), *promoting insight for change* (30), *inquiry about emotional experiencing* (8), *expressing empathy* (31).

The relationship between therapists' experience, adherence to own type of psychotherapy and outcome is reported on and discussed in Tschuschke et al. (2014a).

Amount of specificity (adherence) in each of the five types of psychotherapy (Question 2)

The frequency of interventions that are specific to therapists' type of psychotherapy was significantly higher in psychoanalytic, bioenergetic and systemic sessions as compared to the frequency of application of such specific interventions in sessions of transactional analysis and Gestalt psychotherapy ($t_{PA}(1; 135) = 12.95; p < 0.01$; $t_{BA}(1; 135) = 7.63; p < 0.01$; $t_{SYST}(1; 135) = 10.24; p < 0.01$). Sessions from transactional analysis and Gestalt did not differ from other sessions with respect to specific interventions from their own type of psychotherapy ($t_{TA}(1; 135) = 1.48; p = 0.14$; $t_{GESTALT}(1; 135) = 0.29; p = 0.77$).

Adherence differences between "significant" and randomly selected sessions (Question 3)

Sessions that therapists had qualified as significant for the course of therapy featured interventions specific to the therapist's type of psychotherapy significantly more often than sessions that had been randomly selected ($\bar{X}_{sign} = 11.9\%$ (N=88); $\bar{X}_{random} = 6.3\%$ (N=49); $F(1;135) = 12.52; p < 0.01$), and they included supportive interventions significantly less often ($\bar{X}_{sign} = 37.6\%$; $\bar{X}_{random} = 55.1\%$; $F(1;135) = 45.95; p < 0.01$).

Adherence differences between sessions from successful and unsuccessful treatments (Question 4)

OQ-45 pre-scores and post-scores were available for 31 patients. According to Lambert, Morton, et al. (2004), OQ-45 score differences between pre and post exceeding 14 are classified as significantly improved and smaller differences as unchanged or deteriorated. Patients who achieve total scores < 64 are classified as remitted.

On average, patients in our subsample improved their OQ-45-scores by 24.2 points; 54.8% were classified as significantly improved and remitted, 64.5% as significantly improved, 80.6% as remitted, and 35.5% did not improve or deteriorated. There was no significant difference between successful and unsuccessful treatments, regarding the relative frequency of specific interventions ($F(1;116) = 0.11; p = 0.74$).

Temporal aspects of therapeutic interventions (Question 5)

Looking at the average percent frequencies by which different interventions were delivered and the average percentage of time passing after each type of intervention, the correlation for intervention categories across all sessions was $r = 0.88; p < 0.01$ (big effect size according to Cohen, 1988). The more frequently a given type of intervention was applied, the higher the percentage of the total time of sessions was spent by therapist and patient with this type of interventions. Nevertheless, the duration of time intervals between interventions varied considerably within sessions.

From a total of 7,356 minutes of audio-recorded material, adding up from 137 sessions of 53.7 minutes duration on average, we measured a total of 32,773 therapeutic interventions. From an interactional point of view, therapists' "interventions" could, of course, at the same time have been "responses" to what a patient had just said. But for simplicity's sake, in this report we call therapists' utterances "interventions" and patients' utterances "responses". Since we only tracked the onset of interventions, for further analyses we considered intervals between onsets of interventions, each one representing one interactional unit between patient and therapist. More than half of these interactional units (53.1%) lasted less than 10 seconds; 37.5% lasted from 10 to 30 seconds; 7.3% lasted from 30 to 60 seconds. Only 2.1% of all intervention-reaction units were equal to or exceeded 60 seconds. The normal interactional pace (> 90%) seems to consist of intervention-response units shorter than 30 seconds. Only 9.4% of all time lags between intervention onsets was equal to or exceeded 30 seconds.

Table 4 shows intervention categories, for which the observed frequency clearly exceeded the expected frequency in the class of longest time intervals (≥ 60 sec; amount of deviance in descending order).

Correspondingly, these types of interventions were underrepresented in the class of shortest duration (< 10 sec.). Most of these categories were specific interventions.

Excerpts from 3 sessions and rhythmicity of therapeutic activity

Three sessions from therapists affiliated with three different types of psychotherapy were randomly selected. They included intervals between onsets of verbal therapeutic interventions of long duration (5:02, 4:10, and 7:24 minutes). Transcripts of therapist and patient utterances around these interaction units can be found in Appendices 2 – 4. A commentary was added to each excerpt. In our opinion these texts support the conjecture that certain interventions work like "small surgery"—after the intervention, mental and psychic "tissue" has to reorganize. And this takes time.

To convey an impression of the variability of time lags between interventions (the rhythmicity of therapeutic activity), the figure in Appendix 5 shows intervention onsets as horizontal lines along the time line of whole sessions. These were the same sessions from which excerpts were taken.

Discussion

Psychotherapeutic process cannot be accurately assessed through either therapists' or patients' self-reports alone (Perepletchikova et al., 2007); therefore, we additionally used audio-recordings of sessions, developed a multi-method rating manual, and trained external raters to code category and temporal aspects of therapists' verbal in-session behaviour.

It turned out that under naturalistic conditions therapists applied a variety of interventions. Overall, 67 % were common interventions, and 29 % were specific interventions, only about 10 % from therapists' own types of psychotherapy.

Although the participating therapists were clearly affiliated and identified with different types of psychotherapy, eclecticism was present. All patients received support and encouragement, were asked questions and given advice and information. At maximum, specific interventions from a therapist's type of psychotherapy, as detected by external raters, reached 64% in a single session. On average these interventions were applied more rarely. But the ratio of 60:30, common to specific interventions that we found corresponds well with the ratio reported by Lambert (1992), namely, 30:15.

Psychoanalytic, bioenergetic and systemic therapy sessions each differed significantly from the rest with respect to increased applications of interventions specific to the therapist's type of psychotherapy. Transactional and Gestalt sessions were not distinguishable in this respect. To find out if this result was substantial or accidental, it would need to be replicated.

As foreseeable in a naturalistic study, a considerable number of patients and therapists who had agreed to participate, dropped out, and therapists delivered incomplete data. The Vienna Systemic Institute contributed consecutively recorded sessions but, unfortunately, did not complete outcome measures. Some of the selected audio-recordings lacked sufficient acoustic quality for analysis. And not all of our co-workers completed their transcripts and ratings. Ideally we would have wanted an equal number of audio-recordings from the five types of psychotherapy, an equal number of therapists for each approach, an equal number of patients from each therapist, and three sessions from each treatment, one from the beginning, one from the middle and one from the end of each treatment. Our sample though fell short of the intended size and variable distribution (See Table 2).

Sessions that therapists had identified as significant for the course of therapy included significantly more interventions from the therapist's type of psychotherapy than sessions that had been randomly selected. Therapists' accounts of their interventional behaviour was therefore related to what external raters observed. Accordingly, the correlation between the external raters' and therapists' self-ratings was significant, though far from perfect. Therapists' self-ratings of adherence were considerably higher than external raters' judgments. We suspect that (1) therapists' concepts of treatment adherence included common interventions, and that (2) common interventions prepared the ground for attainment of type of psychotherapy-specific goals. External raters could not know what was on therapists' minds; they only rated manifest verbal behaviour.

Although the authors of the rating manual spent much time and effort to operationally define and distinguish the categories from one another, verbal statements tend to be ambiguous (Watzlawik, Beavin, & Jackson, 2011). If a systemic therapist opens a session by asking, "What may I do for you today?", this could be categorized as *clarifying inquiry*, and, at the same time categorized as a *good parent message* (saying: I am here for you. I am listening). When we constructed our multi-method rating manual, we tried to delineate categories that were mutually exclusive. Empirically, i.e. as measured by interrater reliability and deviances from perfect matches (see Tschuschke et al., 2014), some of them, in fact, overlap.

Successful and unsuccessful treatments according to OQ-45-outcome scores did not differ with respect to the overall *specificity* of applied interventions (adherence). This is in line with the results of Huppert et al. (2001) (see also Lambert & Ogles, 2004) and Webb et al.'s (2010) meta-analytic study, which found no significant relationship between adherence and outcome.

The high correlation between percent frequencies and percentage of time used by patients after different types of interventions means that on average, time intervals between interventions tended to last equally long. However, there were a few types of interventions that in some instances engaged patients in more time-consuming processes (e.g. therapist provides an interpretation, stimulates somatic experiencing, instructs a relaxation technique, guides the patient to focus on breathing; list continued in table 5). Intervals up to 30 seconds made up more than 90% of all therapist-patient / intervention-response units, interactions for which we assumed that patients and therapists had routines in the service of building trust, exchange of information, etc. However, when therapists "hit a nerve",

i.e. asked a question for which the patients had no routine, this took time; the patients had to search for an answer or had to create a novel one. Maybe they had to find words for previously unmentalised sensations, emotions, body states, or opened themselves up to previously repressed memories, or mobilised resistance. We offer three randomly selected examples in the Appendices 2 – 4, to support this assumption.

For example, the category *interpretation*, was – more often than expected by chance – followed by patient activity exceeding 60 seconds. Not all interpretations, of course, were to the point; some may have been delivered at a suboptimal moment, or warded off by a defence; so not every interpretation elicited complex processing.

The result that external raters identified fewer supportive and more specific interventions in sessions that therapists had judged as “significant” for the course of therapy may support the assumption that change occurs when normal routine behaviour is challenged (longer durations of silence being one special type of suspending the regular pace of turn-taking in conversations).

Interventions that – more often than expected by chance – were followed by time intervals exceeding 60 seconds were very often specific interventions. These interventions, we think, are worth pursuing in future research.

Conclusion

Nearly two-thirds of therapists' verbal behaviour consisted of encouraging the flow of communication, supporting patients in their exploration and self-esteem, asking questions, and every now and then providing information – independent of the type of psychotherapy. Proponents of different psychotherapeutic approaches should be aware and appreciative of the common ground on which psychotherapy operates. In addition, there seemed to exist specific categories of intervention, that under optimum conditions and in certain moments, and after long preparatory sequences, suspend routine responses. We think they make patients either mobilize resistance and fall silent or hold on, think, sense and feel, query different modules of their brains to contribute elements to a new and creative response. This is how we believe change and growth comes about. Some of these specific intervention categories may have been elaborated by main-stream psychotherapy approaches, whereas others originate in types of psychotherapy that have been marginalized in past decades. These specific interventions deserve, as our data recommend, further investigation.

The study results demonstrate that therapists affiliated with approaches that lacked “empirical validation” according to Division 12 of the APA were also effective. The results of the present study advise that if we were striving for a “generic model” of psychotherapy as wide a diversity of different approaches as possible should be considered for integration. This is recommended because the investigation of temporal patterns revealed remarkable rhythmic variability in therapists' activity especially connected to specific interventions from different approaches.

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Tables

Table 1 Types of psychotherapy / institutes (a subsample of the PAP-S study)

Type of psychotherapy (institute)	Founder	Anthropological background/concept of human being	Main theoretical orientation/school
Bioenergetic analysis (SGBAT/DÖK)	Alexander Lowen (1958)	Patients are seen as psychosomatic entities. Somatic self awareness, emotional experiencing, body movement and interaction aim at dissolving character defenses and changing dysfunctional relational patterns.	Body-oriented psychotherapy
Gestalt therapy (SVG)	Perls, Hefferline, and Goodman (1951)	Focus is on the experiential present moment and on process (what is happening) over content (what is being talked about). Human beings know themselves against the background of their relationships with others. Enables the patient to become more fully alive and relies on the client's potential for self-healing.	Humanistic psychotherapy
Psychoanalysis (PSZ/DaS)	Sigmund Freud (1895 – 1945)	The therapeutic setting is seen as a laboratory situation, where transference of unconscious conflicts, mostly remnants from the past, onto the therapist is invited, in order to free conflicts from repression and to make them accessible to change.	Psychodynamic psychotherapy
Systemic therapy (SIW)	Virginia Satir (1988)	Problems can be solved by changing interactional patterns in the system - family, couple, group. The interpersonal construction of reality is one of the core concepts.	Systemic therapy
Transactional analysis (SGTA/ASAT)	Eric Berne (1967, 2001)	Stimulates patients' growth in the context of an empathic, facilitative relationship. Four levels of analysis: structural (ego states), transactional (interpersonal relationships), game (patterns of behavior) and script (attitudes, decisions in life)	Humanistic psychotherapy

For more recent conceptualizations, see:

¹ Koemeda-Lutz (2002), Heinrich-Clauer (2011),

² Hartmann-Kottek (2008)

³ List (2009)

⁴ Brandl-Nebehay (1998)

⁵ Hennig & Pelz (2007)

Appendix 1

Example from rating manual (Tschuschke, Koemeda-Lutz, & Schlegel, 2014b)

Category 8: Focus on emotional experiencingDefinition

Therapist's questions aim at exploring patient's quality of experiencing, sensations, feelings. Beliefs, appraisals, explanations or assumptions are not areas of inquiry. Therapist guides patient to focus on her / his present experiencing, sensations, feelings (which the patient supposedly has conscious access to).

Operationalization

Therapist

- asks about present state of being
- asks about present quality of experiencing
- clarifies on an emotional level

Differentiation

↔ (19) shifting focus of attention to present emotion of which the patient supposedly is unconscious

↔ (55) clarifying inquiry: exploration of facts, events, cognitions, not emotions.

Examples

- 1) How do you experience this? How do you feel about it?
- 2) You explained to me the way this happened and why Mr. F. did what he did, but I would like to know how you feel about it.

Table 2

type of psychotherapy therapists	Psychoanalysis	Bioenergetic Analysis	Transactional Analysis	Gestalt Therapy	Systemic Therapy	total
	A B	C D E	F G H I	J	K	
patients	a1 a2 b1 b2	c1 c2 c3 c4 d1 d2 e1	f1 f2 f3 f4 f5 g1 h1 h2 i3 i4 i5 i6	j1 j2 j3 j4 j5 j6 j7	k1 k2 k3 k4 k5 k6 k7 k8 k9 k10	11
no analyzed sessions	1 1 7 3	10 11 18 13 1 1 2	2 3 3 3 3 3 2 1 1 3 2 3	2 2 2 2 4 4 4	1 3 1 1 2 3 1 3 3 1	41
no. "sign." sessions	4	7 8 15 10 2		2 2 2		137
				2 2 2		52

Sample - 4 nested factors: type of psychotherapy, therapist, patient, session - bold numbers include randomly selected and "significant" sessions.

Table 3

Average percentage of the 10 most frequent intervention categories for five types of psychotherapy (manual numbers in brackets)

Gestalt	%	Bioenergetic analysis	%	Psychoanalysis	%	Systemic therapy	%	Transactional analysis	%
Support (46)	39,9	support (46)	39,3	support (46)	25,8	support (46)	49,4	support (46)	58,8
Inquiry / exploration (55)	17,8	inquiry / exploration (55)	10,5	inquiry / exploration (55)	16,7	inquiry / exploration (55)	10,8	inquiry / exploration (55)	8,8
Information / advice (52)	7,6	information / advice (52)	4,9	interpretation (27)	8,8 **	information / advice (52)	10,7	information / advice (52)	4,1
Self-disclosure (78)	4,0	somatic experiencing (56)	3,9 **	empathy (31)	6,6	construction of possibilities (38)	4,6 **	insight (30)	3,5
Emotional experiencing (8)	2,3	focus on breathing (17)	3,4 **	insight (30)	6,0	humour (12)	3,6	empathy (31)	2,5
Dysfunctional patterns (21)	2,3 **	insight (30)	3,4	information / advice (52)	4,6	focus on breathing (17)	3,0 *	emotional experiencing (8)	1,7
Insight (30)	2,2	empathy (31)	3,2	dysfunctional patterns (21)	4,5	insight (30)	1,5	script (81)	1,4 **
Role playing (76)	2,1 **	dysfunctional patterns (21)	2,7	emotional experiencing (8)	3,5	metaphors (65)	1,4 **	unconscious emotion (19)	1,2
Interpretation (27)	1,8 *	emotional experiencing (8)	2,3	confrontation (60)	2,5 **	construction of reality (39)	1,3 **	therapeutic goals (89)	1,2
Mirroring (92)	1,8 *	interpretation (27)	2,0 *	affect regulation (2)	0,4 *	therapeutic goals (89)	1,2	ego states (48)	0,9 **

** specific to the therapists' type of psychotherapy. M = 9 % (Gestalt. 7.6 %, BA: 12.4 %, PA: 16.6 %, Syst. 7.8 %, TA: 5.3 %); * specific to other types of psychotherapy, blank: common intervention

Table 5

Interventions more frequently succeeded by time intervals ≥ 60 seconds than expected by chance (distances from expected frequency - last column on the right; in descending order)

Intervention category	Manual no	Specific to	Int < 10 sec	10 sec \leq int < 30 sec	30 sec \leq int < 60 sec	Int \geq 60 sec
Interpretation	27 *	PA	-10.1	4.7	13.0	7.2
Somatic experiencing	56 *	BA; G; IBP	-6.7	4.2	4.9	6.9
Relaxation technique	33 *	VT; IBP	-0.1	-0.9	-0.9	6.2
Focus on breathing	17 *	BA; IBP	-2.9	1.8	1.2	5.0
Integration of interpretation	29 *	PA	-2.1	-0.6	4.5	4.5
Transference	90 *	PA; AP; BA	-2.6	1.2	2.5	3.6
Diagram of communication	59 *	TA	-1.0	0.1	1.1	2.8
Insight	30	C; IGEAP	-9.6	8.1	6.1	2.8
Emotional experiencing	8	C	-3.1	2.6	1.2	2.2
Body exercise	58 *	BA	-4.2	3.2	3.1	2.1
Imagination	50 *	AP	-3.0	3.3	-0.3	2.0
Empathy	31	C; GT	-2.3	1.6	1.7	1.9
Dysfunctional patterns	21	C; G; TA	-6.6	4.7	6.5	1.8
Purposeful frustration	42 *	G	-0.1	0.1	-0.9	1.8
Invitation to identification	49 *	G	-4.0	2.4	4.7	1.5
Working with metaphors	65 *	SYS	-5.5	3.4	6.3	1.4
Confronting a defense	1 *	PA	0.1	-0.2	-0.3	1.2
Focus on ego states	48 *	TA	-1.4	1.8	-1.0	1.2

Appendix 2

Excerpt from transcript

Psychoanalytic session			Text (T = therapist; P = patient)
Onset	Interval duration	Intervention category (IC)	
00:41:00	00:00:57	27	T: Well, you mean ... I must repeat this once again... this urge for independence could also have something to do with not having to owe anything to anyone.
00:41:17			P: Mhm. (8 seconds of silence). But I simply believe that not everything is so ... well, of course, one could read anything into it now ... that I put myself through my studies at the university, that I owe my parents nothing, um, maybe this was somehow the trigger, but not actively, well, I don't know, I was not conscious of it, that when I let someone pay for something for me that I would then feel indebted. I think ... maybe it's also ...
00:41:57	00:01:16	27	T: Okay, ... may I just ... this would now be, well, you just tended to reject it, so you could take it instead of a hypothesis, that is, it could be that putting yourself through university on your own is concretely related to not wanting to owe your parents anything.
00:42:18			P: Yes, well, I don't say that this can't be true. I simply say it was not an active decision ... well, it was not ... but yes, it was an active decision. Maybe it was ... I come back now and draw a connection to self-confidence. Perhaps my self-confidence is so low that it's like I have to give myself self-confidence, in the sense that ... I have always accomplished everything all by myself and have never owed anything to anyone. Even if I am not the best, the smartest, the prettiest person and so on, anyway, everything I am and everything I have, I managed alone ... even if I am not aware of it, even if there is no self-assurance (the patient now has a whiny voice)... nevertheless!
00:43:13	00:00:09	8	T: Just now something is moving you intensely, strongly ... what is it?
00:43:16			P: Yes! Don't know ... (sniffs)
00:43:22	00:00:21	31	T: This is maybe such a moment, I don't know, when it gets hot in a way
00:43:26			P: (sniffs) These are exactly the questions that put something in motion. I can't say. I don't feel anything. That is, it's not ... I simply feel something coming out ... but I don't feel any sadness, I don't feel any anger.

00:43:43	00:00:07	8	<p>T: Yes, sure, but you feel it is intense, or I perceive it as something intense.</p> <p>P: ...</p>
00:43:50	00:05:02	60	<p>T: And then I embarrass you a bit with my question, because you like to be someone who gives an answer, or, well, because you like to be someone who knows things a bit. And then I confront you, well confront or stress you, well ... it happens that by my question you become aware that something happens inside you that you don't understand and don't have a grip on and can't control so easily.</p>
00:44:22			<p>P: Mhm (8 seconds silence) Now that's a funny subject, touches on a completely different small section of my life. Just today, once again ... I still have no answer on that NZZ thing. This makes me a bit angry. Because I call them, and have to send a CV within 2 hours, send in my application within 24 hours. Then within 48 hours I write on how motivated I am. Why do they set a Friday deadline, because they say they are interested, because then on Friday she said, well, she had other candidates, whom she wanted to see next Wednesday. It would then be decided by Friday, if there would be a second round with the CEO, and who would be invited to this. So why did everything have to be immediately, if they then took their time for another week. And I see this all as negative, you know, this is probably going to turn out to be nothing. And that really pisses me off. Because it ruins another chance to get away from Zurich. So I don't believe ... because I have the feeling with this job ... well, there was a job that I really wanted...and because I am disappointed that I didn't get it. And now with this NZZ job it's more that... I think it's too bad, well, it really looked as if I could quit my job before the end of this month to get away from Zurich, and now again it still isn't happening, now again I have to wait another month. It's a little bit like ... yeah ... for a different reason.</p> <p>But in any case, as I was walking here, I was thinking that everything that has happened in my life ... the good things happened unconsciously, the good decisions ... that is, I didn't go after them intentionally. There are things that I really worked towards, going to Australia ... although ... the distinction now gets a bit difficult. Sometimes I feel that Australia was unintentional, and sometimes I feel that Australia was deliberate. So, the decision to go down there with my boy-friend was</p>

somehow conscious and then it didn't work out and pursuing it was conscious, but what was unconscious or accidental, for example ... or lucky circumstances, was that I went to visit my colleague in Australia, as you know, and found out that this exchange opportunity even existed. So this was somehow not quite so intentional. It was good luck. And, for instance, in the past, well, in the past I always defined myself ... I was born on the 1st Advent Sunday ... a huge child of good fortune. And there are many things in life where I used to always say it is just good luck that it is that way, just good luck that it happened, just good luck, good luck, good luck. And as I was walking here, I was thinking that I hadn't seen the NZZ job advertised and I applied for it but rather it just came my way, so to speak. And that's why I thought, and this is now absolutely superstitious, and I am actually not superstitious, but ... this with the NZZ will work out for sure, because everything that just fell into my lap in the past, through good fortune, worked out. And whenever I really wanted something badly, it didn't work out. Or only with a lot of effort. And concerning being conscious or unconscious of certain things, I somehow feel that the things I am not conscious of are the things that make me happy. And when I do something intentionally, I must put enormous effort into it to make it work, I need to struggle enormously ... and then it also works out eventually. I am cold. Um ... well, I am actually having rather confusing thoughts. The moment you said that you noticed that there were unconscious things in my life, the hot stuff, feelings or emotions, come up. And in that moment I wondered whether that's true. Am I afraid of the unconscious, of stuff that I cannot control? And that's why my answer emerged the way it did. No, that's not actually true, because actually I feel that very many things that happened to me without my intention were good things.

Commentary: First the therapist (minute 41:00) suggests that the patient's urge for independence could be connected to wanting to avoid any kind of obligation to anyone (intervention category IC27). This patient seems to "digest" (8 seconds of silence) what the therapist just said. She then mildly rejects the therapist's proposition ("this is not the whole story; one could interpret anything ..."). She then concedes that this motive might have caused her behaviour, but not actively, she hadn't been conscious of it. Then, 57 seconds later, the therapist repeats her interpretation (IC27). Now the patient opens up more to what the therapist is saying and adds another link. It could be connected to her low self-esteem, and that trying to be independent could be compensation. The therapist notices that she is moved to tears and addresses her feeling (IC8). The patient confirms and then doubts it. The therapist empathically remarks

that this is one of those delicate moments. And the patient sniffs and confirms that she is being moved by the questions. But at present she neither feels sadness nor anger.

At minute 43:43 the therapist repeats that there is something strongly affecting the patient (IC8), at least she perceives it as something intense, and she goes on to confront (IC60) the patient with the fact that there exist things within herself that she doesn't understand and can't control, although she is a person who likes to be in control. Again the patient pauses (8 seconds), and then for the next 5 minutes recollects several events and life decisions and finally revisits and differentiates her image of herself as being a lucky person, turning it into: Good things happen to her. But when she has strong needs and wishes or works enormously hard for things, she often fails. She wants to get away from Zurich but doesn't get the job that would enable her to leave. She comes to question one of her core beliefs: If I really want something, I won't get it. And she realizes that unconscious stuff in her life is connected to "hot" emotions. She finally asks herself if she is afraid of her unconscious and concludes that she is not.

Through cognitive analysis, quite autonomously, she comes up with her own conclusion, which in relevant aspects differs from that of her therapist. Premature or mature autonomy? This patient seems to be caught between achieving an insight and defending her habitual ways.

Appendix 3

Excerpt from transcript

Gestalt session			
Onset	Interval duration	Intervention category (IC)	Text (T = therapist; P = patient)
00:14:21	00:00:09	21	T: What is the function of you, when you start to want to say something, mentioning that I, of course, would say something different?
00:14:28			P: No, no, it doesn't have to be different. It can also be confirming.
00:14:30	00:00:10	46	T: From your point of view, yes.
00:14:32			P: Yeah, yes, no, no ... see, you are looking a bit critically at me right now
00:14:40	00:00:20	20	T: It is a specific wording you have there...
00:14:45			P: It is not really ... Actually, I just said something that is in fact clear, which will be the case anyhow, right? Well, um, what I really don't need to say.
00:15:00	00:00:13	20	T: Well, I don't know. I am only asking, how, um, how come you talk like that. What the function of that is ...
00:15:11			P: I actually don't know either. I could just as well come straight to the point.
00:15:13	00:00:06	46	T: Yes.

00:15:16			P: It would in fact ...
00:15:19	00:04:10	27	T: It sounds as if you want to cover your back somehow. Is it something sensitive you are about to say?
00:15:24			P: No! No, no! Actually, I don't, don't know either. It's curious, in fact ... not necessary, that I, as an introduction, mention, well, I will now just say it like it is (laughs), or as I see it, or, as it went. Um ... Yeah, on the one hand, it's connected with my position that I had there. Well, I was something like ... um ... the project leader, among other things. In fact, it was a bit of all, project leadership and analysis, programming, that is, a bit of everything, really, but also leading projects. I wanted to develop more in that direction there, um, um ... somehow these were also things that I noticed over time that I don't enjoy doing very much, and that I then postponed doing these things a bit, neglected them somewhat, anything that was project management and tracking, such as where do we stand, what actions do we need to take. Yeah, actually I didn't really totally, um, love doing those things, but I never, basically, um, communicated that directly, that is, I actually communicated it more in the sense that my handling of these tasks was a bit shabby and I took care of other things instead. Well, I see actually the mistake that I made, that basically I should have communicated more clearly, about that too, um ... I would prefer to take care of technical matters and that stuff. And administrative stuff, I would prefer that, well, that someone else would do it, I mean, that I be provided with a person who takes care of that, so that I can attend more to the technical tasks and things that I prefer to do and where I see myself a bit more, that I can take care of those things, you see? And so, in that sense I didn't really do that and then, all the same did a bit of everything, and so I did some of the things a bit poorly or, well, neglected them a bit, and because of that, of course ... well, because of that there was a bit of friction, yes friction, true, I failed to meet some deadlines and so I got blamed for that, basically, um ... Somehow I think that I provoked it a bit, basically, so that it ended, that it ended like that. But I basically didn't get sufficiently involved. And later, somewhere in this whole game, um ... as I was responsible, I lost a bit by it all, didn't I?
00:19:29	00:01:20	46	T: Mhm P: With him it was, well ... basically, he is the type of ... who actually ... you can really be frank with him, discuss things, also argue, and, and ... um ... yeah, you can really get involved there. And I realize, I somehow

			<p>didn't do enough of that and kind of slid more and more into the role. I actually preferred then ... yeah ... to not ... um ... yeah, to have as little to do with him as possible. So that's what I most liked to do. I didn't want an open confrontation. And ... yeah ... and so somehow ... I basically felt like a loser in the whole thing, you know?</p>
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Commentary: In this session the therapist asks his patient (minute 14:21 seconds) what the function of his assumption is that he, the therapist, would “naturally” have a different opinion (IC21: Exploring a dysfunctional pattern). A minute later (15:19), after having pointed out the patient’s style of communication (IC20, twice) and supporting the patient in what he said (IC 46, twice), the therapist provides an interpretation: It sounds as if you were safeguarding yourself. Is there something sensitive that you want to communicate?

The patient vigorously denies: No! No, no! In the following 4 minutes and 10 seconds he tries to ward off admitting that he neglected the core tasks in his job and probably therefore got fired. He most likely does not understand why he did that and supposedly has no idea how to change his dysfunctional behaviour. He denies and camouflages this insight towards himself but also the confession to the therapist, by using lots of paraphrases, filler words like “really”, “actually”, “basically”, “well”, and “um”, hardly ever getting to the point of what he is trying to say. In the periphery of his consciousness he recollects what his goal had been (development) but that he experienced unpleasant feelings while trying to act accordingly. Instead, he sought out vicarious activities, e.g. took care of the technical tasks that interested him more. He would have needed assistance, but he never communicated this to his superiors. Instead he acted out and sought friction by missing meetings and deadlines.

After these 4 minutes and 10 seconds the therapist utters a supportive “Mhm”. And the patient goes on for another minute and 20 seconds that indeed his boss would have been open to discussion but that he, the patient, withdrew and avoided confrontation and by consequence became a victim of the whole situation. At this point, he gained insight into his own responsibility for what happened, which is a prerequisite for opening up to possibilities of change.

Appendix 4

Excerpt from transcript

Bioenergetic session			
Onset	Interval duration	Intervention category (IC)	Text (T = therapist; P = patient)
00:40:06	00:00:12	57	T: Yeah, and please take a position that feels adequate to you. Okay? (therapist laughs) This was the position to start with that I had recommended, but ...
00:40:13			P: True, but like this I feel very exposed.
00:40:18	00:07:24	46, 56	T: Yes, mhm, oh, then I shouldn't ... then I'll come over to the other side. Better? Okay like this? More or less? More or less, okay. Mhm.

00:47:42			P: Very effective this (incomprehensible word) ... this kind of contact.
00:47:48	00:00:12	46	T: Mhm. Hm.
00:47:54			P: As if ... uh ... this calmness.
00:48:00	00:00:28	46	T: Mhm.
00:48:05			P: Really very strong now, this image, that if ... uh ... my reaction to people who go away, my ... well, people mainly, my aloneness, it is this contraction and clenching my teeth, and then I somehow manage, but it is always this ...
00:48:28	00:00:17	31	T: Losing your ground, no external holding. Is that it?
00:48:30			P: Yes, and then I pretend ... I really notice that when sleeping I often ... really lie like this or that my arm gets numb when I lie on it, which never happens when G [her husband] is there ...
00:48:45	00:00:03	31	T: Well, it is as if you have to hold yourself, right?
00:48:46			P: Yes, and that this is very strong ...
00:48:48	00:00:19	92, 46	T: When you are alone or feel alone. Yes. Mhm.
00:48:55			P: And it is really this image of the ... Capricorn ... which doesn't, that I don't ... well, it is an image ... all around ...
00:49:07		31	T: ... which provides you with a shelter, gives you grounding.

Commentary: In this session we don't know what the patient is processing during the 7 minutes and 24 seconds of silence. What can be heard from the audio recording is that the therapist motivates her patient to change positions. At first the patient feels too much exposed; both therapist and patient then rearrange themselves. The patient is invited to observe body sensations, feelings, thoughts or images that come to her mind. She seems to be familiar with this kind of experiencing, because although no explicit instructions are given, she retreats into silent awareness. The patient, who normally speaks quite fast and is very eloquent, seems to have a hard time finding words when she decides to come back to verbal communication. She says that the way she has been touched is very effective. She retrieves the words and memories only very slowly, trying to make sense of her experience. She suspects that her contracted body and clenched teeth may be connected with people abandoning her, and that when sleeping her arm gets numb when her husband is not there. She mentions the Capricorn (an image that had emerged during her preceding session, and which represents protection and security for her). Her utterings are slow and not very cohesive. The therapist encourages, supports her (IC46) and makes empathic remarks (IC31). The patient is gradually giving meaning to what she just experienced.

Appendix 5

Figure: Interventional rhythmicity in 3 different sessions – each horizontal line represents the onset of one therapeutic intervention (y-axis: time line in minutes) Transcript excerpts cover the sequences which are marked by brackets (on the y-axis)



Falling in and out of deep sleep Embodied processes of awakesness and sleep in psychodynamic therapy Shinar Pinkas-Samet

Abstract

Body psychotherapy can offer practical clinical tools, as well as theoretical conceptualisations, for working with transitional states of consciousness, both individual and dyadic. This paper examines sleep as a transformative space, which is mostly uncharted territory for the other, and through developing Bion's reverie (and further influenced by Meltzer's and Klein's work), offers ways of joining the other – in our body – into spaces of sleep and awakening. The work on the threshold of conscious and unconscious processes, which is also known as transliminal (Fassler, Knox and Lynn, 2006), is characterised by dreamlike dissociative states of consciousness during awakesness. In addition, the author explores the function of sleep and sleepiness in the formation of mother-baby attachment system, and therefore at the formative stages of psychotherapy, and attempts to translate these understandings into clinical practice. Alongside the theoretical review, the paper presents a clinical vignette from groupwork, to demonstrate the technique of working somatically with states of sleep.

Keywords: Sleep, shared dreaming, container-contained, transformation, dyadic states of consciousness.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 15, Number 2 Spring 2016 pp 66 - 77. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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A. The clock loses its power

In my clinic, I often find myself amidst processes between sleeping and awakening. I find during various therapeutic situations, such as dissociation, where splits occur from the body, the heart (emotional disconnection) the head, or different body organs, it is very difficult to work verbally or interpretatively. We may look at dissociation as an organic state of falling into sleep, in the therapist, client, or both. Sleeping in therapy denotes a sleep, which is qualitatively different to its commonplace occurrence. It is a transitional state between sleep and awakesness – a transliminal state.

While sleep states of the client and therapist have been widely discussed in psychoanalytic literature (Alexander, 1976; Eshel, 2000; Freud, 1900; Geffner, 2004; Watson, 2003), this paper shall focus on two novel aspects: shared sleep of client and therapist, and techniques for shared-sleeping in treatment as part of a practice of active bodily-reverie. Although drawing from psychoanalytic literature, I focus here on clinical psychotherapeutic applications of shared dreaming. To best understand the ideas conveyed in this paper, I want to ask you, dear reader, to approach this paper with a dream consciousness, allowing yourself to float in and out, to associate and dissociate, to permit a certain vagueness of understanding.

She's seven or eight, hovering about the house. Light in her steps, her legs are flying about; arms gently raised and softly lowered; mouth opens and closes, singing silently, nonetheless it roams. The bolero plays in her heart, and the ballerina is flying, careful to only step on the carpets, lest she wakes her mum up. It is half past one. One more pirouette, then another; and relevé and plié. It is now twenty to two. The dancer is tired, so she turns the television on. Quietly. What's on the television? There is only one channel; black and white, one takes what's available. It's hard to hear, as the sound is muted; mum should not be awoken. Looking at the clock; two fifteen. She falls asleep in front of the television and wakes with a startle. She turns on the fan, then turns it off; then practices a few more moves. She opens a library book, smelling the old scent of these books, which she hides deep in her bag. These are Romantic novels, "I'm borrowing them for my mum," she lies to the librarian who stares at her questioningly when she takes this book, as well as *The Clan of the Cave Bear* for the seventh or eighth time; and *Little Women* and *David Copperfield*. The pages are faded from reading. Who reads these books? She wonders. Girls like me? Older women? How come these books pass through so many hands? She is deeply engrossed in her reading, having read fifty pages already and the clock's face shows four thirty. Soon, her heart dances, soon she will wake up.

Excited, she checks the kitchen for cookies and looks for a crossword to solve; choreographing her steps to show mum and it is five o'clock. Shall I knock on the door? Shall I not? To wake her up or not? In her heart she knows she shouldn't, it is never received well. A turn to the right, half a turn to the left, legs wide open, arms high in the air, the face is burning. It is twenty past five. She doesn't understand, it's late. She is also slightly angry. She has been with herself, quietly, for a long time. She doesn't know where her sister is and then decides to go out to the park, to look for her sister. By the time she'd come back, mum would surely be awake. She runs to the park, right behind the house, and there – her sister, sitting on her regular tree, observing life around her. "Come home," she shouts to her sister, "come home." Reluctantly, her sister climbs down from the tree; leaves are decorating her beautiful curls as she climbs down with a newly found walking stick, and both girls skip home. Waiting for mum to open the door. "What time is it?" she asks a neighbour, and he smiles, "Six o'clock." They come in, gently knocking, knowing that mum may not have awoken yet. They open the door to find out that the house is still under a sleeping spell, and dark. They can wait no longer. They barge into her bedroom. "Mummy, mummy," they jump on her bed, "it's five past six." And mother awakes, her eyes are red and duvet's marks weave lattice patterns on her face; her good smell awakes alongside her too. Mum opens the shutters and increases the television's volume. A platter of fruits and cookies is laid on the table by a steaming hot coffee. She and her sisters are singing, taking out some board games to play, and the clock, finally, loses its power.

B. Sleep as a reaction to client's poor associative material

Hazan (2000) divides the literature about sleep in to two groups. In the first, we can find authors postulating the meaning of falling asleep within the transference context with their clients, such as the "frustrating client", the "non-present client", the "half-alive" client and so on. Ferenczi (1919) related to the client's (and therapist's) falling asleep as a reaction to client's poor associative material. Ferenczi argues that once we understand that our sleepiness has been a response to the client, our awakening returns. This type of sleep is clinically described by theoreticians as a depersonalization of kind, an extreme dissociative response, a hypnotic

state, a primitive split or an externalization of pathogenic introjects (Brown, 1977; Dickes, 1965; Dickes & Papernik, 1977; McLaughlin, 1975).

In a second category, we can find theoreticians and clinicians who provide less generic and more specific explanations for sleep. Kelman (1987), for instance, describes himself as feeling sleepy without knowing why until his client shared his childhood difficulty of waking his mother up. Kelman offers the following interpretation: the process began with the client being preoccupied with himself, and the therapist was 'left out', needing to find his way back to the client on a much more primary, primordial fashion. When Kelman almost fell asleep, he in fact identified with the inaccessible mother. This is not a normal transmission of information but instead a first-hand-learning experience, which Kelman termed Forced cognition by resonance, and it took place following a temporary regression of the therapist, and was dependent on the therapist's capacity (and willingness) to identify with processes of loss. Meltzer (in Williams, 2004) similarly relates to countertransference during sleep.

In this paper I focus on the second type of sleep, as a primordial process, one that asks of the therapist, as well as the client, to actively partake in a therapeutic and embodied enactment. It is a search for special dream states, whereupon the therapist dreams of the client while the client concurrently dreams (of himself, the therapist or therapy) during therapy.

C. Sleep as a transformative act

In my childhood fairy tales, heroines often fell into deep sleep (Batelheim, 1980; Renan, 2001). Snow White and Aurora both slept for a long while and were awoken by an external agent. The prince awoke Sleeping Beauty and in Snow White's original story, the seven dwarves refused to give up her beauty and built a glass coffin, placed at the heart of the forest for all the creatures of the wood to enjoy. A prince stumbled upon her and desired to possess her beauty, yet as he tried to load the coffin on his carriage, the coffin fell and broke and the poisonous-apple bite left Snow's body, waking her up (Renan, 2011).

In both stories, the princesses could not be awoken. In Sleeping Beauty, many princes sought Aurora's palace in vain. The thick shrubbery webbed round the castle, gripping it forcefully and freezing it in time, only to open (and this is not a classical interpretation) when the princess was ready to be found¹. Snow White's glass coffin too was only found when the incubation period was over. The two princes represented the manifestation of the transformative process, its external realization. But what happened during the sleep itself? What was that transformative process the princesses went through and why did they need to sleep so deeply because of it?²

Fairy-tale transformation takes place in sleep because the heroine needs to undergo a deep internal process during which the transformation occurs, and only then can the heroine awake into a new reality. The transformative occurrence manifests in the external world but the preceding processes as well as the moment of transformation, are hidden³. Sleep allows the heroine space to develop an inner life, which thereafter fostered change. This process

¹ Princes too go through transformation during sleep.

² In fairytale transformation, the princess' age does not change. Transformation does not interfere with chronological age and the princess is spared the sense of missing out and regret, so common in the clinic (why didn't I do this earlier, my life could have turned out differently). Furthermore, in the real world, transformative processes take time. Sixty-year sleep is a long sleep, too long. I believe that one of the purposes of therapy is to shorten the sleep.

³ Like the ugly duckling story, where a person only realizes his/her beauty and identity when a transformation occurs and is recognized when seeing the already-changed reflection.

resembles a metabolic internalising, complementary to Klein and Bion, a maternal reverie where the therapist can dream, together with the client, her inner world. Body psychotherapy contributes the concrete shared sleep to the metaphoric and symbolic concepts.

Many psychoanalytic and psychotherapeutic attempts were made to trace those transformative moments. Bion (1961, 1962) dedicated much of his individual and groupwork research to transformation. Bion considered transformative processes as existing in a special state of consciousness, where both client and therapist were deeply immersed in reverie. I shall expand on Bion's work (1962, 1963, 1965) to demonstrate how transformative processes existed in a state of mind of reverie, an in-between state between sleep and awakening. I shall illustrate the practice of bodily-reverie (Pinkas-Samet, 2016a), which uses acts of sleeping and awakening in a physical way, not merely as metaphors.

Reverie, as defined by Bion (1962), is a state of hovering attention – being mindful of all that is around. Ogden (1994) adds somatic awareness to Bion's mentalising work. Bodily-reverie means that I enter a sleep-state alongside my client and be with him there. If I can then generate a process within me, my client stands a better chance of doing the same. We are not relating to linking separateness (what Bion termed as "k"), but instead to sharing a fusion where not only the therapist dreams for the client, but both are undergoing transformation. Both parties seek to expand inner space to create an intersubjective field, and they both do so in their sleep.

I shall look at the bodily meaning of sleep and awakening as part of reverie and exemplify how transformation might take place within sleeping-and-awakening practices and techniques which use body psychotherapeutic principles and practices. Embodied and shared sleeping allows intersubjective resonance and novel intimacy – I am not alone, mum holds my hand as I sleep and she is with me, inside my sleep and my dreams; she takes care of me. Shared sleeping allows the therapeutic dyad to mutually regulate (Carroll, 2009; Rolef Ben-Shahar, 2013a). Such technique would be demonstrated within a training group process.

D. Bionian transformation

The nearer the analyst comes to achieving the suppression of desire, memory and understanding, the more likely he is to fall into a sleep akin to stupor. Though different, the difference is hard to define.

Wilfred Bion (1970, p. 47).

As a membrane, Bion asks the therapist to absorb into herself (into her body too) everything that takes place in her external environment, all that pulsates. The body offers a laboratory of filtering, processing, digesting, all of these processes allow for an organising intelligence, one which provides a good-enough form to the chaotic, raw, and fragmented material. This organising intelligence is created as a result of slow sinking of materials, until these become precipitations, and thanks to the therapist's ability to leave them be until she gathers them back. Sleep thus allows for material to flexibly move between liminal states, between unconscious and the threshold of consciousness – it is therefore transliminal (Fassler, Knox and Lynn, 2006). Sleep is also a shaper of memories – we organise and form our memories in our sleep (Freud, 1900; Watson, 2003) – as well as the other organisational processes that take place during sleep.

This is not a trivial task. Usually, the gathering happens momentarily and may seem irrelevant, inevitably creating an enactment. The therapist needs to be awake and asleep at

the same time: sufficiently asleep to reside in a state of suspended attention and sufficiently awake to note these occurrences. Asleep enough so she is not too reactive, overwhelmed or anxious; awake enough so she could process materials and notice different levels of processes as these occur. Asleep to allow the coming in, leaving out, floating and mobilisation of material without interference, and awake to filter out intolerable toxins, and allow the process to be contained.

Sleep and awakening are physical process. In fact, these are primordial process experienced by the baby. The ability to sustain such connection with the client is nothing but obvious.

It is insufficient to write about sleep and awakening from a theoretical point of view alone. These need to be practiced, and practicing bodily processes should be experienced in the body. Margaret Little (1986) beautifully described how, during her analysis with Winnicott, they have together oscillated between sleep and awakening, facilitating her own birthing processes. They were both in somnolence, neither awake nor asleep, and Winnicott gave birth to himself as her therapist, as well as a surrogate parent. Little needed someone who could experience with her a deeply bodily experience, since birth is a process where the labourer and the baby are deeply intertwined, until they become two separate beings and the umbilical cord is severed.

Connecting and disconnecting (attuning and misattuning) are therefore bodily processes which are significant in the process of transformation. In therapy, it may happen spontaneously but could also be fostered by the therapist. The capacity to merge, to enmesh into a single unity with the other and then separate, become individual – the movement between separation and individuation, is a crucial tenet in the connection between two people. The process of merging and separating presented here is not Mahlerian (Mahler, 1967) in its developmental essence. I believe that presenting merging as necessarily pathological (or regressive) results from the dread of merging and fusion – the fear of becoming a shared-body, an undifferentiated self. The individual, who is the celebrated unit and end goal of western civilisation, is therefore threatened by cultural perspectives which see the collective and intersubjective as equally important as the individual. Unlike Mahler, I follow the relational view of the processes of merging and separating as continuously occurring and pulsating between each other, rather than unidirectional development from symbiosis to individuality (Aron, 2013; Aron & Bushra, 1988; Carroll, 2009).

In my understanding of the Bionian model, transformation takes place when three elements have changed:

1. The quality of communicated material of the client changes.
2. The therapist changed, following a novel understanding of the world, which changed how she things and feels.
3. The client changed following the therapist's interpretation (both therapist and client invest in expanding their inner space for work).

There are two people in the room, both immersed in the “therapeutic soup”. Something then happens, yet it cannot be specifically pointed out, it's impossible to say “it happened exactly such and such”. It is a moment which asks for waiting, it is a meditative trance-like state, and it starts with the capacity to courageously sit and admit that “I have no idea where this is going; I don't know where we would be pulled into and in what form we shall return.”

Within this state, we trust that something would happen. And when that something does happen, the quality of communication and of the both persons' material, changes: the client's words, his posture, inner sensations, and thoughts. Concurrently, something changes in the therapist's material – a novel thought will emerge.

There are three possible techniques of working with such reverie. The first is a process of mutual influence – the therapist surrenders to the relationship, and is changed, the field is changed. As something in the client/therapist changes, she attempts to communicate this change verbally and nonverbally to the client. Such nonverbal communication is reverie-resonance, reflecting how the client-therapist relationship manifest in the therapist's reverie, in the thoughts, feelings and sensations she feels. The same resonance phenomenon can happen slightly differently, where the organising intelligence emerges in the room: when time-holes open up within it, something emerges out and into the session. In this case, both therapist and client can sense a different level of intelligence, a third, and are willing to enter it, to allow this intersubjective space influence them. Here, the art of dyadic relationship is in catching that elusive tail, which showed itself for a moment. A third way of working with bodily reverie could be an active technique, instead of merely waiting for the moment to arrive, where I as a therapist am actively surrendering to the process in body and mind, bringing my body into this enmeshed soul despite the fear of merging with the other (annihilation, disease and contamination, and so forth) (Tronick, 1998; 2004), to reiterate – I willingly (and temporarily) submit into our enmeshment.

One of the major fears from directly working with the body is related, in my opinion, to fear of contamination. What would the other pass on to me? While the psyche is not contaminating, the body could be. In Kleinian terminology, we may wonder what would the other inject into me, what toxin would I ingest – or concretely – what if the other person's smell sticks to me? (Becker, 1973; Rick, 2014).

Without expanding on this matter, I still wish to postulate that the archaic fear of working with the physical body might be connected to symbiosis and separation.

Let us turn our attention to the active reverie, where the client's and therapist's body consciously share in the transformative processes. The active reverie illustrated below relates to physical states of consciousness, among these are sleep, stupor and awakening; since it is within this sleep that transformation occurs (and sleep cannot be merely psychic nor can it be solely bodily), where a newness – a novel third emerges into the room, the shared fruit of two people (Rolef Ben-Shahar, 2012; 2013b).

Such sleep cannot be forced; it comes on its own terms. It comes when the two people in the room share a state of consciousness facilitative for such stupor. The deep meaning of reverie is finding yourself in it, and therefore each reverie process also has a mystical element.

Winnicott (1960) explains his concept of being as an axis alongside which early experiences of mother-baby take place; being together in a place without urges as a precondition for development of agency. Thus, the sleep of a therapist is sharing-in-being with the client, and sleep can be not only a shared field for exploration of dreaming, but also of becoming, becoming which unravels tissues and tendons from its bodily origins. But what about shared sleeping? Shared-sleeping, albeit carrying sexual connotations, has more to do with a dyadic state of consciousness (Tronick et al., 1998) than with sexuality. It does not necessitate physically sleeping next to each other, but allowing someone else into a place which is usually isolated.

In discussing mutual regression, Lewis Aron (1988) relates to regression where both client and therapist enter a mutually-dependent relationship. Within this regression the therapeutic dyad emulates a mother-baby (or parent-baby) attachment system, and both parent and child are in a special state of consciousness. I consider the mother's sleep next to her baby as a special sleep, through which the mother constitutes the child's identity within her; she takes a rest from her baby, yet at the same time processes him within her sleeping experience, absorbing his smells and breaths, experiencing his movements in her dreams, gets to better understand which he cries. The same is true for the baby.

Many psychoanalytic processes (Freud's drive theory, Kleinian projection and introjection, Bion's Container-contained concept and more) could be seen as expressions of biological mechanisms. Classic psychoanalytic technique attempt to find words for the bodily container. But what about the other direction, from the psychology to the physiology? How can I, as an adult, trace primordial bodily processes and what can I understand from them? Can we deduce from the experience itself, from the affect and not just from the memory thereof?

E. Waking up and awakesness in groupwork – a clinical vignette

The following vignette is taken from a training group in its first stages of forming, or in Bion's (1961) language, in its pre-mental stage – undifferentiated and dissociative. I wish to illustrate how working between sleep and awakening could be done with disintegrative structures and how somatic practices can be used for such therapeutic processes.

For a group engaging in bodywork, the group-body is of utter importance. The body of the group is the point of attachment, a source of comfort as well as a reference for personal enquiry and an axis of exploring relationships.

During the first stage of building a group, our group-body has yet to develop and the personal body is scared too, wishing to disconnect while also seeking connection. During classes, and within the bodywork we can see all the extremes: the obedient body that executes every directive and the dissociated body sitting still and unable to move. We notice the responsive body and the placating body, the frozen body and the body parts which arrive scattered into the work, while other parts are left behind. Frequently, while doing deep regressive work there is neither body nor mind nor a distinction between the two. All we can do is go to sleep; adopt a sleeping posture and breathe the group inside, just like a baby and his mother, smelling our environment, evaluating the space which expands or contracts around us.

Upon waking up, it is very difficult to speak. The group is still immersed in a schizoid experience, disconnected, and sharing many dissociated elements. The speech is fractured, distant. Different body movements, organs are moving disharmoniously, scattered, a sense of embarrassment and sleepiness helplessness. The body is rigid, pulling down, back into gravity. Nearly everybody yawns. The only verbal reports are of dizziness and headaches, not feeling the personal body, fear and anxiety expressing in respiratory difficulty or contraction, narrowing down of the self.

I ask them to lie down once more. Each trainee tries to sleep on the floor, as close as possible to the ground, and while adopting a posture he or she can sink into. I ask them to sink, to drop down and sink and collapse into this posture, to surrender into the ground, to merge with that which is underneath, to let go, "can you melt into the ground? Can you deeply sink into the self or into the ground? To fall asleep, to doze off, to nap, to be and not to be, to sleep".

A long time passes.

I ask them to slowly leave that posture into a new, calming movement. A repetitive movement, possibly an obsessive-compulsive movement, the same balance and rhythm and size⁴. An emergent movement, starting from inside.

One by one. Distant apart. Like organs spread in the room. one is rocking, the other singing to himself; one strokes his head and face repeatedly, another one rocks her leg; one person is praying, and another is hitting himself.

There they stay for a long hour, repeating that movement time and again until I ask them to cease; to enter the basic posture, to collapse into the self, to get lost and rest.

Again they get up into the movement; not playing with it yet – that would come later – but merely exploring it, checking how it touches other body organs, wondering about its foundation and its direction, what does it feel like? What organs tire first? What is this experience like? And again, back to the basic posture.

We practice sleep and awakesness like a baby, who conducts a basic exploration of his body – moving his limbs about, opening and closing his fist, rocking his body, searching for a posture for sleep, so that he may internalise his experiences.

What makes my body relax? What regulates me? What happens within those states of rest which are part-doze, part-sleep, part-daydreaming? What happens from entering the posture until I go back to rest? Perhaps this is an attempt to explore foetal positions, repetitive movements as a ritual; perhaps we explore our basic needs, both connected and disconnected, conscious and unaware of our surrounding.

I let go from trying to understand, from observing. I too am lying there, searching for my posture within this group atmosphere. I want to feel the group inside of me. I want to fall asleep in it and wake up within it, to absorb the group's precipitations into my body. I practice with the group, sometimes I observe from outside and at other times going in, coming in and out, I am in the group and the group is in me.

The emphasis in this work is experience rather than words or emotions. Such experiential onus is paramount to body psychotherapeutic practices, wishing to track primary processes through the body (this is supported by the work of Daniel Stern, 2004; Ramberg, 2006). These are hour-long practices which are repeated for about two months. After two months we seek to explore the experience differently – we work with our movements with another person, in front of a small group, until at the end the group creates the group-body, one which shares movements and organs of its own. This group-body is not just an epistemological body; it is body acting as such in the world.

I ask the participants of the group to pair up. We practice shared sleeping. We practice a few types of shared sleep. At first, each one sleeps by the other, practices the repetitive movement next to the other; in effect – conducting his or her own private ritual next to the other. The partner watches; she may watch silently or listen to the voices that emerge in her or she may imitate the other in her own body or through the movements that emerge from her. Sometimes these are micro-movements, and they may regulate the other. Sometimes these are mirror movements, reflecting the other what he is doing right now. At other times, these are complementary movements which connect fragmented, unsequenced movements. Sometimes these are different movement's altogether, bodies dialoguing among themselves, a question and a reply, bodies expressions, forms (Keleman, 2012). Slowly, one is immersed in the world of the other; I practice this repetitive movement next to the other and something of my movement

⁴ Not unlike Tustin's (1981) ritualistic shapes.

is ingested by him. His movement changes from my own, and my movement - from his. We slowly synchronize into a shared, wordless movement. Perhaps this is not synchronization, but a third, novel movement.

We may also simply sit by one another and breathe together. I listen to his breaths and come back to mine. And again. And again. Sometimes I am with my breathing cycles alone, sometimes only with the other's.

We practice entering sleeping positions next to one another, and waking up. We wake into each other, and go back to sleep. Each time, sleeping changes, the other enters my sleep, dreams become enmeshed.

We could have thereafter spoken about the dyadic sleep we shared, but we elect not to. We do not seek to prove that we shared similar experiences or that we shared thoughts. The presence next to the other in such an intimate ritual like sleep suffices. It is transformative – I do not sleep alone, I do not wake alone from my sleep, be it from a dream or a nightmare. Someone is there, with me, in my sleep, sharing his sleep with me. Within this process, part of the transformation is a creation of shared sleep, something new was created.

Discussion

I postulate that these processes are active bodily-reverie, pre-cognised (and pre-linguistic) processes and nonverbal which exist and operate in our body. I further believe that these processes form part of the body's language (Bucci, 2001, 2011) and that we don't exactly understand how repeating these processes serve our understanding of them, but that within the bodily practice, they offer both the capacity to tolerate early experiences in our body and are facilitative in constructing a shared, intersubjective, body.

- 1. Tolerating early experience:** internalizing unconscious bodily processes: movement patterns, bodily organizations, familiarity with my somatic-self and its language (Pinkas-Samet, 2016a, b).

The capacity to tolerate early experiences in the body and examine them from inside is an expression of bodily-reverie, since it allows for understanding that has no words for shared bodily experiences, or bodily expressions of the self as manifesting, and reflecting the other. It is like being deep in meditation and at the same time physically being inside the other. The physical aspects allow us to explore, understand and experience such processes from inside, from within our body. This is more than cognitive understanding, as our body experiences early pre-mental states afresh. By experiencing these we may repeat and heal early processes of closeness and distance, symbiosis and separation.

- 2. Constructing a shared-body** (for the purpose of shared-dreaming, Rolef Ben-Shahar, 2014a, b)

Building a shared body may assist unconscious survival goals of the group, as Bion argues (1965), but the bodily expressions of the group construct a different kind of a group, one that can lean against intimate processes, which reflects the other and is reflected by the other physically. As a group, the shared group moves as one, as a unified bodily entity. A bodily group has power and meaning in the world – the individual may experience him or herself as a part of something bigger, not just psychically but through his body. He is an organ of something, he breathes for someone, he does not exist as a shared body without the other, he needs the other and the other needs him. Thus, the

relationship weaved in such a group and within the people of the group, are based on intimacy. As such, they teach us about being together. As I hope to have demonstrated, I believe that body psychotherapy techniques can significantly contribute to the formation and sustaining of intersubjective processes.

F. The clock loses its power

The clock loses its power.

And tomorrow is a new day, one without transitional moments between waking up and awakesness, but instead falling into deep, autistic sleep, which offers no transformative moments, which offers no way out.

But this dancing girl would forever remain. A girl who does not stop moving, as if she attempts, with her own small body, to enliven all that is dead in this world.

BIOGRAPHY

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Neuropersonality: A Psychosomatic Unity Paradigm

Luisa Barbato and Nitamo Federico Montecucco

Abstract

In this paper we discuss how recent discoveries and insights in neuroscience and psycho-neuro-endocrine-immunology (PNEI) confirm and support the “psychosomatic unity paradigm,” which views human beings as a “unitary psychosomatic system” and highlights how the Self and the main psychosomatic functions are regulated by seven “emotional systems” (Panksepp 2012). The disequilibrium of these seven systems may have a deep impact on consciousness and on the neuro-psychosomatic structure of the Self, thus providing a scientific explanation for human personalities, for the origin of psychosomatic blocks and for Reichian character and muscular armour. This scientific evidence suggests the need and the challenge for a more scientific body-oriented methodology that can include the development of a more integrated therapeutic approach based on self-awareness and deep psychosomatic consciousness.

Keywords: Psychosomatic PNEI paradigm - integrated approach - emotional systems - hormones and neurotransmitters – neuropersonality – self-awareness.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 15, Number 2 Spring 2016 pp 78 - 96. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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1 - The Psychosomatic Self: a scientific approach for body psychotherapies

Psychoanalysis, and later psychotherapy, have continued to question the connection between mind and body; each providing different answers according to their own paradigm. Wilhelm Reich (1945, 1948), as well as numerous body-oriented psychotherapy schools such as Alexander Lowen’s “Bioenergetic”, Ola Raknes’s “vegetotherapy”, Malcolm Brown’s “Organismic psychotherapy”, David Boadella’s “Biosynthesis”, Federico Navarro’s “Somatopsicodinamica”, John Pierrakos’s “Core Energetic” Gerda Boyesen’s “Biodynamic psychotherapy”, Jerome Liss’s “ Biosystemic psychotherapy,” Charles Kelly’s “Radix” (Lowen, 1958; Boadella & Liss, 1986; Navarro, 1988; Latorre, 2000), have extensively investigated this paradigm since the early 1900s and have adopted an integrated approach in which psyche, emotions and body are perceived as a unitary psychosomatic system. This paradigm has been the core of ancient Eastern traditions and worldwide holistic medical school trainings. Current neuroscientific evidence (LeDoux, 1996; Damasio, 2010) endorses this psychosomatic paradigm. Candace Pert, the NIMH researcher and internationally recognized pharmacologist whose early work identified the first opiate receptor and neuropeptides in the brain, stated that we have to think of the mind and the body as an integrated whole (Pert, 1999), as a “*psychosomatic network*” (Pert, 1985).

The research and theories of Nobel Prize winner Gerald Edelman (2003), Antonio Damasio (2010), and Jaak Panksepp (1998a), include body, emotions, mind and consciousness as dimensions of an interconnected psychosomatic unity in which the Self is understood as the cognitive center that governs and gives coherence to the whole network system.

In particular, scientific evidence from the new interdisciplinary field of *psycho-neuro-endocrine-immunology* (PNEI) (Ader et al., 1995, 2006; Blalock, 1997; Bottaccioli, 2005) considers the physical-hormonal and psychological-emotional dimensions as complementary aspects of the human being that deeply reflect and influence each other as functions of the same system.

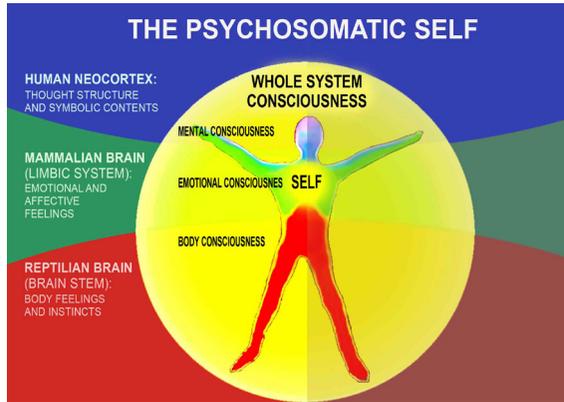
In contrast to the traditional reductionist neuropsychiatric model, which believes that neurotransmitters and neurophysiological structures can explain and determine the entire dimension of the human psyche and considers mental disorders as neural “mistakes” that must mainly be “repaired” by psychoactive drugs, the psychosomatic unity paradigm, based on PNEI systemic vision, suggests that any psychological, emotional, or body-oriented intentional therapeutic action can eventually modify and re-organize the individual’s neural and endocrine system resulting in psychosomatic equilibrium. According to the psychosomatic unity paradigm, the psyche-body relationship is firmly established—it is not merely a metaphorical reflection or a somatic repercussion of psychic tensions. In this light, a deeper understanding of neurocognitive structures and their functions can facilitate a better understanding of the character analysis of the person and the alterations and distortions that lead to mental disorders, supporting more precise therapeutic orientation and practice.

The psychosomatic unity paradigm considers human beings as a whole, multidimensional psychosomatic system. The term unitary in this context means that each person has his/her own unique self-awareness (the sense of body-mind identity or individuality). The term multidimensional means that every human being has a complex structure and lives simultaneously at different psycho-somatic dimensions, from physical-instinctive consciousness, to affective-emotional consciousness, to mental-cognitive consciousness. Today, insights from neuroscientific research and PNEI contribute to a deeper and more complex understanding of the nature of the Self and of these dimensions of consciousness based on successive developmental steps of the brain/mind evolutionary process.

These modes can be expressed in a unitary way through Paul MacLean’s concept of the “triune brain” (MacLean, 1990):

- 1) The body structure and physical-instinctive dimension controlled by the reptilian brain is the oldest and most primitive level of consciousness.
- 2) The emotional and relational dimension, our affective level of consciousness, is controlled by the mammalian brain (limbic system).
- 3) The cognitive, mental dimension, and its rational and imaginative contents, controlled by the neocortical brain, represent our most evolved level of consciousness.

The “psychosomatic Self” in this perspective can therefore be considered the center of the “triune brain” and our whole system consciousness—the awareness of one’s own global identity—that represents the effect of the coherent, synchronic activity of the three brains’ neural networks and their physical, emotional and cognitive functions and dimensions.



2 – Neuroscience, system consciousness and the “Psychosomatic Self”

According to “general systems theory” (Bertalanffy, 1968) each system consists of a number of sub-systems that operate and function according to their own intelligence and complexity (Capra, 1996; Jantsh, 1980; Laszlo, 1996). The global system has rules that are evolutionarily superior to the sum of its single parts. We can also refer to such a coherent, intelligent network as “system consciousness”, where the concept of consciousness is decoupled from the concept of spirituality or mysticism.

Starting from David Bohm’s insight that “*meaning is the bridge between consciousness and matter*” (Peat, 1987, p. 74), we can define consciousness in a cognitive way as “*the system’s capacity to perceive the meaning of information and to use it for the whole system’s wellbeing and evolution*” (Montecucco, 2001, p. 120). The concept of consciousness therefore becomes anchored to our psychosomatic perception, our personality traits, and our mental architecture.

Until a few decades ago, scientists believed that consciousness and the sense of Self were the expressions of the higher cognitive functions of the neocortex: the most evolved and mental part of the brain, while the emotional and bodily functions, connected with the ancient subcortical areas of the brain—the mammal and reptile (limbic system and trunk)—were essentially automatic and unconscious. Today, neuroscientific research shows that surgically removing an animal’s neocortex at a young age does not result in a deficiency of consciousness; therefore, the center of consciousness and Self is subcortical (Merker, 2007).

Edelman (2004), Damasio (2010) and Panksepp (2012) have shown that consciousness and the sense of Self are strongly related to the neuronal network that connects the thalamus (the center of the limbic system and the brain mammal) to the whole neocortex (higher human brain) and to the lower reptilian brain. The Self is able to be conscious and to unify the information of the brain-mind system through a higher level of network communication between the thalamus and all brain areas, which is measured as electroencephalographic (EEG) coherence (Llinas, 2001; Montecucco, 2006).

Panksepp showed that this consciousness network is triggered by the old reptilian brain, which regulates the basic bodily and instinctive functions and awakens the state

of consciousness. He proposed the term “primordial seven self” (Pankesep, 2012, p. 390) to highlight that the primary center of the Self-consciousness that arises from the peri aqueductal gray (PAG) in the midbrain (reptilian brain). It controls the basic body and emotional perceptions, a kind of ‘bodily-instinctive self’ that has a complete neural representation of the whole body and regulates all the body instinctive functions and the basic emotions fundamental to life (Pankesep, 2012). Edelman called it the “*bodily self*” (2004, p.73).

The PAG activates the thalamus and the thalamus then activates the neocortex. Both the PAG and the thalamus are now considered the two main areas of Self-consciousness. In fact, even small lesions of the thalamus and/or the PAG seriously affect or nullify (“switch off”) consciousness. The thalamus-neocortex network that Edelman called the “*dynamic core of consciousness*” (2004, p.71), represents the higher and most Self-conscious part of the network.

The thalamus and PAG are the primary centers of consciousness, with strong psychosomatic activity that regulates all major bodily and emotional functions. The neocortical functions govern the higher cognitive consciousness functions related to psychological, social, rational and ethical behavioural aspects (Uddin, et al., 2007), as well as the unique and prominent human capacity of Self-awareness, that Edelman called the capacity to be “*conscious of being conscious*” (2004, pp.7-8).

According to this neuroscience evidence, the “self”—the psychosomatic consciousness of our being—appears to be primarily rooted in the body and in the emotional levels, and only secondarily in the mind.

The psychosomatic Self that emerges from neuroscientific and PNEI research represents the center that governs the whole being by generating a highly coherent EEG communication between the physical, affective and cognitive areas of the brain. The Self is the core of the psychosomatic unit paradigm.

Reich Freud divergences on libido

Reich suggested to Freud that he consider the libido not just as a psychological concept but as a real and measurable energy (Reich, 1948, introduction). Today we have to reconsider the Self not only as a mere psychological or metaphysical concept but as a real entity that governs the psychosomatic system with measurable psychosomatic effects. In recent years there have been thousands of neurophysiological and clinical studies on meditation and more than 2,400 on mindfulness alone (PubMed, 2013) showing that the development of a deeper “self” awareness produces a substantial and lasting balance in the psychic, nervous, hormonal and immune systems improving relationships, empathy, learning, family and working relationships, and developing a greater self-esteem (Chiesa et al., 2010; Davidson et al., 2010). Many studies have validated the clinical effects of the practices of Self-awareness to promote the healing of stress, anxiety, depression, emotional distress and other psychological and psychosomatic problems (Miller et al., 1995; Segal et al., 2002; Young et al., 2010).

In order to complete the whole human psychosomatic system, we have to understand the most recent significant discoveries of the brain-mind neuronal anatomy and of the “emotional systems” originating from the subcortical areas of the reptilian and mammal brains that are connected with the higher neocortical areas.

3 – Personality and the seven emotional systems

Personality, defined as a particular combination of behaviours, emotional features and psychological patterns, has been deeply investigated by neuroscientific researchers in the last years. According to Jaak Panksepp (1998, 2012), the human Self appears, operates and is accomplished through seven main emotional systems common in all mammalian and human brains. The seven emotional systems are: RAGE/DOMINANCE, FEAR/ANXIETY, LUST/SEXUALITY, SEEKING/ENTHUSIASM, CARE/LOVE, GRIEF/PANIC and PLAY/DREAMLIKE. These emotional systems are the basic psychosomatic functions that manifest through specific physical, emotional and cognitive behaviours essential for the survival of the Self.

The seven emotional systems are activated by neurotransmitters, neuropeptides and hormones, that Candace Pert (1999) called “molecules of emotions”. The emotional systems are modified by epigenetic, familial and social conditionings creating a unique pattern of body, emotional and psychological traits interacting with the Self-consciousness neural network and also creating the roots of personality. Like the seven basic colours, the unique assemblage of the seven emotional systems can create every imaginable pattern of personality with infinite and unique shadings and traits.

While the reductionism vision believes that neurotransmitters are the main cause for psychic unbalance, we believe, out of robust scientific evidence, that by voluntarily changing our physical, emotional, and psychological behaviours and consciousness we can change our neurosystem patterns and our neurotransmitter, neuropeptide and hormonal levels thus promoting a new psychotherapy approach.



The seven emotional systems, along with their activating hormones and neurotransmitters, constitute the human “psychosomatic network” (Pert, 1985), and the neurophysiological roots of the psychological, emotional, and somatic expressions of personality and character (Panksepp, 2006).

We coined the term “neuropersonality” (Montecucco, 2009, p. 325) to represent these expressions in order to highlight the strong neural grounding of the emotional systems. Through the study of neuropersonality we hope to understand the neurophysiological roots of the various definitions of personality and character that are used by the psychotherapeutic schools (Reich, 1945; Eysenck, 1953; Lowen, 1958, Cloninger, 1994, 1999).

The Emotional Systems and their Complex Psychosomatic Effects:

The Homeostatic Body Pleasure system and serotonin

The Homeostatic Body Pleasure system is the brain's primary somatic energetic system source. It is evolutionarily connected with the basic need for food in order to survive and is present in the most primitive animals around the digestive tract. Thus, serotonin transmits the pleasurable sense of satiety in the presence of food or a state of unpleasant sensation and alarm due to lack of food; it stimulates the food search. This very primitive system can therefore be considered the "vital engine" that sustains all of the other seven systems. Ninety percent of our serotonin is located in the gastro intestinal tract.

Serotonin is the main neurotransmitter regulating this system and it is connected with all of the well-being physical perceptions: the sense of corporal pleasure resulting from food, eating, stability, sleep, territory, relaxation, dominance, sex and muscular strength (Bottaccioli, 2005; Panksepp, 1998a). In the absence of danger, it leads to a behavior of relaxation, pleasure, and enjoying life. We consider this system the biopsychic substrate that generates the neurophysiological basis of Bowlby's and Ainsworth's secure base attachment theory—the basic sense of physical security and the pleasant and protective (not yet affective) maternal energy (Bowlby, 1969, 1988). Serotonin is the neurotransmitter related to homeostatic stability, presence, and physical and psychological grounding that increases during meditation. Serotonin stimulates oxytocin and prolactin production.

It is a fact that when the body consciousness and the pleasure system, mediated by serotonin, become weak, psychological and psychiatric disorders begin to emerge (Cloninger, 1999; López-Ibor, 1992; Bottaccioli, 2005). Clinical researchers have suggested that high levels of serotonin are related to a maniac state, while lower levels of serotonin are related to depression (Owens et al., 1994).

High serotonin levels reduce aggressive behaviors in rodents and primates. (Panksepp, 1998a, 2012). Low serotonin levels indicate low impulse control in rodents, primates, and in violent suicide (Golden, 1991). In conditions of difficulty or physical weakness (with low testosterone and high cortisol), it generates avoidance behaviors or "harm avoidance" and results in the search for physical security and avoidance of risks and dangers (Cloninger, 1999).

Body-oriented psychotherapeutic efforts to enhance better body awareness, trust, confidence and pleasure, along with "grounding" practices are related to this system. Many psychological and psychiatric disorders, from depression to mood disorder, alimentary disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social phobia, and generalized and social anxiety disorder, are based on a deficit of serotonin. In a reductionist psychiatric approach, they are usually treated with selective serotonin re-uptake inhibitors (SSRI drugs) that increase serotonin. Our clinical research suggests that deficit serotonin production usually emerges when the body-consciousness and pleasure system become weak and insufficient to ensure a satisfying physical life; it can be improved by psychotherapy work aimed to reintegrate somatic self-awareness, grounding, and bodily pleasure (Ghiroldi & Montecucco, 2011, 2013).

1. **The SEEKING system and dopamine:** the SEEKING system (Panksepp, 2012), is activated by dopamine and governs all the active emotional processes: exploration, passion, and the search for pleasure. The SEEKING system is the most important activating system of the limbic system, the heart of the mammalian emotional brain. It stimulates the brain's active functions. Its main characteristic behavior is called "novelty seeking" (Cloninger, 1999). Allan Shore (2003) suggested that the dopaminergic activation, related with

positive emotions, represents one of the main pathways for infant development, maternal security and self-regulation. In association with serotonin, high levels of dopamine are related with the arousal of the SEEKING system that promote a maniac state, while lower levels of dopamine promote depression. People with high levels of dopamine tend to show a narcissistic and exteriorized behavior.

The psychosomatic aspect or the neuropsychology associated with the SEEKING system is related to the passionate, physical, and energetic activity connected to emotional and cognitive attention and enthusiasm—a sense of vitality in every movement, dynamism and warmth of the body, watchful, lively and brilliant eyes, and open breath in the chest. We developed a special training process that enhanced this system in depressed and avoidant patients.

2. **The FEAR-ANXIETY system:** The FEAR-ANXIETY system (Panksepp, 2012) is connected to the emotion of danger (shock, trauma) and activates the hypothalamus-pituitary-adrenal (HPA) axis and the “fight or flight” active response (Fink, 2010) or the “inhibition of action” passive response (Laborit, 1969). The “inhibition of action” plays a major role in the genesis of human emotional and psychosomatic blockages. In fact, the majority of children and people cannot react with an active, aggressive “fight or flight” response (mediated by adrenaline) to negative situations with their parents or with school teachers (Laborit, 1969); therefore, they must inhibit their active actions and emotions. This generates an over-activation of the fear system and of the inhibitory hormones like cortisol and norepinephrine.

In clinical psychotherapy, the psychosomatic aspect of the FEAR neuropsychology is, in many aspects, similar to Lowen’s “masochist” character and is related to decreased sympathetic tone, and inhibition of instinctive (muscular) and emotional (affective) activity. Thus, it is related to the inhibition of breathing with contraction of the throat, chest, and diaphragm, with tense muscles and contracted shoulders, buttocks (anus) and legs, deep neuro muscular tension, deflated and weak chest, stiffness of the neck, downcast eyes and a weak and insecure voice (Lowen, 1958, 1975; Reich, 1933). The neuropsychology shows a specific alexithymia related to the emotions of anger and aggression.

Cortisol is a stress related hormone. Its levels increase in states of fear, action inhibition, anxiety, and “harm avoidance”. It is the most studied hormone in international stress research (Fink, 2010). The presence of anxiety and stress in mothers is an important epigenetic and psychosomatic factor in child development: the research shows that high cortisol levels in pregnant women epigenetically activate the highest levels of cortisol release and the FEAR system response in children (Austin, et al., 2005; Essex et al., 2002; Weinstok, 2005). Even low levels of emotional care in early childhood increases stress and cortisol sensitivity. The “inhibition of action” increases the cortisol level and creates sympathetic nervous and muscular tension with progressive difficulties in parasympathetic relaxation and somatic serotonergic pleasure. Cortisol is therefore related with the need for stability and security by inhibiting aggressive actions and avoiding the related strong emotions (Kertes et al., 2009). In this context, cortisol and serotonin are considered activators of the “harm avoidance” neuropsychology described by Cloninger (1999).

Norepinephrine generates a state of attention, mental acuity, clarity, determination, speed of response and presence (Fink, 2010). The norepinephrine excess, generated by the stress and by the “inhibition of action”, creates and maintains anxiety, fear, arterial hypertension, mental tension, blockage of the diaphragm and of breath rhythm, and muscular rigidity. The decrease in norepinephrine (as in depression) determines confusion, dependence, uncertainty and lack of mental determination. It is the neurophysiological root of all “rigid” characters and tense behaviors in personality.

The psychosomatic aspect of the FEAR neuropersonality is related to decreased sympathetic tone, inhibition of instinctive (muscular) and emotional (affective) activity; thus, it is related to the inhibition of breathing, with contraction of the throat, chest and diaphragm, with tense muscles and contracted shoulders, buttocks (anus) and legs, deep neuro muscular tension, deflated and weak chest, and stiffness of the neck. Characteristic are downcast eyes and a weak and insecure voice. The neuropersonality shows a specific alexithymia related to the emotions of anger and aggression.

- 3. The RAGE-DOMINANCE system and testosterone:** the RAGE-DOMINANCE system (with the help of testosterone, serotonin, and adrenaline) is one of the most powerful emotional systems (Panksepp, 2012). It is based on aggressiveness, anger and dominance—the basic emotions that allow living beings to defend themselves from attack—to preserve well-being (food, sex) and to defend the territory. Testosterone is the main hormone correlated with inter male aggression and dominance. Athletes who take testosterone become physically stronger, more aggressive and engage in more risk taking behaviors. In our clinical work, we observed an evident inhibition of the RAGE-DOMINANCE system in children and persons who have lived in aggressive, abusive, and unprotected families that strongly inhibit their personal power, courage to live, and strength to be themselves. Due to this consideration, in our practice, we developed some exercises to reduce the over activation of the FEAR-ANXIETY system by enhancing the RAGE-DOMINANCE system, through activation of the primary defensive reaction (anger, aggressiveness) that showed to be particularly useful in action inhibited patients. Through careful reinforcement of the primary vital reactions of defense and aggression, we have seen excellent clinical results helping submissive and weak people to react and defend their “territory” (personal space, work place, etc.), their personal values and themselves. In case of hyperactivation of the RAGE-DOMINANCE system, we usually work to enhance the CARE-LOVING system, which has significant efficacy to reduce and calm anger and aggression. The RAGE-DOMINANCE system is the neurophysiological root of all powerful charismatic leader’s neuropersonality. In some points similar to Reich and Lowen’s “psychopath” character, and, in the worst cases, of the DSM-V aggressive behavior and personality disturbance like antisocial and borderline.

The “inhibition of action” based on the FEAR-ANXIETY system, typical of babies and children living in aggressive and unprotected families, can deeply inhibit aggressiveness and anger within the RAGE-DOMINANCE system and strongly inhibit personal power, the courage to live and the strength to be themselves.

The psychosomatic aspect of the RAGE neuropersonality is characterized by increased sympathetic tone, strong and erect physical structure, a high and growing chest and high nasal breathing, with a high degree of muscular tension in the right arm, intense aggressive emotions and thoughts of conflict and revenge. There is also a decisive and

determined look, volitional movements, and a strong and directive voice that is often prone to verbal aggression.

4. **The LUST-SEXUAL system:** the LUST-SEXUAL system (Panksepp, 2012) is activated by sex hormones: testosterone, estrogen and vasopressin. It influences physical strength, dynamism, sexual energy, aggression, competitive game, risk and individualism. In animals it is correlated with inter- male aggression and dominance. The “inhibition of action” based on the FEAR-ANXIETY system, typical of babies and children who have grown up in aggressive and unprotected families, can deeply inhibit the LUST-SEXUAL system. The psychosomatic aspect of the LUST-SEXUAL neuropersonality is characterized by sensual and relationally open behaviors, with an attractive look and sensuous and pleasant behavior. The pelvis and the legs are loose and relaxed. In our clinical studies we observed that the inhibition of this system is associated with closure of the muscles of the pelvis and thighs, and relational behaviors of closure and rigidity.
5. **The CARE-LOVING system and oxytocin:** the CARE-LOVING system (Panksepp, 2012) is probably the most important human affective system for the development of a functional and mature self (Schore, 2003a). It is present only in mammals and human beings; it is absent in reptiles. It activates the behaviors of affection, parental care, intimacy, empathy, friendship, affective memory (baby recognition), attention and kindness (Bottaccioli, 2005; Panksepp, 2012).

The function of the CARE-LOVING system is of vital importance for all mammals and human beings in particular because babies are completely dependent on their parents in order to thrive and become adults. The CARE system is activated by oxytocin, which increases the affectivity and the empathy between mother and baby and enhances their memory for the cross recognition of face, body and smell to synchronize with one another. It is the psychobiological foundation of the affective quality of Bowlby's and Ainsworth's secure base attachment theory (Bowlby, 1969, 1988). Because of the large connections with the frontal cortex, the thalamus, and the PLAY-SEEKING dopaminergic system, this affective system seems to be one of the main psycho-neural functions that promotes the development of the self (Schore, 2003a).

Oxytocin slightly inhibits the male and female sexual steroid hormones promoting a different, more intimate and loving sexuality (Panksepp et al. 2012; Unkelbach et al., 2008). Oxytocin is the most powerful anti-stress hormone. When it is given to autistic children it tends to minimize their relational difficulties and facilitates better expression of emotions (Guastalla et al., 2010). The psychosomatic aspect of the CARE-LOVING neuropersonality is characterized by increased parasympathetic tone and calm, affectionate and friendly behaviors. The look is loving and empathetic, hands tend to be warm and gestures are reassuring.

In our clinical studies we observe how this neuropersonality shows a strong tendency to justify others and a specific alexithymia related to the emotions of anger and aggression.

6. **The GRIEF/PANIC system:** the function of the CARE-LOVING system is vital; therefore, the absence of care and love arouses the GRIEF/PANIC system (Panksepp, 2012), which is the system of loneliness, affective needs, sadness, crying, and, ultimately, depression. It is the neurochemical ground of panic crises. The dysregulation of the

CARE system and the parallel activation of the GRIEF-PANIC system, appears to be one of the main causes disorders of the self (Schore, 2003b) and the different forms of depression and panic crisis.

In our clinical studies we observe that the psychosomatic aspect of the GRIEF/PANIC neuropersonality is characterized by insecure, needy and anxious behaviors. The eyes are sad and look for loving kindness. The chest (heart) is contracted with narrow shoulders. The voice is characterized by high-pitched and plaintive sounds (crying, whining) oriented to the request for help and kindness.

We developed a number of psychotherapy practices and trainings to “calm” the grief and panic of this neuropersonality by restoring the full activity of the CARE system. We used many kinds of warm affective body contact: “maternage” exercises; regressions and emotional release of sadness and grief; and expression of personal affective needs and negative feelings. These practices help people to feel part of a protected, supportive, understanding, and loving group, to “reopen the heart”, and trust that they deserve love. The interventions were particularly useful with depressed patients.

Particularly in patients with panic crisis, we observed a consistent emotional alexithimic “compression” that can be cured by specific emotional release exercises and by enhancing the capacity of emotional expression.

7. **The PLAY/DREAMLIKE system:** the PLAY system (Panksepp, 2012) is activated by dopamine and governs the play and socialization processes: from “hide and seek” and “rough and tumble” childhood play to adult sports and dances.

This is a fundamental system of human activities that must be widely applied in education and psychotherapy (Shore, 2003). The psychosomatic aspect of the PLAY system neuropersonality is similar to the SEEKING system with a marked feeling of joy, playfulness, and laughter and fun. This neuropersonality can often manifest as “narcissistic” character.

The DREAMLIKE or SATISFACTION system represents the higher part of the PLAY system and is connected with the higher values and meaning of life, related to the frontal and prefrontal cortex, like knowledge, beauty, unity, meditation and spirituality (Pert, 1999). It is activated by endorphins—hormones that are secreted within the brain and the nervous system. Endorphins (endogenous morphine) have an anesthetizing effect on increases in pain and stress as they activate the body’s opiate receptors resulting in an analgesic effect thereby reducing our perception of pain and triggering positive feelings in the body similar to that of morphine resulting in a sense of global satisfaction, pleasure, wellbeing and serenity. The SATISFACTION system is activated by harmonious and friendly relations (oxytocin), by relaxation (serotonin), meditation and orgasm. It slightly decreases the effects of sexual hormones and the more instinctive libido in favor of a deeper sexuality.

To conclude this complex and fertile argument, we underline how Panksepp suggested that the seven emotional systems are the main biological foundation of our soul (Panksepp, 1998b) and that their inhibition or over-activation are the biological substrate of many psychological and psychiatric disorders (Panksepp, 2004). In our therapeutic practice we realized that, by enhancing psychosomatic and emotional awareness, we have not only cured the disorders, but also people’s self-awareness and inner spiritual dimension.

4 – From Reichian characters to neuropersonalities

Body-oriented psychotherapies, as described in the beginning of the article, in relation to human development of personality and psychosomatic blockages, have adopted an integrated approach where body and emotions play a leading role. Reich captured the connections among these various human psychosomatic experiences and emotional expressions and referred to them as “character”, from Greek *kharakter*, etymologically the “engraved sign”, but also the “imprint on the soul”. The character shows the individual’s biological, relational and biographical history (Ferri & Cimini, 1999) and has a temporal evolution and stratification. The detailed map of body blocks is truly a picture of the personal psychosomatic biography of an individual. It is as if each person carries a picture of his/her own ancient and recent personal history through the body-mind expressions and shape.

Reich supported the idea that *“a genetic-dynamic theory of the character... and a well-founded examination of the genetic differentiation of character types would be of importance for the theory and therapy”* and for *“a comprehensive, systematic psychoanalytic characterology”* (Reich, 1933, preface to the first edition).

Reich evidenced that the human personality is the complex result of three main elements: the biological-genetic structure; the affective and psychological maternal, familial and social conditionings; the deep sense of self-identity of the person.

Neuroscientific and PNEI understandings of the psychosomatic origins and the development of emotional systems and neuropersonality create a scientific root for the Reichian discoveries and the subsequent psychosomatic unity paradigm, providing the scientific genetic foundation for a modern theory of personality.

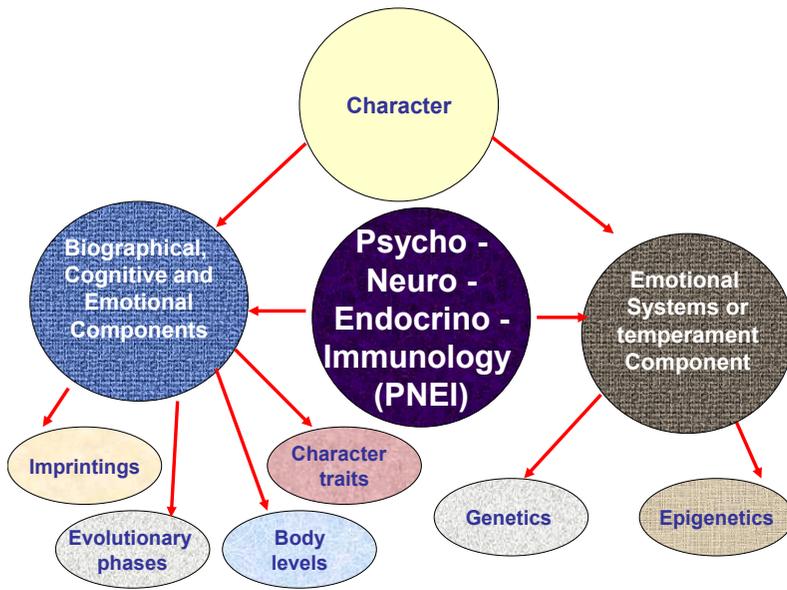
There is robust evidence from PNEI research that the emotional system’s expression and the neuropersonalities’ activity are in part determined by genetics and epigenetics and in part by external conditioning (Cloninger, 1994, 1999; Talge et al., 2007; Masterpasqua, 2009).

In *Character Analysis* Reich (1933, pp. 198-199) wrote: *“We do not deny that the modes of reaction are hereditarily predisposed, in fact the newborn already has its own character. It is likely that some deeper qualities of personality are innate.”* Therefore, it appears that every human being is born with his/her own temperament (neuropersonality), which will be modified in a unique way by life experiences and maternal, affective and social conditionings, leading to a specific personality or character.

Numerous PNEI research results have evidenced that pregnant mothers who are in a state of stress, depression or trauma during pregnancy have a deep epigenetic and psychosomatic influence on the emotional systems (cortisol) and on other fetal psychosomatic parameters developing traits that persist for years in the child as neuropersonality structures particularly exposed to anxiety and fear (O’Connor et al., 2002; Ruth et al., 2007; Weinstok, 2005; Talge et al., 2007).

The concept of character is very near to that of neuropersonality; it can be described as an extended structure, the evolution of personality. Indeed, this is a complex system that can be seen from two viewpoints: the emotional and psychological component and the temperamental component that refers more specifically to the neural, genetic, and epigenetic components.

As Reich understood, the ancient personal emotional experiences developed as early as during intrauterine life, and the more recent experiences produced by the repetitiveness of our cognitive and emotional mechanisms tend to “reiterate” the same specific character and blocks throughout our lifetime.



The inhibition or hyperactivation of every single emotional system simultaneously blocks specific muscular, emotional and psychological structures expressed through the body as muscular armour. So, a particularly strong or deep inhibition or hyperactivation, as happens in trauma, can cause a state of entire Self inhibition or hyperactivation.

The structure and the modes of inhibition and hyperactivation of the seven emotional systems are stored in brain areas as body remembrances (cerebellum, striatum), emotional reminiscences (hippocampus, amygdala) and psychological autobiographic memories (neocortex, prefrontal cortex).

The neuroscientific understanding concerning the body's response to "negative" emotions, and the activation of the FEAR-ANXIETY system, connected to the stress response and to the "inhibition of action" (Laborit, 1969, Fink, 2010), provides the scientific basis of the "instinct-inhibition" of the emotional energy that Reich posed as the main origin of the various types of characters.

Most of these specific character blocks are not consciously perceived. They constitute the unconscious, the place where the history of the individual resides, which is out of awareness but emerges through the verbal, oneiric and body languages. In other words, fixations originating from childhood experiences combine to determine in the unconscious way how the individual feels, expresses himself and behaves during life. Body-oriented psychotherapy can help people become conscious of these blocks and restore a more authentic and natural psychosomatic consciousness.

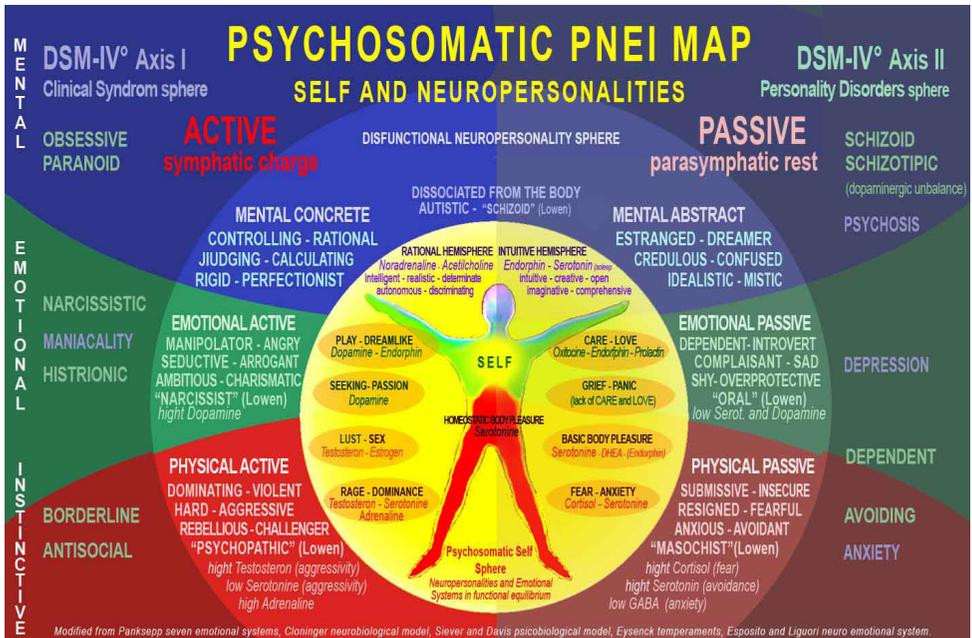
Over the past twenty years, in our Institute, we developed specific psychotherapy practices and exercises to help people restore and activate their repressed and/or inhibited emotional systems, and/or calm and govern their overstimulated systems. All of these practices are performed in a space of deep self-awareness and are based on a psychosomatic use of mindfulness and other types of active meditations. This produced an important

improvement of the symptoms and disorders, a psychotherapeutic process acceleration and an improved sense of identity and self-awareness.

For this reason, the psychosomatic PNEI system, governed by the Self and by the seven emotional systems, may potentially offer a scientific foundation for modern body-oriented psychotherapies and a strong support for the development of a new and more psychosomatic Self-consciousness therapeutic approach.

5 - The “psychosomatic map” of Self and neuropersonalities

The seven emotional systems are considered the basic ways through which the Self can manifest in life. In fact, their inhibition or imbalance is associated with the entire range of psychosomatic and psychological disturbances: from light unbalance of the personality traits to major forms of psychological distress; to psychiatric and personality disorders, in which the sense of Self is altered, fragmented or dysfunctional. The interaction and development of these seven emotional systems allows us to understand the scientific basis of human personality and character. Their inhibition or hyperactivation easily generates an immediate, parallel, inhibition or disharmony of the natural bodily, emotional and psychological functions that are the basis of the psychosomatic blocks, of the muscular armour and of the structure of the “character” as expressed by Reich (1945) and Lowen (1958).



In other words, these distortions lead to the development of a “false self”, a structured and dysfunctional personality designed to adapt to a specific family or to social constraints.

The PNEI Psychosomatic Map

We created a PNEI Psychosomatic Map where we systematized the main neuronal structures according to their anatomical evolution and functions. The three main levels of

evolutionary development: instinctive, emotional and mental, corresponding to the reptilian, mammalian and neocortical brains, are represented respectively in red, green and blue. On the right side of the human figure, we find the emotional systems and hormones stimulating the active response (charge) of the sympathetic system, on the left side we have the systems and hormones stimulating the passive response (rest) of the parasympathetic system. The three concentric areas are related to the levels of clinical severity:

- **the central area:** the yellow “psychosomatic self sphere” represents the Self’s essential functions, the core of the psychosomatic system. This is the functional and balanced neuropersonalities area, where all the main emotional systems and their hormones and neurotransmitters are in a natural equilibrium
- **the middle area:** represents the “slightly unbalanced and dysfunctional neuropersonality sphere” and the homologues character. In this area we find one or more personality traits that people tend to identify with, thus creating a “false self”
- **the external area:** represents the severe personality disorders sphere corresponding to the highly unbalanced and dysfunctional neuropersonalities, from here we can define a connection between the neuropersonalities and the personality disorders as defined by DSM-V. We can say that a disequilibrium of the emotional systems, with a prevalence of one or more, creates a neuro-hormonal inhibition or disharmony that is the root of personality disorders or of the characters.

In the PNEI Map, we established general correspondences that take into account several factors: the seven emotional systems, the triune brain, the sympathetic/parasympathetic autonomic nervous systems, and the core Self. The interaction of these factors must still be deeply studied, which could be one orientation for future research. Above all, we need to study how the basic neuropersonalities react with the personal history and with the childhood imprintings beginning with intrauterine life. We believe that we now have the instruments to connect what Freud already wanted to discover: the human being’s basic biological structure as neuro-scientifically studied, with the evolutionary biographical history studied by modern psychology. What we already know is that this interaction creates the personality and its disorders in all the physical, emotional and cognitive aspects.

From an integrative and holistic perspective, we can say that the emotional systems effects and hormonal actions do not appear to be purely mechanical, but are largely affected by childhood imprinting, upbringing, familial traditions, individual determination, and personal awareness. It is, therefore, essential to avoid any form of scientific reductionism, which is always a danger when trying to interpret the complexity of the human being.

The results of current and forthcoming neuroscientific research must be considered complementary to the research in the field of mental and symbolic processes, personal emotional experiences and ancient memories, as they enable us to gain a deeper understanding of the personal history and of the developmental process of each human being from birth onward.

6 – Conclusion: brain-mind integrity and Self-awareness

The model of the human being that emerges from neuroscientific and PNEI research is a “unitary psychosomatic Self system”, an organic and inseparable body, emotional and cognitive unity that supports the understandings and the clinical fields of action of the psychosomatic unity paradigm we have proposed.

The concept of psychosomatic self-consciousness emphasizes the need for advancement in psychotherapy that promotes an integrated psychotherapeutic approach for the dissolution

and melting of bodily, emotional and cognitive inhibitions and blockages, and simultaneously for the development of a more global and deeper self-consciousness.

In the human being, psychic and cognitive modalities are strictly related to “functional operation”, namely to the functioning of the inter-relation and exchanges between the various sub-systems. The mind and the seven emotional systems can be considered a privileged gateway to the Self. If the levels of consciousness change, the bodily functions and the perception of reality change. Thus, we can say that at the end of the psychotherapy process, when remission is achieved, many patients perceive an expansion of their personal awareness marked by emotional de-conditioning and a minor repetitive perception of reality less influenced by the childhood experiences (Barbato, 2011).

When defenses, fears or emotional blocks fade away, when the mental “cage” of our own conditioning, opinions and our often preconceived assumptions slowly dissolves, then it may happen that Self-consciousness and our perception of reality becomes clearer. Life is revealed in its deepest essence without being filtered through any psychic and bodily obstruction. Clients often express a feeling of integrity, a “state of oneness” that is essentially analogous to the meditation or mindfulness state, a stronger contact with their inmost energetic core, which is naturally in harmony with other people and with nature energetic processes (Montecucco, 1997, 2003).

This only happens as a result of an integrated psychosomatic process in which physical, emotional and mental components are processed by the individual’s Self-awareness and then re-arranged according to their symbolic and abstract expressive capabilities and connected to the biological-biographical history. The disconnection from these elements, the separation between mind, body, and emotional systems, is the evidence of the first primary separation of the human being from its own real natural Self, the primary breeding ground of psychopathology and its symptoms.

Therefore, we can assume that spiritual evolution is tantamount to moving from knowledge to deep psychosomatic awareness and finally to deep Self-consciousness. At the end of the journey, our techniques, pains, fears, and words are like life rafts that must be abandoned; at that point, we are able to land safely at the harbour of our inner Self, the intangible being who helps us share the love we cannot contain.

To conclude, we quote Sri Aurobindo (1996, p.7) who beautifully described the connection with the Self as follows: “*The body is the divine instrument provided for the fulfilment of the right law of our nature.*”

BIOGRAPHY

Luisa Barbato certified Reichian body psychotherapist, is a member of the Board as well as supervisor of SIAR (Italian Society of Reichian Analysis) and is the director of the Scientific Committee of AIPC (Italian Association of Body Psychotherapy). She was elected member of the Italian Board of Professional Association of Psychologists and was a member of the Executive Committee of the Forum of European accredited body psychotherapy training institutes. She teaches body-psychotherapy in numerous Italian post-graduate schools of psychotherapy.

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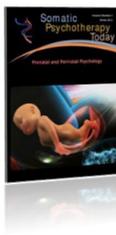
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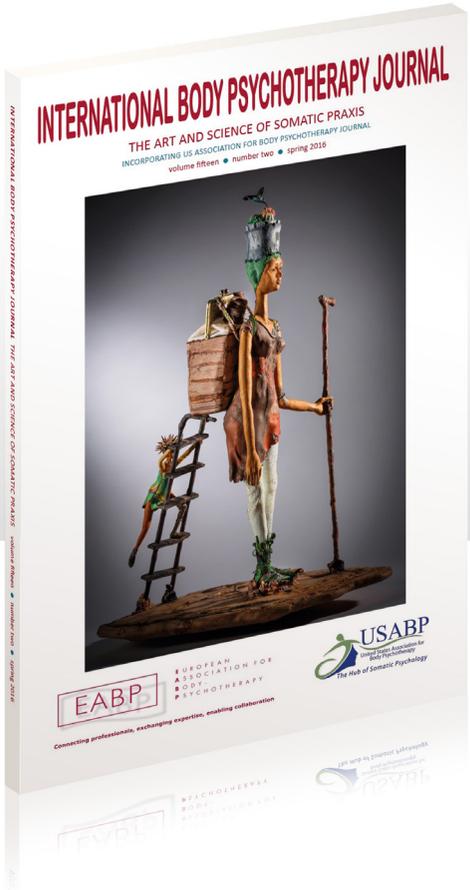


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INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS
INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume fifteen ● number two ● spring 2016

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Journal (ISSN 2169-4745)