

Working Safely With Trauma Abused and Still Alive

Will Davis

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ABSTRACT

There are two related themes in working with trauma patients in a safe manner. First, I introduce how a functional approach allows for the possibility that it is not necessary to work through, re-experience in a safe therapeutic environment, or have knowledge of the trauma in order to be freed from it. It is possible to treat trauma patients below defenses, working with the "undamaged" endo self that exists before the trauma. The second theme is a functional model of how to understand this unlikely phenomenon, considering that it seems to go against the basic therapeutic principles listed above.

Keywords: Reich, instroke, trauma, endo self, dual nature of relationships, functional model

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Over 30 years ago I began to witness an unusual phenomenon. While working with the instroke—the gathering, self-oriented movement of the life pulsation—patients spontaneously moved into quiet, calm, deep contact with themselves without expressing emotions or movements. While I was doing a gentle touch technique, they would often turn on their side and curl up on the mat. While I had the impression that nothing was happening, patients reported that profound events occurred. Simply stated, patients were able to reorganize primary object relations with no new additional information, no elaboration of their history, and no further intervention from me. They were doing this by themselves, and when reporting the changes later, some commented how easy it was. They created a different version of the same historical, sometimes traumatic event, finishing with it, and moving on in their lives. This was particularly confusing, for it fit none of the therapy models I had learned. Of course, the reorganization of a primary object does not go against any of the principles of psychotherapy. But what was new was the way in which this was achieved; that is, working without the drama of re-experiencing the trauma, and the patient achieving this change spontaneously within themselves.

In some cases, the patient had not mentioned the trauma, and therefore it was never worked on. For example, by the beginning of the last of a series of nine sessions with a patient in a week-long workshop, there had been no revealing discussions, movements, or emotions. He was lying on a mat on his abdomen, and I was gently touching his back.

He started crying quietly and deeply. He later explained that he realized his stepmother loved him. “I always thought that the things she did to me were because she didn't love me. Now I see that this was her way of showing she did love me!” Additionally, there had been none of the typical vegetative signs of trauma emerging: rapid heart rate, hot or cold sensations, panic or fear, sweating, shivering, shaking, or splitting off. Yet he cleared this trauma by himself (Davis, 2012, p. 71).

In other cases, people passed through their traumatic history between sessions, during training workshops while I was demonstrating techniques, or when other trainees were learning and practicing the techniques with each other.

The Phenomenon

The case below is an example. After an introductory workshop I received the following email.

Something changed in me during this training. I wasn't able to define it back then, but in the last days I just observed myself and a new feeling of relief and calmness deep inside me emerged. Many memories popped up, memories that I had locked deep down and tried to ignore. Before coming to you I have read carefully the materials you suggested. I have understood intellectually the concepts of the endo self and the Instroke. But they were just the next concepts, the next smart words. In the workshop, I experienced it. I felt this place inside me where it is all fine, calm and peaceful. I didn't understand it at once, but then those memories that came back made me recall that I used to know this place.

During the instroke exercise, I saw my dad. He died in my arms when I was 13. And that was the moment I lost the way back to myself and I did it on purpose. In the last days I remembered how my dad used to take me to a river, or up in the mountains when I was a child and we just sat in silence. He used to tell me that this is a way to find peace within, to find strength. He taught me how to listen to my inner voice, how to feel my body, how to find the strength in me. And when he died, I was so angry at him that I just blocked it all, I threw away the key for inside and started to live only by “going out”.

I have worked on my anger, and my sorrow and so many other emotions in my personal therapy. I do yoga and numerous kinds of meditations. And all I was looking for, all I was struggling to find is exactly that feeling of calmness and “it will all be fine” that I knew so well in my childhood. The insight that I just have is so powerful. I feel on the right path for the first time. I want to reconnect to myself. And this changes so much...

In this passage, we read the major themes of the phenomena I have described. There was no specific focus on the traumatic event. There was no specific release or insight that happened while the trainee was practicing the technique. There were also the classic signs of the endo-self state (Davis, 2014): all was fine, calm, and peaceful, and she already knew this state. She was returning to it, returning to herself. As Merleau-Ponty pointed out: “At the root of all our experiences, we find, then, a being which immediately recognizes itself...not by observation and as a given fact, nor by inference from any idea of itself, but through direct contact with that experience.” (in Pagis, 2009, p. 267)

Further, she did not describe any classical trauma signs. She was realistic and she took responsibility: angry, "throwing away the keys," going away from herself. And, she acknowledged what a loving father he was. In addition, she processed all of this *after* the workshop, *by herself*, even though she had already worked on her anger, sorrow, and other emotions in her therapy.

Colleagues have suggested that this was a result of her previous therapy. But if this is true, then most patients who have long-term therapy should spontaneously undergo this sort of experience. I had not seen this phenomenon during the first 15 years of my practice while doing encounter groups, Gestalt therapy, and then Radix neo-Reichian therapy. It did not appear until I became proficient in helping patients mobilize their instroke process and deepen their contact with themselves. And in the example of the transformation in a patient's perception of his stepmother, the patient was a "beginner." It was clear that something else was happening that I had not learned in my therapy trainings. Additionally, I have since trained therapists who report similar phenomena. What we are witnessing is a complete restructuring of a negative, lifelong primary object relation or experience that is happening intra-psychically, sometimes alone, with no new input available to the patient. How is this possible?

To answer this question, we begin with the Gestalt principle of figure-ground. The neurologist Kandel (2013) described the self-referential nature of perception, and how we create our own reality. Throughout his discussion of visual perception, he emphasized that "the eye is not a camera" (Kandel, 2013, p. 234), "every image is subjective" (Kandel, 2013, p. 200), and "there is no innocent eye" (Kandel, 2013, p. 200). This is true for touch, hearing, taste, and smell as well. (Kandel, 2013). Our perception of the physical world is "... an illusion created by our brain" (Kandel, 2013, p. 203), which is why we can view the same painting over many years and see and feel different things each time. This also accounts for our varying response to the same object/other. This ability is the basis of how we can restructure a primary relationship years later with no new input, and how the changes experienced in depth psychotherapy are achieved. The object remains the same. The story remains the same. It is the patient's experience that changes. In the phenomenological point of view, "The learner remains unchanged. It is his *experience* of the situation which changes." (Syngg, 1941, p. 406)

To illustrate his point, Kandel (2013) used the Gestalt drawing that appears to be a rabbit or a duck, depending on how one looks at it. The first point is that the visual image on the page doesn't change. What changes is the interpretation of the image. In therapy, it is the patient's experience of the historical data that changes.

Kandel's second point was that we "decide" unconsciously what we see, and these decisions are based on hypothesis testing, grounded in a combination of our innate neural recognition patterns and our past experiences. It is important to note that in conscious perception, there cannot be ambiguity. It is either a rabbit or a duck. On the cognitive level, we *have* to make sense of everything.

But, on the unconscious level, we are capable of maintaining a number of coherent, often contradictory, interpretations. (Kandel, 2013; Raichle, 2010; Schore, 1999) The unconscious can tolerate ambiguity, which gives it access to more information, more possibilities, and offers an alternative interpretation for the conscious mind when it is ready to "see" that.

Conscious thought works from the top down and is guided by expectations and internal models; it is hierarchical. But unconscious thought works from the bottom up or non-hierarchically and may therefore allow more flexibility in finding new combinations and permutations of ideas. While conscious thought processes integrate information rapidly, unconscious thought processes integrate information more slowly to form a clearer, perhaps more conflict-free feeling. (Kandel, 2013, p. 469)

This helps to explain how the original data — the patient's history — can be reorganized, resulting in a restructuring of a primary object or event, with no new information added. The same phenomenon was recorded in pupillometry.

During changes in perception, nothing changes in the world of environmental input, so any change in perception must be attributed to an internal change of the state of the brain that results in interpreting the same world state as a different event. (Laeng, Sirois & Gredebäck, 2012, p. 22)

Coming back to the rabbit/duck image, there is only a single two-dimensional image on the page. In fact, there is no rabbit or duck there. But on the conscious level, we need to classify and organize the input in order to make sense of it.

In addition, Laeng, Sirois, and Gredebäck (2012) indicated that pupil responses to images, thoughts, and emotions are the same. Imagination and perception are based on the same neural processes: the same brain state is activated. Your body is reacting as if you are there. Changes seen during imagination of an object “are a result of an active process of imagining and not as an after effect of episodic trace of a previously seen picture. In other words, what is happening in the imagining phase is actually happening, and not something left over.” (Laeng & Sulurvedt, 2013, p. 4). We will return to this theme in the section “A Functional Model.”

The fact that we are creating all these objects explains why we can continually misinterpret and see the same object “incorrectly” again and again — for example, in transference or with a “bad” stepmother.

This idea is also supported by the neurological research of Raichle (2010) and Buckner, Andrews-Hanna, and Schacter (2008) concerning the default mode network. Raichle has shown that there is a subcortical system involving different brain areas that unconsciously organizes all incoming information without conscious awareness, and then informs cognition as to what it has “decided.”

[T]he default mode network is a specific, anatomical defined brain system. It is active when individuals are not focused on the external environment. It is active when individuals are engaged in internally focused tasks including autobiographical memory, envisioning the future, and *conceiving the perspectives of the other*. ([Italics added], Buckner, Andrews-Hanna, & Schacter, 2008, p. 1)

There is no objective object. (Davis, 2015 p. 14-18). Campbell's Psychiatric Dictionary (2004) described introjection as “The incorporation into the ego system of the picture of an object as *he conceives the object*” ([italics added] p. 348). Idealization is an extreme example of a self-created object. In idealization, the internal object representation could have none of the characteristics of the “real” external object. This is a result of the earlier

mentioned necessity for the conscious mind to organize and make sense of what it is experiencing. It also is the basis of the narrative the patient creates about past traumatic events.

Investment

In creating our objects, the self invests a specific quality into the object, a charge of energy. Most theorists argue that it is not the object in itself that is important, but the investment made in the object by the subjective self. Mitchell (2000) commented that the mother and baby co-create each other. Loewald suggested that objects "... do not exist independently of the subject. Objects are created by being invested with significance" (Mitchell, 2000, p. 38). Kohut (2001) took a similar view: "Narcissism is defined not by the target of the investment, but by the quality of the investment." (Kohut, 2001, p. 26) Social psychology showed that "It is the quality that determines functional significance rather than the particular event or object." (Ryan, 1991, p. 220) As well, in a quantum model of transformative processes. "The essential element is not the amount of energy involved but its quality; if it is able or not to trigger an information process of phase coherence." (Casavecchia, 2016, p. 10) The subject chooses what to focus on. It is not what was done to the patient by the other, but the patient's experience of the other/event.

Green (1999) criticized object relations theorists as being too focused on the object to see the objectalizing function of the life drive. They do not appreciate the endo-psychic strivings, the investments by the self in creating objects and then relationships to satisfy itself. For Green (1999), the object does not create the drive; it only reveals the drive toward the object. In this same manner, Damasio (1999) described the object as an emotionally competent stimulus, capable of meeting a response but not creating it. The role of the drive is:

...to form a relation with the object but it is capable of transforming structures into an object even when the object is no longer directly involved. To put it another way, the objectalizing function is not limited to transformations of the object but can promote to the rank of object that which has none of the qualities, characteristics and attributes of the object, provided that just one characteristic is maintained in the psychic work achieved, i.e., meaningful investment. (Green, 1999, p. 85)

He even suggested that the self will create objects in their absence! We create what isn't there out of our desires, needs, and beliefs based on our own experience of events, not the external "reality" of those events. Loewald brought this discussion to a final point:

I am my objects and my objects and I are always inseparable. They can never be expelled. This suggests that what happens in psychoanalysis is not a renunciation, or exorcism of bad objects, but a transformation of them (in Mitchell, 2000, p. 44).

Objects don't change. We transform them. More precisely, we transform our experience of them. This is also exactly what happens in a healthy development process. As the child goes through a progression of developmental stages, it continually reorganizes the representation of the mother object into adulthood. The mother is not so much changing as the child is experiencing the mother's various aspects as he transforms and develops himself further.

But Who is Transforming What?

The following is a typical representation of the basis of effective psychotherapy. “By confronting these fears from the past with open eyes in the now a person can find the strength to overcome most of his/her psychic and somatic dysfunctions in everyday life.” (Adler, Gunnard & Alfredson, 2016, p. 8) A specific example of this comes from Epstein (2014):

“Miriam came from a remote, former Soviet Union, a harsh reality of survival and everyday difficulties - both externally - as a Jew in an anti-Semitic society, and at home where she was treated violently, and taught to serve her parents, to be a good, obedient, and useful citizen - and later as a woman who takes good care of her husband. She was a nurse; for her entire life, she served others. She received long and rigorous training in self-deprecation. Worth and temporary calm came only in serving others. She knows almost nothing of herself, her desires, her wishes, and passions. (Epstein; 2014, p. 73)

Yet, at 40 years old, one day “something woke up in me,” and she came to therapy to help herself.

But what “woke up” in her? Where does the force to confront and the strength to overcome come from if the organism has been so severely damaged? And in the specific theme of this paper, how is it possible for a severely damaged person to not only be able to find this but to restructure herself, often by herself, in a calm and clear manner? The answer is the part of the psyche that has not been damaged by the trauma; the endo self. (Davis, 2014)

The endo self describes an early, self-organizing, embodied, coherent sense of self whose unique quality is that it exists prior to relationship; an autonomous self, grounded in relationship (Davis, 2014). Besides the earlier reference to Merleau-Ponty, Maslow's (1968) “being states,” Reich's (1967) “core,” Guntrip's (in Buckley, 1986, p. 467) “inner core of selfhood,” Winnicott's (in Buckley, 1986) “incommunicado core,” Loewald (in Mitchell, 2001), who describes primary experience as being “...an experience of a perceptual affective nuclear consciousness that resonates in the quality of being the experience of himself” (Casavecchia, 2016 p; 16), and “A nascent core of self is not a social construct but a natural endowment of the organism” (Ryan 1991 p. 214-215) all suggest a deeper sense of consciousness/being/self. Jantsch (1979) comes directly to the point: “...with existence comes consciousness” (Jantsch, 1979, p. 10), while Maturana and Varela (1972) define consciousness as a biological phenomenon: “If you are living, you have consciousness” (p. 5).

The Cambridge Conference on Consciousness (2012) emphasized that there is subjectivity in the fetus before the development of cortical activity: before cognition, language, and relationship. In the same tone, Solms and Panksepp (2012) identified an embodied, affective core consciousness in the brainstem, and that higher cortical brain functions — cognition, language, representation and object creation — are built on and informed by this earlier emotional, embodied core consciousness. “The brain mechanisms of the internal body function largely automatically, but they also arouse the external body to serve its vital needs in the external world.” “[...] in the sense that exteroceptive consciousness and learning reflect and serve interoceptive needs” (Solms & Panksepp, 2012, p. 155, p. 165). A core consciousness exists without cortical consciousness. The reverse is not possible.

Experiences are lived not only below cognition, but without it. For example, it is possible to "traumatize" insects. Scientists selected a type of insect that shows maternal care of its eggs and young. They removed eggs from some of the mothers, and one set of eggs were cared for in laboratory conditions. "The researchers found that nurtured female nymphs matured into devoted mothers assiduously cleaning eggs and feeding and defending their young. In contrast, females raised without mothers did not excel as caregivers. They fed their offspring less frequently and were not as effective at protecting them from predators." Similar results were found with another set of eggs inserted into a "foster mother's" egg collection. (Scientific American, 2016, p. 13)

Of particular interest for body-oriented psychotherapists is Solms and Panksepp's core consciousness. The true internal subjective body is represented not in the cortex as has been assumed, but in the core consciousness of the brainstem — not as an object, but as the subject of perception. On this level of functioning, "...perception happens to a unitary, embodied subject" (Solms & Panksepp, 2012, p. 156), which I am referring to as the endo self state. The interoceptive brainstem generates internal states, not external objects of perception. It gives rise to a background state of being: the endo self, where, as Carl Rogers (in Ryan, 2003, p. 75) commented, "All the facts are friendly."

There are a "vast variety of selves" to work with in therapy on the conscious, cognitive level — false self, social self, true self, fragmented self. But on the functional level there is but one self, the undamaged endo self. This is the root of my argument for *who* is doing the transforming of past object representations. It is an inherent endo self that is undamaged by the trauma, and therefore still capable of transforming an object with the same history once the experience of the object is altered. Functionally, this is a natural, universal characteristic. The healthy child utilizes its endo self to let go of one representation of the mother object and create another. So too can the traumatized patient call upon this still healthy endo self to transform and reorganize primary objects and the experience of events from the past.

Rewriting History

If we postulate an undamaged, embodied, psycho-emotional core called the endo self, we have answered the question of who is doing the transforming. But the question remains: how is the experience altered with the same data? How do patients now access information that was there but not available to them before? The answer to this question lies in the dynamic of what Guntrip originally called the "dual nature of transference" (in Buckley, 1986, p. 467), just as Reich had already differentiated between false positive transference and genuine transference (Reich, 1976).

Freud observed that transference is not limited to neurotics, but is essential for both healthy functioning and healing. "[...]the tendency to transfer in neurotics is only an exceptional intensification of a universal characteristic" (Davis, 1989, p. 4). For Guntrip, a good object is the basis of mental health. In its absence, the patient finds a good object in the analyst in both the transference relationship and in real life. "In analysis and in real life, all relationships have a subtle dual nature" (in Buckley, 1986, p. 447, [*Italics added*]).

A Duality: Need and Desire

It is this dual nature of relationships that allows for the possibility to transform objects and historic events. I have framed the dynamic of Guntrip's duality in terms of need and desire — a dual flow of both need and desire within all relationships (Davis, 2015). Desire is the natural impulse towards contact, the “universal characteristic” in all relationships. Need is frustrated desire adding an overlay to this universal characteristic, and creating the neurotic's “intensification” or Winnicott's “rupture of continuity,” thus distorting the natural flow towards relationship and resulting in the distorted need states.

Maslow (1968) wrote of a “hierarchy of needs” from safety to social to self to altruistic onto transcendence. with the “lower” needs having to be satisfied before the later ones could be engaged. But to differentiate between desire and need changes the theoretical landscape. Need arises when desire is not met. Need is a state of difficulty, a sense of deprivation with a goal implied — usually at a distance. In the language of psychotherapy, this distant goal is the other. Desire suggests mutuality, a give-and-take dialogue by placing a “request” to respond upon the other to whom the desire is expressed. It has an impervious quality, a request that must be responded to (Crabb, 1917). Desire is a request. Need is a demand.

Thus, need is unmet, distorted desire. A desire to be in contact is a different state than a need to be in contact; they have a different purpose and outcome (Davis, 2014, p. 14). If the desire is not met, it “sours” and becomes need — a state. The “pushy,” “gluey”, shrill quality of the need state is a symptom of the unmet desire. In Reichian terms, needs are emotions from the armor that have lost their pulsatory contact with the core.

Need is other/object oriented. It has lost direct contact with its source, through a rupture, and the result is that it must be satisfied from outside. The other satisfies the need. In contrast, desire is endogenous in its origin and functioning, and in its satisfaction. Because desire is still in direct contact with its source, the self satisfies its own desire because it determines what is desired and what is satisfaction.

Another difference between need and desire is that with desire. there is no tension that has to be discharged, as in drive theory. The “tension” is an energetic excitement, a concentration of internal energy, that acts as a spontaneous, natural, mobilizing force towards object relationships and is well within the tolerance levels of the organism: Freud's “universal characteristic.” It is pleasurable (libido means “it pleases”). Surprisingly, Piaget spoke directly to these twin themes of flowing out towards the other and the pleasure found in this movement, describing development as “[t]he very nature of life is to constantly overtake itself” (in Ryan, 1991, p. 208): to extend itself outward even further. And this striving outward, what Piaget called intrinsic motivation, is merely for itself. There is a pleasure in mastery, in efficacy, in experiencing merely for its own sake. This is a “basic fact of psychic life” (in Ryan, 1991, p. 209). Fifty years later, the neurological research of Ramachandran verified that the wiring in our brain ensures that the very act of searching for the solution is pleasurable (in Kandel, 2013).

Immutability

Additionally, it should be noted that satisfying needs only creates the possibility that the desires will be met, which brings up the all-important theme of the immutability of the desire of life to “constantly overtake itself” (Piaget in Ryan, 1991, p. 208), to go beyond itself into contact and relationship. And herein lies the nature of the duality in relationships. This is desire, also known as investment, Freud’s universal characteristic, Green’s objectivizing process, Guntrip’s dual nature, etc.

As Reich’s energy concepts postulate, it is possible to interfere with and distort this movement towards completion. The interference pattern, typically inadequate parenting, creates need. But the energetic movement of desire cannot be eliminated. It can never be prevented from trying to move forward towards pleasurable satisfaction. This impervious investment quality is the basis of healthy, loving relationships. And with an understanding of duality in relationships, it is clear that this impervious investing is also what underlies the distorted, deregulated need states of sublimation, transference, projective identification, etc.

These need states are a reflection of a continuing attempt to get what has not been gotten and is still desired: to make happen what has not happened. For example, in transference, the patient is not seeking the original father in the therapist. But rather, as Guntrip pointed out, a “good object;” exactly what he did not get in the original father relationship. As Perls said, transference is “[...] about what did not happen” (Perls, 1972, p. 40). Without this still healthy continuing search, in-depth psychotherapy would not be possible. There would be no healing, only repairing; no reconstruction, only renovation.

What I call desire, Kohut (2001) described as the “narcissistic stream,” which remains *unaltered throughout life*—immutable—and is the basis of creativity, love, and all future relationships. Even when met, this innate push towards development and satisfaction will spontaneously continue to transform into the next phase of development, as described in Maslow’s hierarchy of needs and object relations theory. It is embedded in health, and disguised in deregulated dysfunction for a lifetime. The patient cited earlier is an example. Despite her traumatic history and her negative emotional states, she continued to desire a loved and loving father, and once this was achieved, she could move past her resentment and enter into an adult, reality-oriented relationship with her father and not remain in a bad father/resentful child relationship.

Schore (1999), like Kohut (2001), emphasized this immutable search for completion, Echoing Guntrip’s subtle dual nature, he wrote:

Embedded within the patient’s often vociferous communication of the deregulated state (need in terms of this discussion), is also a definite, seemingly inaudible, urgent appeal for interactive regulation (desire/relationship). This is a lifelong phenomenon. (Schore, 1999, p. 14)

Bowlby reflected this when describing attachment. “While especially evident during early childhood, attachment is held to characterize human beings from the cradle to the grave” (in LaPierre, 2015, p. 86).

In an earlier formulation of this same understanding, Reich (1976) emphasized that analysis could not proceed without reaching a level of “genuine transference” with the patient; “...the glimmerings of rudimentary genuine love;” again, a subtle dual nature

(Reich, 1976 p. 143). Reich understood that the original desire for the object is still intact, but obfuscated by false positive transference. Genuine transference is desire for contact and relationship, rooted intrapsychically in the endo self. False positive transference, Guntrip's transference, Schore's deregulated state, and emotions from the armor are need and lack, rooted in dysfunction and defense, and sought externally in the object.

Diagram I below delineates the dual flow in all relationships.

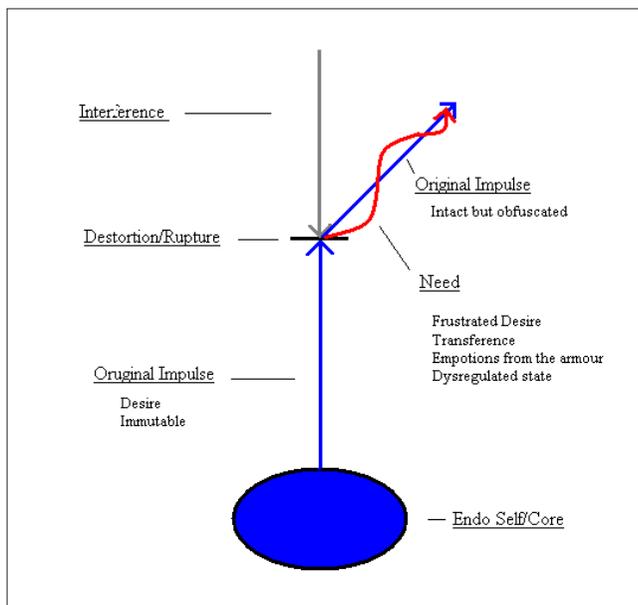


Diagram 1. *The dual flow in all relationships*

The continuation of the straight (blue) arrow past the rupture point represents the original impulse — Freud's universal characteristic — from the self/core towards the other. The continuation of this impulse is embedded within the distorted need state represented by the irregular (red) arrow, revealing the still-alive desire for contact and relationship that underlies all neurotic need states. Because both are there, Guntrip referred to a "duality." And because both are there at the same time in the therapeutic setting, the therapist can decide which to focus on, the need or the desire; the "emergent resource" or the "structural deficits." Fairbairn (in Buckley, 1986) reported that a patient once said to him, "I want a father." From this, he deduced that the goal of the drive is the object. I am arguing that he is correct only when the drive is a need state, a ruptured desire. Differentiating between need and desire, the therapist can choose to work with the need for the "father" object, or the desire of "I want...".

If it is, as Fairbairn suggests, the object that satisfies, why is it that even when the object wants to satisfy, it cannot? We know this as therapists. Any parent knows this feeling. Any lover who has been left knows this experience. It is not about what is offered; it is about what is taken.

The combination of this immutable desire towards mutuality and the innate ability of the patient to create and recreate his or her own objects lies at the source of all in-depth psychotherapy. It lies in the dual nature of relationships, in what did not happen and the simultaneous desire to make it happen. Without these two themes, there is no healing. We are left with compensation, adaptations, compromise, and, too often, resignation.

Green wrote:

[...] what brings a subject to analysis is... a compulsive need [desire] to rebuild his story in order to carry on with his life. (2005, p. 424) ...how far does what unfolds in the treatment involve a repetition of the past and how far does it concern not what has been repeated but, on the contrary, what has never been experienced." (2005, p. 71, [italics added])

The clinical implication of this model is evident. Without some model as I am suggesting, as Strecker (2018) has pointed out, we are left with a quite different position whereby the patient is left with compensation and adaptation, and possibly resignation about what still has not happened.

Stanley Keleman was always very clear that for him there existed no "real self" that could show up after all the distortions and deformations of education and biography had been peeled off. His sober analysis was that there existed no healing in the sense of finding the perfect condition under the surface of alienated existence. So, you have to deal with what you have developed so far, involuntary and voluntary. (p. 54)

A Functional Model for Rewriting History

By mobilizing the instroke it is possible to work safely with trauma patients by going below the cortical level of cognition and emotions, below the defenses and even below the trauma itself, to the undamaged endo self state. Trauma needs objects, others. The endo self seeks itself. As one patient explained, "I love myself beyond the good and the bad."

Neurological research confirmed the position taken in pupillometry; what is happening in the imagination is actually happening, and is not a memory. Cozolino (2002) and others have pointed out that all trauma is stored sub-cortically and in the present moment in the more primitive regions of the brainstem and limbic brain, with little cortical and left-brain involvement, resulting in the absence of localization of the memory in time. "Flashbacks are always in the present and total system experiences" (Cozolino, 2002, p. 272-273), reflecting the position taken in the Cambridge Declaration (2012): "The neural substrates of emotions ...are therefore 'out of time.'"

All of this discussion confirms Reich's earlier insight:

There is no antithesis between the historical and the contemporaneous. The whole experiential world of the past was alive in the presenting form of the character attitudes. (1967, p. 121)

And,

The schizophrenic does not "regress to childhood". Regression is merely a psychological term describing the actual, present day effectiveness of certain historical events. The schizophrenic does not "go back to the mother's womb"; what he actually does is to become a victim of exactly the same split in coordination of his organism which he

suffered when he was in the deadened mother’s womb; and he has maintained that split his entire life. *We are dealing here with actual, present day functions of the organism and not with historical events.* (1976, p. 492)

Diagram II shows how on the more superficial, psychosomatic/cognitive level, the patient has organized himself in response to a trauma. Below that is where the trauma is, and how the person is defending against it on the vegetative level. The deepest level is the undamaged endo self, which houses the ability of the patient to transform events and objects, and rewrite history.

The psychosomatic level contains emotions and the central nervous system-based cognitive and neuromuscular system. This level is the location of the body/mind defenses that protect the patient from the underlying trauma. Defenses in the forms of thoughts, emotions, and muscular reactions are evaluative responses by the patient to what he is still afraid of re-experiencing from past event(s). It is an avoidance reaction, preventing it from being experienced again. Defenses are “decisions” made to protect the patient from what s/he experiences as dangerous; the horror of the trauma that lies below these defenses. The patient must protect her/himself from this abomination.

Herein also lie the symptoms and narrative of how the trauma occurred, and how it continues to negatively impact the patient's life. This is what the patient presents in the therapeutic setting. According to Cozolino (2006), the vast majority of memories are unconscious (pre-cortical), but shape our emotional experiences, self-image, decisions, and relationships. The speed of the amygdala in processing information generates a physiological reaction before we are conscious of what is being processed. He calls this the “known and unremembered” (Cozolino, 2016, p. 130)

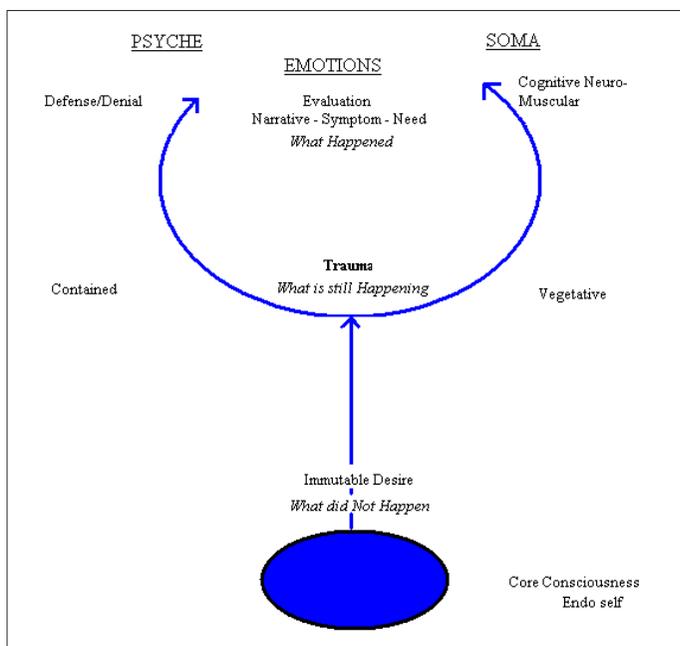


Diagram II. How on the more superficial, psychosomatic/cognitive level, the patient has organized himself in response to a trauma.

On the cognitive level, a difficult issue about memory and narrative is whether or not the traumatic event actually occurred. Kohut referred to “telescoping.” Looking through the telescope from the other end, experiences are grouped together and condensed to form a narrative; a scenario that may not have happened at all. In this case, it is not a remembered event as the patient believes, but a condensed collection of related sensations, experiences, and mixed memories formed into a coherent narrative. Oliver Sacks (2017) pointed out that it is not possible for external events to be directly recorded in the brain. Our only truth is narrative truth: the truth we tell ourselves and others.

It is very frustrating to both therapist and patient to pin down this “memory.” Yet it is imperative to respect and accept the patient’s version of what happened. Freud was flummoxed by hysteric descriptions of alleged sexual abuses until he gave up on it altogether. What helped clarify this issue for me was that while a patient was talking about her abuse story, she suddenly interrupted herself, looked at me intently, and said, “I don’t care if it happened or not. I feel abused!” And that is the point: the *experience* of a relationship or event that went badly wrong. The emphasis in therapy is not about the story, the past, or the object. The focus of therapy should be on the patient’s living experience: about what may or may not have happened. It is too easy for both patient and therapist to get lost in the drama of the narrative.

As we move down the diagram, we come below the cognitive/neuromuscular, to a pre-cortical, yet knowing state on the vegetative level. And here again we have evaluation. Below the cognitive-neuromuscular based defenses, the vegetative state is still out of balance because of the trauma. The organism reacts first to any shocking event on the vegetative level, but not all shock is traumatizing. If the shock is not released, the vegetative system stays out of balance: this is trauma. The cognitive/neuromuscular response is secondary, built upon an evaluation of the more primary response to danger on the vegetative level. The vegetative response is the active, living level. As Reich emphasized, it is not historical. It is not a story of what happened, but what is still happening. This is why it must be defended against continually. If it truly were in the past, there would be no threat to the patient. The problem for the patient is that it could happen again right now, because on this level, there is no time. It is always now. It is always haunting the patient, threatening to happen again. The psychosomatic narrative level is about what happened in the “past,” and the patient is desperate to keep it there. In reality, and understandably so, it is simply being avoided. Unfortunately, in the deeper vegetative level, it is still happening. It is, hopefully, contained by the vegetative response, but it has not been eliminated. Further down the diagram, represented in brainstem functioning, is the endo self, the level of what has not happened; the incomplete, immutable desire for satisfactory contact and relationship.

The psychosomatic level is the manifestation of the incompleteness in terms of need-based behavior: over-dependence on the object, isolation from or rejection of the object, transference, false positive transference, projection, projective identification, idealization, etc. On the vegetative level, we encounter the caged “alive” trauma experience, the contracted, imbalanced state of the vegetative response to this non-historic, living event. On the deepest level, we encounter Solms and Panksepp’s embodied, subjective core consciousness housed in the brainstem. Or Maslow’s being states. Or Reich’s core. Or my elaborated synthesis, the undamaged endo self.

One patient reported this state as “I feel an extreme presence in the absence of myself.” Another commented: “She is back!” But who is back, and where was she all this time? The answer is the immutable, undamaged endo self, the original source of desire for satisfactory contact and relationship, and the continued hope that what has not happened, will. This is where the self seeks, chooses, creates, and transforms objects and experiences. It is an individual, self-referential, interpretive process that decides and creates one's own reality based on the experience of oneself, not the other.

Often in Functional Analysis, nothing happens in the sessions and the object reorganization happens safely later. In this case, using an older mobilization technique, the partial release of a deep contraction on the vegetative level allowed the patient's whole body to be involved. She began the gentle, gathering, curling movement of the instroke with her head and shoulders rising up gracefully from the mat. But suddenly she interrupted this flowing movement with a strong contraction in the rhomboids pulling her shoulders backward, contracting her throat, and preventing any further gathering, instroke movement. I supported this defensive movement by placing my hand on her rhomboids for a few moments and applying light pressure upward in the direction of the contraction. I then told her to stretch and move on the mat. She then described the interruptive, blocking quality she felt in the rhomboid contraction. Returning to the work on the mat, the same gentle rising up movement came again but this time she did not interrupt it and gathering herself, she came into a curled-up ball where she felt satisfied.

Afterwards, I asked her what happened to the block/contraction? Where did it go? She replied:

“It joined the party! How beautiful. It tells us how our body and every part of our self are in favor of our self. I feel fluid, a unit. It creates a nostalgia in me. A beauty I want to be more and more of.”

I commented that nostalgia implies that there is something known; something you had or know of and want to have again.

“Exactly.” She replied. “To go back to who I used to be — who I am. I am a unit. The contraction in the back of the shoulders was separating me from myself. Then I realized everything was intact. At first, I felt this rigidity here (rhomboids) and when I released it, I became aware of my heart.”

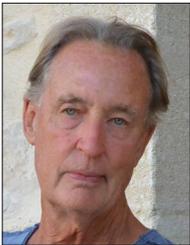
Summary

During the physical treatment phase when generally the patient and I do not converse, a patient suddenly opened her eyes and said, to no one in particular, “Abused and still alive.” Then she laughed. This was not a recounting or a reliving of the trauma and the sufferings incurred from it. It was a profound self-affirmation. “I made it.” She was not stuck in the trauma or the defenses around the trauma. She was below that, declaring herself.

I have argued that despite the fact that the unimaginable has happened, there is still a reserve, a resource that continues to seek unity, wholeness, and satisfying relationships. It lies below the defenses and below the turmoil of the trauma contained by the vegetative system; the endo self. By not getting lost in the drama of the narrative and the historic past, by working below the defenses, by contacting and supporting the ever-present, embedded,

subtle desire for contact within all relationships, we can help patients to not continue to be haunted by their "living past."

Those who know about ghosts tell us that ghosts long to be released from their ghost life and laid to rest as ancestors. As ancestors, they live forth in the present generation, while as ghosts, they are compelled to haunt the present generation with their shadow life...ghosts of the unconscious, imprisoned by defenses but haunting the patient in the dark of his defenses and symptoms. In the daylight of analysis, the ghosts of the unconscious are laid to rest as ancestors whose power is taken over and transformed into the newer intensity of the present life, of the secondary process and contemporary objects. (Leowald, in Mitchell, 2000, p. 25)



Will Davis has 45 years of experience practicing and training in America, Japan and Europe. He developed Functional Analysis which focuses on the energetic instroke, plasmatic origins of early disturbance, the energetic qualities of connective tissue and its role in character development, the endo self, the gentle self-oriented release technique of Points & Positions, and a unique synthesis of verbal therapy. He is a member of the editorial boards of two journals, the Italian Society of Psychologists and Psychiatrists, the EABP, AETOS and teaches as a guest trainer. He lives with his wife Lilly Davis in the south of France.

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