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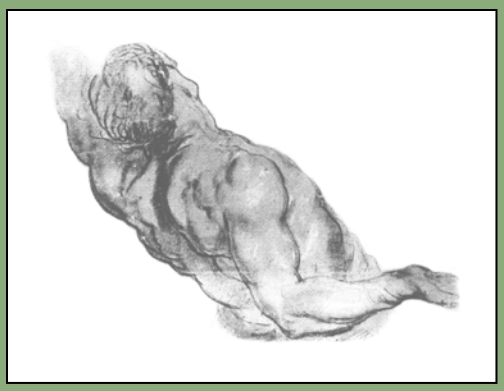

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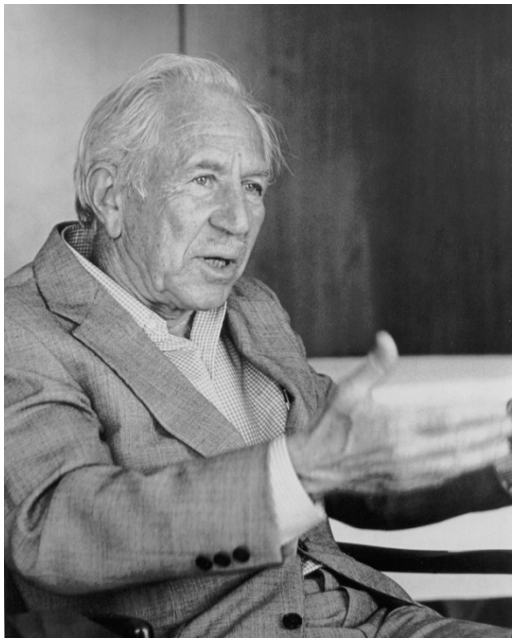
USABP Mission Statement

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



Alexander Lowen, M.D.

Dec. 23, 1910-Oct. 28, 2008

A student of Wilhelm Reich's in the 1940s and early 1950s he developed a form of body psychotherapy known as Bioenergetic Analysis with his then-colleague, John Pierrakos.

The Clinical Theory of Lowen, His Mentor Reich, and Possibly All of Us in the Field, as Seen From a Personal Perspective

Robert Lewis, M.D.

Abstract

This paper examines the proposition that we therapists are all wounded healers. The focus is on the manner in which these empathic, intersubjective wounds are interwoven with details of our chosen somato-psychic clinical theories and approaches. The theme is elaborated as regards the work of Lowen, his mentor Reich, and, potentially, all of us working in the field.

Keywords

Bioenergetic – Self – Wounded – Intersubjective – Healer

Introduction

This paper is an elaboration of an earlier work, entitled, "Bioenergetics in Search of a Secure Self". The earlier paper was focused on Lowenian bioenergetics and, to a lesser extent on Reichian vegetotherapy . I was interested in exploring the relationship between the personal insecurities of these gifted men and the therapeutic edifices which they created. In addressing the USABP readership, I hope to extend the issues I raised and explore their relevance for therapists in general, but specifically for those of us who practice some form of somato-psychic therapy. Both papers express my fascination with wounded healers and the way their self-chosen craft can be understood as a complex tapestry. Following on Maley's paper (1988), "the Wounded Healer", I understand that the wounds, no less than the gifts, of each therapist, one often emerging from the other, are interwoven as the very fiber of that tapestry. The paper you are now reading might more properly be called "Bob Lewis in search of the wound of the healer, so that he (Bob) can heal him into the parent with whom he can finally become secure". With Maley, Searles (1979) and others, I believe that we are all more or less wounded healers and that a crucial quality in our being healing to others is that we model the ability to face and live that wound. I also believe with Maley, who quotes Searles' conviction that we foster our patients' healing by allowing them in some measure to help us with our woundedness. Thus, my conscious desire is that the bravura of the clinical model I (and my professional community) work from, be liberally tempered by the reality of my (our) all too vulnerable personal brokenness (Hilton, 1988-89). Beneath this, I suspect (one's shadow tends to be elusive) is the "Scorn, Disillusionment and Adoration" (Searles, 1962) I feel towards those who weren't as strong as I had hoped they would be. And beneath this may be my heartbreak that their inability to live their woundedness prevented me from healing them into the secure souls for which my spirit has always longed.

I rely heavily in this paper on my personal experience of Lowen over the 48 years that I have known him. For years as a young man I idealized Lowen and felt soothed and secure that he had the answers to life's problems. Unfortunately for all of us, I would argue, he called the therapy he created "Bioenergetic Analysis" rather than Lowenian therapy. I will look in greater detail in this paper at the implications of the names that any and all of us give to the approach that we use.

Lowen saw many of the problems from which he and his patients suffered as given in the human condition, at least in our western, contemporary culture. Perhaps like many charismatic leaders in our field, it was not a strong suit of either Reich or Lowen to consider that the way they saw things, was only one of many possible perspectives.

Because of my personal history with him, it has been important to me over the years that I gain a more objective perspective on Lowen's life and work. In this regard, my wife and I once overheard a nugget of wisdom from a grey-haired man during a concert intermission. "I always find", he said, "that the older I get, the more I become who I really am, because I just don't have the energy to cover it up". Now while Lowen always had energy to spare, he may indeed have gotten tired of having to be the bearer of the Reichian standard, which he often told us he had inherited from his mentor. In any event, as he has aged, I have found increasing candor in his writings. Lowen's openness, particularly in his Festschrift interview in the IIBA Journal (1990) and his autobiography (2004) helped me to understand with more clarity the relationship of his own mind and body. This, in turn, enabled me both to preserve the bioenergetic treasures he gave us and to better see how easy it had been as a bioenergetic patient to surrender my psyche-soma in the hope of being cured.

This is an intensely personal paper, perhaps a latter day version of a paper (1996) entitled: Bioenergetic Analysis: My voyage to self-discovery. But the paper is also at the same time a commentary on a topic with which the IIBA (International Institute for Bioenergetic Analysis) is currently struggling as it attempts to chart a realistic course with Lowen no longer at its helm. The topic I am referring to is the proper scope and importance of the therapist-patient relationship in the theory and practice of Bioenergetic Analysis.

Additionally, I hope to relate the specific issues I identify in the Reichian/classical bioenergetic traditions, to an issue of basic relevance for therapists and patients engaged in any school of somato-psychic therapy: the relationship of our own capacities for intimacy and reflecting on the inner life of others to the forms of therapy to which we are drawn.

Mentoring

My Bioenergetic Therapists

The three charter members of the New York Bioenergetic Institute were at one time or another my therapists and mentors and second family. As I slowly became better able to tolerate reality, they taught me, in spite of their Reichian beliefs, that there was not *a truth*, a story to be read in the form and motility of a person's body. When these idealized mentors looked at and worked with the same patient at a conference, they each saw different things. I began to understand that the psychosomatic story they read was so complex (currently, I would add, and so influenced, in split-second time, out of awareness, by the unique limbic dialogue with each therapist), that each of my three mentors trusted themselves to work with that part of the story that spoke to them at the moment.

Winnicott and my abiding professional interest in early terrors for which there are no words

Then there were my "unthinkable anxieties" (Winnicott, 1962). I felt deeply spoken to by the work of Balint, Guntrip and especially Winnicott. Indeed while I was still in bioenergetic therapy I formed a transference to Winnicott; I found myself wishing that my own body-oriented therapy had been more informed by Winnicott's deep understanding of pre-symbolic issues. In particular, the essay in which he described the "mind as the locus of the False Self" (Winnicott, 1949), galvanized my sense that the head was a misunderstood part of the body in bioenergetics. Over several decades, I elaborated the somatic aspects of this alternative, Winnicottian view of the dissociated mind and body. I called it 'cephalic shock'. I consider it my most important contribution to our work, and it plays a central part in the main thrust of this paper.

The attachment paradigm and its implications for relationships

Mary Ainsworth and colleagues (1978) did the first empirical, observational studies that focused on the normative (healthy) developmental psychology of attachment. A multitude of confirming studies have brought an exciting new empirical and predictive power to our field. Not surprisingly their model stresses the importance of sensitive and responsive parenting as the heart of what results in a secure, vital child.

But there is a problem here. In the attachment model the relatively secure mother possesses an essential quality that enables her to be sensitive and responsive to her child. This is the capacity to see, consider and relate to her child as an autonomous being with rhythms, feelings, intentions and perspectives of its own. Her secure infant senses his (for simplicity's sake I will use the masculine pronoun) efficacy in the many exchanges every day, from the earliest moments, as he both regulates and is regulated by the mutual interaction with his mother. Further, he experiences her recognizing his movement as a gesture, his babbling as the beginning of speech. Thus, to their surprise, Ainsworth and her colleagues (1978) discovered that the factor that distinguished the mothers whose infants were rated as secure at one year from those rated as insecure was **not** the quantity of physical contact that their children received, but the quality of contact. Quality referred to attunement, the ability to tune into the child's unique rhythms that was, for instance, reflected in the space given or not given for the child himself to initiate the contact.

The bioenergetic problem that we are left with here, I would suggest, is that the Reichian/Lowenian developmental model tends to be so exclusively quantitative that it simply does not map onto the qualitative factors supported by controlled, longitudinal research. The classical bioenergetic model is about the amount of time (three years) that the baby should be nursed and given body contact. I will return to this theme, but for now, let me say that it would be reassuring to believe that Lowenian bioenergetic theory takes for granted the above crucial parental capacity to tune in and consider the child's unique rhythms, intentions and desires. But this is not the case. The Lowenian bioenergetic infant's self consists of a desire/need to be nursed and held for three years. The parental qualities that predict a child who will be nursed and held in such a way that it becomes a secure individual are simply not in focus and therefore not dealt with in Lowenian bioenergetic theory and practice. These same qualities were sorely lacking in the parents of both Reich and Lowen. Thus Lowen is not able to describe what he never experienced. What he can tell us about is the attributes his parents did have. For instance, his mother's obsessive and shaming preoccupation with his bodily functions, his father's easy-going, un-ambitious nature.

Attachment research (Fonagy et al., 2002) has now followed insecure infants whose insecure parents did a poor job of reading their intentions and desires into early adulthood and found that they are lacking in this same ability to reflect on the inner life of others. Attachment-oriented clinicians such as Holmes (1993) and Lyons-Ruth et al. (2004) tell us that the way a secure parent is with his child is a good model for an effective therapist. A basic tenet of the bioenergetic model is that one can read a person's secrets, conflicts and traumas in the form and motility of his body. While most of us value this insight deeply, I would suggest that this tenet also curiously reproduces the way an insecure parent inadequately appreciates and therefore diminishes the autonomy and ultimately unknowable inner life of its insecure child. It was classical bioenergetic protocol, for example, to routinely have all of one's patients strip down to a leotard or bathing suit. I remember taking considerable heat from the chain of command, when word got around that I was applying the protocol selectively. It had begun to make sense to me that in additional

to the importance of "reading their bodies", I had to also consider their inner experiences. I sensed and they confirmed, that if they did not feel safe enough, they would merely present me with bodies from which they had dissociated.

Underlying Assumptions of the Central Thesis

Therapists choose the modality that suits their own proclivities...specifically, their own capacity for intimacy/autonomy, their own attachment style as well as their own mix of issues in their own domains (Stern, '85) of self: core (bodily), inter-subjective, verbal.

There is always a relational significance to any therapy process; it may be explicitly and fully acknowledged or not. In the latter case, regardless of the explicitly stated vehicle of healing, the relational process will operate, out of awareness, on an implicit, nonverbal level.

Central Thesis Proposed

In bioenergetic analysis (better described as Reichian/Lowenian therapy), the above relational significance has been distorted in a manner that weakens the otherwise deep healing power of a relational somato-psychic approach.

This distortion, which Lowen inherited from Reich, is at the heart of a poignant attempt to find a personal solution to Lowen's deep woundedness. Further, this distortion is richly documented in recent autobiographical material from Lowen himself; and must be understood and faced if we are to integrate our powerful psychosomatic legacy with a more mutual and realistic model of the clinical encounter.

While the above propositions can probably be illustrated from a number of relationally-oriented perspectives such a self-psychology, object-relations theory, etc., I have found the attachment paradigm (with its empirically derived model of normative development) particularly helpful in illuminating how relationship issues are woven into the fabric of bioenergetic analysis.

It is clear that Lowen has left us a rich legacy in the clarity and depth of his understanding of the body and its dynamic interaction with our thoughts, feelings and emotions. He and Reich are indeed the giants on whose shoulders we who follow stand. Lowen's passion and penetrating insights about the life of the body are clearly unmatched. But we are also left with the practical question as to how therapy actually works. I am suggesting that to properly evaluate any school of therapy, the interactive field is so complex, that, for a start, we are well advised to understand the relationship between who the founder is as a person and the "method", the therapeutic edifice he is presenting as "the way". Finally, I am aware that many of my colleagues no longer practice "classical" or Lowenian bioenergetics. They are no longer poor copies (as I was for the first five or more years of my practice) of Dr. Lowen himself. Nonetheless, it behooves us to look carefully at where we come from, and, to date, I am not aware that the message in this paper has found its way easily into print.

Over my many years in the bioenergetic community I have contributed articles that attempted to integrate a developmental, relational perspective into our psychosomatic approach. But it was only recently, thirty-six years after my first article, that I was able to get to the heart of my lingering dissatisfaction with the official Lowenian model of bioenergetic analysis. I was helped to do this by looking at some recently available biographical material about Dr. Lowen from an attachment perspective.

What became clear to me was that both Alexander Lowen, and his
teacher, Wilhelm Reich, came from families of origin in which they had two strikes against them. Both were insecurely attached and sexually overstimulated children. If you want to check this, I refer you to Sharaf's biography of Reich (1983), Lowen's recent autobiography 2004), and an interview of Lowen on his 80th birthday (1990). Here are several illustrative quotes from the interview (Lowen, 1990) about Reich, and, as I read it, many therapists, himself included

> ...naturalness is a funny word for Reich, because while he says "natural", I don't know if he ever knew what naturalness is. How can he, given that background? Being that tormented, that obsessed with sex, how can he know what naturalness is? All he knows is that he has a tremendous sexual drive (p. 4).

Earlier in the interview, Lowen is asked what he makes of the fact that Reich had such early sexual relations with his nurses:

> I think that saved his life and his sanity. You can see that this boy (and man) was sexually tormented all his life. And that is not normal. That is compulsive. He is obsessed with sex. But that doesn't mean that he is screwy! We are all obsessed with sex in this culture. I know I am. Once in a while you meet somebody who isn't obsessed with sex, and you realize what a difference there is between the way you feel and the way a really healthy person feels about sex … and the reason he (Reich) was obsessed with sex is because it came upon him at an age when he couldn't deal with it. How can you deal with it when you are over-excited as a child with a mother who is beautiful, seductive, voluptuous and soft?

I believe that these two gifted men, each in their own way, created a school of therapy which reflected their doomed attempt to compensate for the inner emptiness that in turn resulted from their lack of ever having had a fundamentally secure relationship with their fundamentally insecure parents. Their solution was to substitute their bodies, their sexuality and energy for the missing external secure base. This is not to minimize the deep and abiding gift they gave to our field and society with their pioneering focus on the body and its vitality. It is rather to illuminate the subtle lack of focus in classical bioenergetic analysis on the qualities that enable a person to parent a child whose sexuality is a natural part of a secure self. Indeed, the wounded healers of any persuasion, body-oriented or not, are an unlikely source for the requisite parental qualities of basic security in oneself and a natural sensitivity to the people in one's life. This is the debt we owe to the prospective, normative research of Ainsworth and others in the attachment tradition. In this regard, Tucillo (2006) has recently proposed a much-needed somato-psychic, relational model for the healthy development of human sexuality.

So, to reiterate, a central issue which I attempt to illustrate in this essay, is an understanding of bioenergetic analysis as Lowen's life-long attempt to find in the body a better substitute than the dissociated mind for the missing, attuned, maternal (parental) care. We are describing here an attempt to restore psycho-somatic unity by escaping the dissociated mind (mind as the locus of the false self) and getting back to the body. This attachment to the body is then a more wholesome, but still inadequate replacement for the original failed secure base with one's parents.

Consequences

Grounding and Cephalic shock

In the biographical and autobiographical material cited above, in exploring the mind/body split, Lowen frequently mentions the threat of insanity, which is often warded off by masturbation, athletics, sexuality and working with the body. He is, I believe, describing what I call "cephalic shock" (Lewis, 1976, 1984, 1986, 1998), or, as Winnicott (1962) described it "unthinkable anxiety...falling forever, having no relationship to the body" (p. 58). I believe that this underlying fear of insanity in both Reich and Lowen is responsible for the paradoxical failure of bioenergetic analysis to include the head (which is experienced as housing the dissociated mind) along with the rest of the body as part of a truly *psycho*-somatic unity. It was back in 1976 that I first put in print my divergent understanding of the relation of the head to the rest of the body (Lewis, 1976). Over the years, I developed my clinical construct, cephalic shock (1984, 1986, 1998), more fully. Lowen (2004), as he tells his story, sensed, following his therapy with Reich, that his basic insecurity was still with him. He also realized that Reich himself had not dealt with his own deep humiliation and resultant messianic grandiosity. So, going his own way, Lowen pursued a more secure connection and contact with the earth through his pelvis, legs and feet. This, then, became the unique focus on grounding of Bioenergetic Analysis. In his autobiography Lowen makes it clear that he has struggled mightily to personally achieve this secure connection to the earth right into the ninth decade of his life.

I, on the other hand, following my first Bioenergetic therapy with William Walling, realized that I did not experience my shocked head as part of my body and could not trust it to another human being. So, although Lowen and I both sought a more grounded body, mine included the head. He tried to let down into a connection of his legs and feet into the ground; I tried to deal directly with the shock in my head that had been causing me to unnaturally fight the force of gravity since I was an infant. Neither of us had had much peace of mind. Until his autobiography, Lowen has not written directly about being in a state of shock. Without using the word, however, he has previously shared the story of the spontaneous screams that came out of him during his initial therapy session with Reich. As he describes it in the recent book (2004)

> … but I felt something in my personality that was not healthy. The screams had surprised me, because I did not feel any fear. My conscious mind, which was split off from the action, was an observer, unconnected to what was happening (p. 39).

I would argue that this is a very clear description of a state of shock in which a trauma has split a dissociated mind from its anchorage in a feeling body. Lowen tells us on the same page that it was his mother's eyes which caused him to freeze and that "I knew that I had to do a lot more work in therapy to free myself from that fear" (pp. 39-40). I believe that the older he got, the more Al Lowen realized that the grounding, as he originally understood it, did not do the job unless it also included his shocked-since-infancy-head. I would ask the reader to view the touching photo of Lowen as an infant in the autobiography (2004), about which he says, "even as a baby my head is straining from my body" (p. 95).

In 1995, when Lowen was 84, he tells us that

> I had come to some awareness that the neurotic character structure was a frozen state, as if the person had been shocked at some earlier point in his life (p. 142) … I had been in a state of shock that prevented me from seeing the deeper dynamics of my problems. The issue was still grounding, but I needed a technique that would help me break through the shock state (p. 143).

The older he gets, the more Lowen puts in writing the basic insecurity and shock in his structure and his lifelong, poignant struggle to free himself from the ***driven sanity of a man who cannot risk losing his head***. Each innovation is presented as finally creating the energetic connection he is seeking. He has the patient raise his head while kicking the bed; he has the patient do somersaults; he hits the patient on the head. Al explains, "At age 87, I began to feel the tensions in my neck muscles, and I realized that it was associated with my fear of losing my head or breaking my neck. This fear of losing the head or breaking the neck is common to all of my patients" (pp. 164-165). At 93 years of age, Lowen is still on the quest with a new exercise, which he calls "connecting the feet to the earth", the goal of which is to "have the vibrations begin with the feet and move up the body" (p. 240). In summary, Lowen's odyssey is about never having come to terms sufficiently with the shock in his head (cephalic shock) to find the peace of mind that eluded him. I do not know if I have done any better with my own shock, but I believe I had no choice but to look it more directly in the face/head.

A Therapy Model Amiss

Part 1: Cautionary Tale

This is a cautionary tale about what may well be going on psychosomatically in any therapy approach that deals explicitly with the body, but does not view the central task of therapy as engaging and reworking the patient's embodied attachment relationships. The tale is also a commentary on how ***the attachment style of each therapist and of his preferred therapeutic method impose a specific attachment dynamic on the patient.*** Sadly, during most of the close to 10 years of my three bioenergetic therapies, my compliant, avoidant self was quite comfortable surrendering my body to the therapy with the understanding that once my underlying stasis and biopathy was corrected, I would somehow be returned a healthy psychosomatic self. In hindsight, I was only too happy to go along with this understanding of what bioenergetic therapy involved: I would not have to deal with relational intimacy, of which I was terrified. (The reader is referred to an earlier paper (2007) in which I detail the ***shifting attachment relationship which my avoidant style makes with my 3 therapists' own attachment style and, additionally, at the relational significance of the therapeutic method in question.)***

In my second therapy, this time with Alexander Lowen, I continued watching the interaction from a secret, broken place within myself, but I was a little less avoidant. Less terrified of my grief and brokenness, I was less content with a bioenergetic method that never asked me about my internal experience. The use of my body and its energy as a self-object to stand-in for an attuned, responsive relationship with another human being, was not working as well for me as Lowen tells us it had for him.. As I lay back over the Bioenergetic stool, I barely heard a whisper from my secret self, wishing that I could just lie there in my oral collapse and not do anything … just luxuriate in my apnea … slow down and face the part of me that was mostly dead in my chest, and maybe even come to life a bit as a result. But I am not sure that I really made sense of the whisper until some time after the therapy ended, and so I "breathed" on top of this half dead, low energy, despicable part of me, convinced that Al had no patience for such lack of energy.

In the grounding position, the dynamic shifted slightly, but as I had done for most of my career as a patient, from the unattached place where I lived, I never stopped watching the interaction between my therapist and my body. From the waist down, my body had a higher charge and energy than my upper body with which I was more identified. So, for some minutes, as I stayed in the grounding position, Al Lowen sat, seemingly fascinated, perhaps, I thought, even enraptured with the energy and vibrations that emanated from my legs and pelvis. The mostly dead child in my chest, who has never been enough, felt deeply envious of my strong lower body which did not have to do anything more than to release its tension and energy to hold the attention of my therapist.

Part 2: Muddling through – In Praise of Common Sense

Today, in 2007, most therapists are aware of the centrality of attachment and inter-subjectivity in the therapeutic process. I will argue, nonetheless, that an empathic flaw inherent to therapists as a group puts them at risk for more or less subtle versions of the same cautionary tale I have just told about my work with Lowen. As already stated, the Lowenian bioenergetic vision suffers from a subtle, at times not so subtle, lack of understanding of the personal qualities in a parent that recent research has shown to predict a secure child. The subtlety is to be found in the way Reichian principles are imposed as explanations that oversimplify life issues. The principles, as an attempt to substitute for the missing security that comes only from a secure relational base, cannot be questioned. They focus on the issue of childrearing and, inevitably, have implications for the therapy process.

On the other hand, off the written record, Lowen spoke with common sense. He knew that one cannot actually raise a child according to a consciously held belief system. He and Leslie, his wife, only tried it once. Although he has remained committed to the Reichian principles in his written work, the life lessons of raising his son Fred were not lost on him. He told me personally on several occasions during his son's teenage years, that the only way to really raise a child was to "muddle through it". This advice helped me with our two adopted children. I must confess that after surviving the Watsonian behavioral principles that my own mother employed, and sensing the unreality of some of our own bioenergetic principles, I was actually somewhat

relieved that my wife, Barbara and I, and our two adopted children would have to do the best we could without the prescribed three-year nursing experience. We would have to settle for less than perfection.

This having been said, I share the following vignette, as an extreme example of what I believe to be an issue that falls on a spectrum for those of us who are wounded healers. The vignette centers on a brief, but spirited confrontation I had with Lowen, many years ago, when my wife and infant son accompanied me on a professional trip with Lowen and his wife. We enjoyed our social time together, except on the occasion of my inadvertently challenging Reich and Lowen's view of normal development by suggesting that my infant son, in the midst of teething, had been suffering quite a bit for the last week or so. I apparently really rubbed salt in the wound, by noting that this seemed to be an early normative experience in which the child's own body was the source of significant pain. Lowen's eyes flashed in anger, as he asked, "How do you know what he is feeling"? A propos the importance of subjective experience, let me pause briefly to tell you how shortly after this conference I was to find myself in considerable hot water with Lowen and two of his lieutenants (my colleagues) as word got around that I was not routinely having all of my patients strip down to a leotard or bathing suit. Some of them, I felt, had to feel safe enough to be so exposed or they would merely present me with a body from which they had dissociated. In other words, I was putting the importance of their internal experiences ahead of my "reading" their bodies.

Looking back, I find it ironic that Lowen's devotion to some kind of Reichian belief (i.e., nurse the child for three years and all will be well) had led him to tell me to doubt my common sense (my eyes, ears, and limbic system) regarding my son's being in pain. In this instance, reading the truth of his experience in his body had become taboo. Had I not been so in awe of Lowen at the time, I would have told him that my wife and I had been up with our son for the past few nights, that we explicitly hear his pained cries, see his facial grimaces, inflamed gums and twisting body and that we implicitly trust our attuned bodies more than we trust bioenergetic beliefs. Happily, Lowen's view on teething never made it into his books. Unhappily, however, I find that the vignette captures only one of many idealized, unreal, Reichian/Lowenian beliefs that lack an empathic sense of others' complex internal experience

Part 3: Empathic Spectrum Disorder?

To what extent are my stories about life and therapy with Alexander Lowen only of historical interest, rather than of relevance to all wounded healers in 2008? How much have Reichian/Lowenian insights and all the elaborations and discoveries that they inspired, made it less necessary that we therapists live the question? The question to which I refer concerns the ultimate unknowableness of the other. In struggling with these questions, I will ask whether wounded healers bring an unbalanced ability to know others to their work, or whether they employ theory and interventions in the hope of compensating for said imbalance. I will conclude that in 2008 it is still wise to ask our patients what is happening for them subjectively.

Do therapists, psycho, somato, somato-psychic, or of any persuasion at all, as a subgroup of the general population, suffer from an inherent defect in empathy? At first, this sounds unlikely, since empathy is known to be crucial to the therapeutic process. Actually, like any other trait, other things being equal, empathy should be expressed in a bell curve in the population at large**. I am suggesting a kind of empathic spectrum disorder for the subgroup of therapists, or, as they are also known, wounded healers.** Lowen (1990), speaking of Reich, and all therapists, cautions us on this issue as follows

> On the one hand there was a sensitivity to people, which is very evident in his work with them. But there was no sensitivity to people who were not working with him --- not a general sensitivity to people--- because he was too preoccupied with himself... *if you need him (my italics),* he is very sensitive, very caring, very in touch with you...But as a person in his social life, he doesn't contact you; he doesn't see you as a person. You have to watch out for that in all therapists! ...The thing about Reich is that he can sense the health of a person, but he can't measure up to it himself. I guess that is true of all of us. (p. 5)

I believe the key to the split that Lowen describes above, is given by the phrase "if you need him". I translate this to mean that Reich is resonantly sensitive to you if, as is largely true of the people who seek out therapy, your attachment history has left you a relatively insecure individual. I understand that Reich, Lowen and more or less all of us wounded healers have a special fascination with and limbic resonance to the variety of insecure attachments (and the corresponding neurobiologically imprinted, unbalanced form and motility of the body and its emotional expression) that our patients bring to us. I am not aware of empirical research on the earlier attachment status (as documented on the Adult Attachment Interview (Main and Goldman, 1995) of twelve-month old infants who later become therapists. As noted earlier, Attachment researchers (Fonagy et al., 2002) however, have now followed insecure infants whose insecure parents did a poor job of reading their intentions and desires into early adulthood and found that they are lacking in this same ability to reflect on and attune to the inner life of others. In the absence of hard prospective research, I will stand by never having met a therapist (wounded healer) whose formative mid-range, balanced attachment experience engraved into his limbic relational circuitry an intuitive resonance with people who were relatively securely attached. Simply put, we do not come to our work with an intuitive sense of what is healthy from our family of origins. This, I believe, is what Alice Miller (1997) meant when she claimed that we become therapists largely as a way to repair our attachment losses, by somehow giving to others what we never had.

Before I explore Miller's claim a bit further, let me note that therapists are an infinitely varied group of real people, whose complexity is not done justice by generalization. Furthermore, of course we often become more secure people, with the help of

our own therapies and fortunate choices in partners. But, still being in recovery from our limbic wounds, I would suggest that our brand of empathy tunes particularly well to the extreme relational behaviors found by Beebe and Lachmann (2002) in their studies of insecurely rated mother-infant pairs. These dyads were characterized by a combination of interactive vigilance and self-preoccupied introspection.

Lowen tells us that therapists lack the essential capacity to attune to and be with a healthy individual. Lewis, Amini and Lannon (2001) tell us why this may be the case

> People differ in their proficiency at tracing the outlines of another self, and thus their ability to love also varies. A child's early experience teaches this skill in direct proportion to his parents' ability to know him. A steady limbic connection with a resonant parent lays down emotional expertise. A child can then look inside someone else, map an emotional vista, and respond to what he senses (p. 207).

To summarize, If we have been securely attached infants and children, we will have internalized (for that matter, neurobiologically imprinted) a mid-range, balanced interactive experience. Numerous longitudinal studies now suggest that as adults, we will be naturally caring and empathic people, and that, generally speaking, we will not tend to the extremes of interactive vigilance on the one hand and withdrawn, preoccupied self-regulation on the other... extremes which are seen in insecurely attached children. Rather, we will be like the relatively secure parents who tend to raise children who test (in double-blind rating) as secure. These people, whom van Ijzendoorn & Bakermans-Kranenburg (1996) and other attachment researchers consistently find make up about 60% of not-at-risk populations, are sensitive and responsive to their children, give them firm boundaries, and accept their protest without retaliation. If the reader is a therapist, the above description may strike him as a touch unreal, because such people do not spend much, if any, time in therapy and therapists, who work a lot and spend a lot of time with colleagues, may not meet such people very often. I say this because of a personal conviction that most therapists (wounded healers) were not securely attached children, even though their own therapies may have helped them rewire their limbic imbalances in a more secure direction. In any event, understanding all this will not so easily change the problem that Lowen describes. The fortunate, relatively secure souls just described, do not tend to choose the profession of healers. As stated, they are not fascinated by and specifically attuned to the varieties of outcome of insecure attachment. If you question this, how many therapist readers recognize yourselves in this description (Lewis et al., 2001) of 3, 4 and 5 year-olds?

> Happy, socially competent, resilient, persistent, likeable, and empathic with others. Had more friends, was relaxed about intimacy, solved problems on his own when he could, and sought help when he needed it (p. 74)

This is typically the way teachers describe children who showed secure attachment behaviors at 15 months.

Part 4: A Look at Us All

A Non-Linear Spectrum

But how, as Miller suggests, do therapists give patients what they themselves have never been given? How, as Lowen states, can a therapist be sensitive to his patients and out of touch with people outside of his office? First, I believe we have partially answered this by clarifying that the mutually insecure beginnings of both therapists and patients enable the former to attune to the relational wounds of the latter. But beyond this, as therapists we each bring to our craft a unique blend of gifts and wounds, one often spiraling out of the other. The spectrum of security/insecurity among therapists is at least as nonlinear as it is anything else. Some of us are better than others at tracking, matching, stimulating or dampening our patient's affect and arousal. Some of us have preferred modalities: vocal, linguistic, visual, motoric that render us more or less effective with a given patient. A body-oriented psychotherapist once told me," I don't know how to relate to people- I can approximate contact- there is a void- I don't know if I can feel you if we are not touching physically".

Some of these qualities can also be helpfully understood as imbalances in our domains of self (Stern, 1985). I am thinking of a colleague and his wife, also a therapist, who visited with me and my wife years ago. As their infant son sat in his carrier, at first distressed and then screaming loudly, the couple looked at each other and then at us, in puzzlement. "I wonder what he wants?", they finally asked. Neither my wife nor I "knew" what the infant wanted, but our body-limbic-inter-subjective circuitry was screaming to us (and finally to them), "for God's sake, pick him up!" I would now describe the couple as having highly developed, verbally organized reflective functions (theory of mind) that were quite dissociated from or otherwise lacking a base in an intuitive, procedural sense of how to be with their baby. To support my contention that these kinds of imbalances in core bodily, inter-subjective and verbal senses of self are almost the rule in therapists, I would like to put myself in the data base. The first few times our young children collided while playing and sat crying on the floor, my wife's implicit relational knowing (Lyons-Ruth, 1998) interrupted my compulsive attempt to investigate the accident, as she picked up and comforted one child and told me to pick up the other.

Legacy

I said earlier that classical bioenergetics, even as it purports to penetrate beneath our words to the core level of our organism, is at risk for paradoxically repeating the original traumatic failure to attune to and reflect on the inner life of that same organism. In fairness to Reich and those who have been informed by his vision, even a genius may not be able to embrace everything that developed from the nematode (worm) to the human being, without losing crucial detail. For instance, the pulsatile wave that flows through a worm's body, may be much more important than the worm's inner experience of that wave. So, while there is brilliance and clinical power in the model of homo sapiens as the trillion-celled amoeba/worm, we must not let it dim our awareness of the rich inner limbic life of our own mammalian species.

Following Reich, Lowen taught us not just to listen to the patient's symbolic language; it was only a fraction of his total organismic reality. Rather, we were to look and see who and how he was in the room with us... that his nonverbal presence was a living signature made up of gesture, flow, vocal tone, timbre, etc. But the emphasis was on the practitioner seeing more deeply because he consciously "read" the body's nonverbal messages. Then, via interventions that involved the patient's body, the therapist healed the patient's biopathies. This model did not include two limbic systems in diagnostic and therapeutic dialogue. Indeed, classical bioenergetics abstracts the instantaneous, mutual ongoing capacity we are born with to understand another fellow human being into the ability to "read" his storyline from the form and motility of his body. This vision, I believe, has been elaborated with endless creativity in a number of the great variety of somato-psychic approaches that currently exist.

Reich's emphasis was more on how he perceived the patient, than on how he experienced him. One does not hear about Reich's inner, personal emotional experience as informing his clinical work. In this regard, I find that Lowen was a true disciple of Reich. Those of us who were in therapy with him, can attest to his keen attention to the rapid, nonverbal postural, facial behavior and expression of which we would otherwise not have been aware. But one rarely finds in his written work descriptions of his own psychic, somatic, emotional experience of the patient as it informs his understanding of him. Indeed, although I have not seen it in print, I will paraphrase what I remember him saying on a number of occasions: if I get too caught up in what the patient is feeling, it interferes with the clarity with which I can see their problem in their body.

Reflections on and from a Diffuse Sun

But how, with our most current models, do we attempt to provide the empathic presence that has been deficient in our patient's lives? As it turns out, we are each so unique, that no two therapists really do it the same way. I like the way Kramer (1989) puts it: "I became that part of me which was closest to him" (p. 138). The sentence captures two central qualities for me. First, to "become" something has a passive quality, as in being acted upon by a force greater than one's own volition. Second, Kramer is clear that there is an irreducible abyss, that he can only come so close to his patient. This fits with my experience that the interactive dance is deeper and quicker and truer than anything you can explicitly decide to do. Rather, you can try to become more aware of it moment by moment, the way you can become aware of your own respiratory wave as it moves you, or note how you spontaneously are moving (within yourself or outwardly in the room) closer to or farther from the patient.

I like Kramer's version of the dance, because it close to what happens to me perhaps several times a month in my work with patients. Initially, I am dismayed by how disturbed and in pain the patient is with attributes and issues with which I cannot identify. They are beyond the confines of the images of Bob Lewis that I ordinarily entertain. Then, as moments or minutes go by, I slowly get in touch with aspects of myself that indeed are resonant with those of my patient. These moments always come as a bit of a surprise.

Then there is body mirroring, a more purposeful approach to acquiring bodily empathy, described by Resneck-Sannes (2007) as a classical Bioenergetic intervention. She elaborates

> In order to empathically know the body of another, we arrange our body in the same holding pattern as our clients, to enable us to sense our clients' experience of their bodies by sensing ours. By aligning our bodies to that of our clients, we are activating a neuronal mirror of their neural activation patterns... And, after all, we are in an intersubjective matrix, so while we are realigning our bodies to our clients' they are also, most likely, aligning their bodies with ours (p. 52).

I am sure, like almost anything in our field, this works well for many therapists, but I am not drawn to it, and Resneck-Sannes' closing sentence speaks to my concern. Whether or not they are being prompted by their mirror neurons, the patients she describes are **not explicitly** aligning their bodies with those of their therapists. Indeed, they are becoming, out of awareness, that part of themselves which is closest to their therapists. Not, I would suggest, via a clumsy, conscious, explicit effort to mirror, but via the split-second intuitive dance that is moving both parties, out of awareness, to mirror each others' breathing, vocal rhythms, posture and gesture. The challenge is how to get better explicit glimpses of the mostly unseen implicit process. I am tempted to use data from neuroscience to justify my preference for keeping my neocortex from interfering with my intuition. Rather than doing a crude job of "arranging my body in the same holding pattern " as my patient, I would rather sense how my body is arranging itself as my mirror motor, sensory and emotional neurons do what they do best to help me feel how the patient is in his body. I am interested in being as aware as I can of the self-touching or other self-regulating the patient and I engage in as we regulate the painful or pleasureful affect and low or high arousal that is moving between us. How are our mutual gaze and breathing patterns are modulating and being modulated by our interaction? Lewis et al. (2001), speaking of our intuitive processes, say, "they reveal our lives lit by the diffuse glow of a second sun we never see" (p. 111). I never do well when I look

directly into the sun. Especially when it is a diffuse sun, I see more when I settle for a reflection from a place that no one can touch or see.

How smart are our mirror neurons?

Having extolled these recently discovered groups of neurons, let us consider how helpful they actually are to us in our clinical encounters. The study of these type of specialized neurons, is in its infancy, and has raised as many questions as it has answered. As you may know, this set of neurons in the pre-motor cortex, becomes identically active both when a primate or human carries out a goal-directed or intentional behavior **and when they merely observe** another performing the same behavior. On the one hand, it is exciting to see confirmed how specifically our brain has been equipped to read the intention of another person by watching his behavior... all without any conscious effort. On the other hand, while much recent neuroimaging data is confirming of our somato-psychic approaches, I believe that, in our enthusiasm, we tend to exaggerate their clinical relevance. Pally (2005) states the positive case

> Together, these systems enable us to know what others feel and intend from watching them act. When the pre-motor mirror system matches and represents the behavior of others, it sets up inside a person the behaviors and feelings of others . For this reason, when one person watches another's behavior, the person can know the other's intention, because he knows what he would intend if he were performing the same behavior. [When watching another's facial expression of emotion or other emotional behaviors, one can know what the other feels, because one's own limbic system knows what one's feeling would be when making that same emotional expression with its concomitant facial muscle feedback] (p. 205).

I would add two sobering considerations here. First, mirror neurons are necessary for our attunement, but they may not be sufficient. Some variety of them may help us to see into the mirrors (eyes) of our patient's soul, but we still have to be able to tolerate what we see in their mirror. We will not be relieved of the struggle to stay present with the patient when what they bring into the room is too intense, not intense enough and/or brings up material in us that is too uncomfortable. Second, we are a tough read. Ekman and Friesen (1980) studied facial emotional expression for decades, and concluded that it is the rare person whose natural intuitive talent enables them to read what is on the heart and mind in the fleeting nuances of facial expression. Then, as Reich taught us, there is the patient's character armor. Whatever of the impulses and desires of our patient that were intolerable in his environment, have been unconsciously defended against and disguised. Any specific gesture, or posture of part of the body, for example, may be a complex compromise between core impulses, traumatic experience, and chronic defenses. Then there is projective identification adding a layer of complexity to what the mirror neuron has to decipher. Then there is irony. It was the two ironic smiles of Yalom's (1989) patient that brought home the limits of intuition. Each time, the smile expressed such a nuanced, complex reality within her that no one could possibly grasp its meaning without knowing many interlocking details of her current and past life. So, it remains to be seen if these poor neurons can decipher the array of inner experiences that can lead a person to smile or fathom the multiple, contradictory levels of meaning embedded in character structure.

What's in a name?

Consider that Lowen, being the founder and creator of Bioenergetic Analysis, was the only true practitioner of it. It was his truth… But he did not give it his name. For most of his life he was not comfortable with simply calling it his truth. How true might this be of many of us in the field of therapy? Pursuing this question, let me cite May (2005) who compares the kind of stories that psychotherapists create to Kurosawa's movie Rashomon. May tells us that Kurosawa's message, " as noted in his epigraph... was about the inability to tell the truth because of the need to assign to ourselves positions of inflated importance" (p. 23).

May stresses the importance for the credibility of body psychotherapy as a field, of "systematic objective studies, such as experiments" (p. 23). Such experiments, he hopes, will balance what is otherwise the personal perspective of the person who builds clinical theory from his self-experience and his work with clients. I, with May, consider theory to be one of the kinds of stories that are told by therapists. As Kramer (1997) puts it, "psychotherapeutic theory is often veiled autobiography..." (p. 94). May (2005) asks the provocative question,

> Would not the parallel be that when body psychotherapists create stories about the therapeutic process, they are inevitably subject to distortions deriving from a need to elevate the importance and nobility of themselves and of their theories?

My answer is that until the day comes when we are better able to subject the mysterious encounter called somato-psychic therapy to empirical study, it would be wise, so to speak, to put the ingredients on the label and let the consumer make a more informed decision. What I mean by the "ingredients", the personal trauma, struggle and so on of the creator, which have resulted in his therapeutic edifice. In Lowen's books, for instance, the truth might have been better served, if in the thousands of instances

where he wrote "the body", if he had written instead, 'my body". I believe this is doubly important if the theory builder has not put his personal name on the product.

Barshop (2005) has compiled a fairly comprehensive, though not yet fully agreed upon, list of body psychotherapies. Of the forty-two modalities she describes, only five have the name of the founder in the description of the modality. Why is this such a relatively infrequent practice? There are probably as many reasons as there are modalities. Hilton (2007) helps us here by suggesting that therapists,

> …present to the world an "image" which is expressed in the form of a role which the person plays, a "character" if you will, in the drama of life. The person playing this "character" attempts to offer what he never received and thus hopes to repair his own narcissistic wound by being the idealized parent to others (p. 301)

If this is true, it strikes me that the larger the piece of truth that our modality claims to hold out for those in need, the more likely the latter are to idealize us. Our mainstream "scientific" colleagues may contribute here by denigrating the value of personal vignettes and anecdotes. In this view, validity resides in the size of one's sample, not in one person's truth. Thus, we shy away from simply saying, for instance, "I do Robert Lewis therapy; I call it by this name because the process worked for me in my attempts at self-healing, or as a patient in therapy, or as a therapist." If we do this, it immediately calls for or opens one to a request for self- disclosure as to what kind of issues one has, that made Robert Lewis therapy work for one as a patient and/or therapist.

But, you wisely rejoin, Ibsen and many others have taught us that we need our illusions. Heroes inspire us and a little illusion goes a long way in tipping the balance from despair to hope. We need to be able to idealize our therapists and become disillusioned with them in better ways than occurred with our primary attachment figures. Kohut (1971) taught that this process will spontaneously be renegotiated in the transference if we do not interfere with it. Although we do not have the empirical data, it is not at all clear that in the earlier phases of treatment a patient's hope and idealizations would be well served by his therapist detailing how his clinical theory and methods have helped him (the therapist) recover from his wounds. Rather, what I am pulling for is that we therapists not forget that Kurosawa may have been correct, and that we struggle to be aware of the measure of our need to be of more value to the patient than we really feel we are in our private selves. The more we remember this, the more likely it is that the patient's needs will be met by how we participate in the mutual process of idealization and disillusionment that is occurring. Freud, for instance, had both "scientific" and personal reasons for choosing the prescribed physical relationship of the patient and himself in the treatment room. There was the blank screen theory and there was his physical discomfort with face-to-face mutual gaze. I can imagine that if Freud had been capable of not taking his own blank screen theory too seriously, he would have been able to respond in a more healing fashion to a patient's expression of a need to both see and be seen by him. Not only Freud, but the Wizard of Oz, and all of us, for that matter, serve our patients better, when we are not so ashamed to be seen through our therapeutic screens. It probably doesn't hurt the cause if our therapeutic edifice elevates us just high enough off the ground, so that a little clay can still be seen on our feet.

If shards could whisper

In this final section, I am going to argue for a dictum I learned in my medical studies. A patient was presented whose confusing physical symptoms and diagnostic test results could only be made sense of when a careful history was taken. The ironic advice we were given was: when all else fails, sit down and talk to the patient. I am going to suggest that we not wait until all else fails.

The complex and unique ways in which therapists are wounded healers are likely too varied to be classified. I know that I have never met a healer who was not also a significantly wounded human being, and I would guess that, if they exist at all, they are rare creatures. I propose that most of us are wounded healers in recovery from the infinite ways in which our inner states were poorly read. I propose further, that those of us who have been drawn to somato-psychic approaches that focus on pre/non-verbal issues, have been poorly attuned to specifically in regard to our wordless inner states. It is also true that many of us, myself included, have been helped towards a more secure, more psychosomatically integrated self by the somato-psychic therapies which we experienced as patients and now practice as therapists. This having been said, I believe the inter-subjective, embodied limbic healing I experienced with my bioenergetic therapists, was hindered by the clinical theory and practice in which they believed. Let me explain. It was Frank's (Frank & Frank, 1991) research that pointed successful therapy outcomes as having more to do with the patient's experience of his therapist as trustworthy and empathetic, than with the specific therapeutic approach being employed. Frank's data suggested that the specific rituals of the method were merely the vehicles for the actual healing factors. So we are on the edge of paradox here. Suppose, for instance, our work purports to deal with somatic consciousness at a variety of levels of the organism, and we have chosen the approach because it compensates for a limbic wounding of our inter-subjective empathic ability. This would be one example of the many ways that the somato-psychic details of an approach are interwoven with the details of a therapist's wounds. These complex inter-weavings are only a problem if it is also true that our ability to model for our patients the facing and living of our own wounds is central to our being able to help them. Our chosen methods, then, all carry the risk of making us look better (less wounded) than we are.

I hope my own therapy experience is both illustrative and still relevant in 2008. I do not remember any bodily, energetic intervention by my therapists, the three founders of the IIBA, Walling, Pierrakos, or Lowen, that ever got me to a level of

psychosomatic unity at which my dissociated, shamed, subjective observer- self came into the room. There were always at least three of us; my therapist, my compliant self... the patient, and the vigilant observer self. My therapist working on a particular muscle, or any other part of me and causing/discovering movement, sensation/emotion/memory/altered consciousness... did not in and of itself heal the dissociation. I suspect that I would have needed a direct invitation from my therapist to tell him how this split off self, the remnant of my inviolable spirit, had experienced whatever was going on in the room. And, of course, over time, I might have come to feel safer rather than threatened that he realized that I existed. But he would not have been able to coax me out into the room until I sensed that something deeper than his therapist's identity... call it his humanity, was willing to abide with me in our mutual helplessness. I would have needed to feel that he was able to tolerate my hatred and brokenness... to spend as much time with me, not knowing if we would make it as he spent with the therapeutic approach that made him comfortable.

My point is that Lowenian bioenergetics or any somato-psychic approach that does not privilege the details of both the therapist's and the patient's subjective experience, makes such a healing shared space unlikely for at least two reasons. First, how were my three therapists going to coax even a whisper from my shamed shards of a self, if their theory did not include modeling of their own shame? Second, the bioenergetic method itself was understood to be deeper, to go deeper into my organism than anything words could convey. The belief was that the shards of a self that had never come together from within an inter-subjective empathic matrix were now going to, via the core energetic work, become a cohesive psychosomatic self.

So I am wondering if the subjective experience of self trumps any other organizational level of the human organism in the sense of being the final arbiter of what is most deeply and personally true for that person. Granted that self may need lots of careful therapeutic work before its somato-psychic fragments cohere enough so as to find a voice. I myself have been fascinated for many years by shocks to the infant organism, the terrors for which there are no words, and I am not minimizing how indispensable healing work with sensory-motor precursors of self can be. The issue is more that we admit we don't really know when the patient's subjective self is ready to join the encounter, and that we not let our "deep" approaches interfere with our hospitality.

Consider, for instance, how most of us are comfortable with the humbling humor that is delivered when we are surprised by the occasional report from a patient of the crucial meaning to them of a casual gesture or comment of ours to which we had attached no significance. We can joke among ourselves about how such comments by patients reveal how little we actually know of our impact on them. The moment of humility, which such data force upon our professional persona, is relieving to most of us. For a playful moment we get not to have to take ourselves and our methods so seriously. But how many of us are ready to accept that the humorous moment has given us a glimpse of an all-to-serious reality which does not go away just because we feel obliged to reassume the mantel of serious therapist again? The reality I refer to, of course, is the irreducible gap between what we think we are doing, and what is happening for the patient. How do we build safeguards, against what Kurosawa might call our pretentiousness, into our daily clinical work? How do we conduct ourselves as though that odd comic moment above is actually a more or less constant, subjective, sub-textual experience for our patients?

Ask the patient a few times each session what is going on for them. In this regard, Tronick (1989) teaches us that the well-attuned parent in a secure mother-infant dyad is in matched harmony with her child only 30% of the time. In the secure dyad, however, the parent repairs the derailment within 1 to 2 seconds. I understand this crucial ability to follow from the parent's sense that his child is a fascinating creature with an ultimately unknowable inner experience that shifts from moment to moment. The parent, in other words, is well-attuned enough to realize how partial and evanescent the empathic meetings are. I hold that this applies to therapists, as well, and particularly with an adolescent/adult patient whose subjective world is often organized via symbolic language, I suggest that we regularly inquire of the patient as to how they are experiencing our method. I apologize to those readers who have done this for years, but I do not often see this perhaps crucial intervention written about in our literature. Of course, like everything in our field, none of this is as simple as it sounds. Both the disclosure and the withholding our subjective experience as therapists can end up being experienced by the patient as a necessary evil which, in their avoidant way, they will put up with so that we remain optimally available to them. The happier outcome is for the patient to experience it as safe enough to engage with your being both interested in what is going on for him and having the reflective capacity to realize that he is a separate being whose mind/inner experience is never fully captured by you.

Wheatley-Crosbie's (2006) demonstrates the latter in a touching and impressive case vignette. Her work is particularly nuanced and respectful of "Beth's" subjective experience... judiciously self-disclosing her own visceral somatic experience... weaving back and forth among levels of experience- sensation, imagery, behavior, affect, motoric expression- but not losing sight of Beth's inner experience.

Today, in 2008, a lot of inter-subjectivity has gone under the bridge, and most therapists are aware of the above issues. For some interpersonal/relational psychoanalysts such as Mitchell (1988) and Bromberg (1998) the interaction of two subjectivities is what co-constructs the therapeutic action, and is foundational. **But it is still a good idea and no small order, to look at how our specific inter-subjective strengths and weaknesses are interwoven with the many psychosomatic details of our chosen therapeutic modality**. Our patients often instinctively close their eyes in order to focus on their inner experience. How many third eyes must we have as therapists to be able to attend to the nuances of our own and our patients' subjective worlds plus the nuances of their posture, muscular activity, alignment, and the many, many other aspects of the same trillion celled patient to which the multitude of somato-psychic therapies attune?

Speaking of why it might not come naturally to some of us to ask a patient to tell us about their inner experiene, the following is part of a definition of bioenergetic analysis that I wrote some years ago,

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

But we also listen carefully to your words and we are touched by them when they come from a depth of your being that no one can put a hand on

I have italicized the sentence about spoken language, because words have long been second-class citizens in the pychosomatic equation of Reichian/Lowenian therapy. This has been the case because, in spite of the brilliant vision of psyche-soma equivalence, both men had a strong belief that words could not be trusted to convey a person's deeper truth. They, in common with most victims of family of origin trauma, had very personal reasons for this mistrust. Their primary attachment figures consciously disavowed and/or were unaware of their feelings, thoughts and behavior - such that their verbal descriptions of what took place denied Reich and Lowen's experience of that reality. This is commonly described as a particularly destructive aspect of trauma within the family. As is also well known, these patients, for many reasons, "live in their heads" and are both cut off from and do not trust their deeper feelings. But we also tend to filter our experience of others through our own structures: What if Reich and Lowen, and other body-oriented therapists, sensing their own cephalic shock (dissociation), assume that others' words are also not to be trusted as direct expressions of their essential being?

So, on the one hand, we somato-psychic therapists are lifesavers when we pay less attention to the words of the dissociated patients, and help them to come down into the life of their bodies. On the other hand, let those of us therapists, like Reich and Lowen, who have felt traumatically betrayed, be cautious that our deep mistrust of our own parents' words, does not blind us to the moments when our patients' words, come from a depth of their being that no one can put a hand on.

Coda

Finally, there are the rich and varied ways that somato-psychic therapists have discovered to enrich the nonverbal dialogue with, and give access to the fullness of our psycho-spiritual-somatic beings. For me, there is also the irreducible human reality that is negotiated, often silently, beneath whatever ritual, beliefs, models, and modalities have been agreed to. I refer to the patient's experience of how much both of the shameful shards and remaining inner flame of his being his therapist can tolerate and be with. One of the most interesting things about the details of a therapist's clinical approach, is how it both helps him with and hides his limbic woundedness. Both pieces of information can be profoundly important to the patient. What better proof that he, the patient, can face and tolerate his own brokenness, than that his therapist has recovered sufficiently from his own shame, to be with him in it now. Where shame has been, dignity is not out of the question.

Epilogue

Finally, I am initially ashamed, and increasingly at peace that I do not truly grasp how it is that our clinical theories both help, and hinder our wounded humanity from healing ourselves and others. When I try to go back to what felt like healing in my own bioenergetic therapists, it is tempting to say the fire in their bellies, the heart, the light in their eyes which no theory could extinguish. In addition to my disappointment – verging on heartbreak- with my second (Lowenian bioenergetic) family, I feel deep love and gratitude for the gifts they have given me.

Even as I finish this paper, I cannot find one way to refer to Alexander Lowen that captures the many textures and layers of relatedness that I have with him. At times, I enjoy the distant, academic "Lowen", at others, the respectful "Dr. Lowen" and yet I am still drawn to the human "Al". Along these lines, my editor (one of my co-) encouraged me to share the following vignette. Once upon a time, I wrote a paper that expressed a distinctly different point of view from that of Dr. Lowen (Al). Although the then editor of the Bioenergetic Journal had graciously helped me to smooth out as many hard edges as he could, Lowen wrote me a very angry letter about the paper. However, he did leave the door open, even suggesting we meet for dinner. With a good bit of angst, I rang Dr. Lowen's office buzzer. To my surprise, an animated Al opened the door and immediately asked me if I would possibly do some work with his patient, currently in his treatment room, and suffering, said Al, from cephalic shock, the very condition I had detailed in the paper at issue (among others). Rallying as quickly as I could from my own shock, I said I would be glad to meet the man and get a sense if the proposed encounter was a good idea. I did so, and proceeded to work with him for about a half an hour while Al sat quietly in the back of the room. Afterwards, Al came up to me and said in a quietly convincing tone, "that was good work, Bob." I remember feeling, "Gee, that is all I've ever really wanted to hear Al say to me". I imagine many of us over the years had such precious moments with Al. I thank Jacquie for her encouragement, because precious moments, while they often occur in private, feel good to share with fellow travelers.

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Biography

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

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