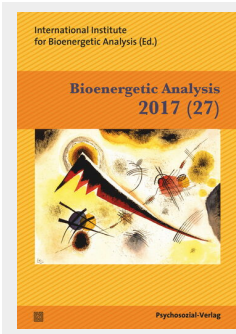


*Fina Pla*

# From Body Structure to Bodies in Resonance



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# From Body Structure to Bodies in Resonance

## Evolution of the Therapeutic Relationship in Bioenergetic Analysis

*Fina Pla*

### Abstracts

English

This article takes the reader on a journey with two different parts. In the first one, contributions on the transference/countertransference theme provided by bioenergetic authors are presented giving an overview of the richness and creativity of each author. In the second part, a reflection about the impact of Attachment Theory, Relational Psychoanalysis and Neuroscience in the therapeutic relationship in Bioenergetic Analysis is provided. The impact of new concepts is exposed and the rethinking of old ones is revised. The result is a new, enriched view of the therapeutic relationship and its transferential/counter-transferential processes where the therapeutic process becomes an interrelational somatosensory process within the therapeutic dyad. Some short clinical vignettes are provided.

*Keywords:* therapeutic relationship, transferential/countertransferential processes, somatic attunement, empathy, intersubjectivity, relational matrix, self-regulation

German

Dieser Beitrag nimmt seine Leser/innen auf eine Reise mit zwei unterschiedlichen Etappen mit. In der ersten werden Beiträge von bioenergetischen Autor/innen zum Thema Übertragung/Gegenübertragung geliefert, die einen Überblick über die Differenziertheit und Kreativität der einzelnen Autor/innen bieten. In der zweiten wird der Einfluss der Bindungstheorie, der psychoanalytischen Objektbeziehungstheorie und der Neurowissenschaften auf die Konzeption der therapeutischen Beziehung in der Bioenergetischen Analyse dargestellt. Als Ergebnis resultiert daraus eine angereicherte Sicht auf die therapeutische Beziehung

und ihre Übertragungs- und Gegenübertragungsprozesse, wobei der therapeutische Prozess zu einem interrelationalen, somatosensorischen Geschehen innerhalb der therapeutischen Dyade wird. Es werden einige kurze klinische Vignetten geliefert.

### Italian

Questo articolo conduce il lettore in un viaggio composto di due parti differenti. Nella prima sono presentati dei contributi sul tema del transfert/controtransfert forniti da autori bioenergetici, fornendo una panoramica della ricchezza e della creatività di ogni autore. Nella seconda parte, è proposta una riflessione sull'impatto della teoria dell'attaccamento, della psicoanalisi relazionale e delle neuroscienze sulla relazione terapeutica in Analisi Bioenergetica. È esposto l'impatto dei nuovi concetti e il ripensamento di quelli vecchi. Il risultato è un nuovo punto di vista, arricchito, della relazione terapeutica e dei suoi processi di transfert/controtransfert in cui il processo terapeutico diventa un processo somatosensoriale inter-relazionale all'interno della diade terapeutica. Vengono presentate alcune brevi vignette cliniche.

### Spanish

Este artículo lleva al lector a un viaje con dos partes distintas. En la primera, se hace un recorrido por las aportaciones de autores bioenergéticos al tema de la transferencia/contratransferencia dando una visión de conjunto de la riqueza y creatividad de cada autor. En la segunda parte se aporta una reflexión sobre el impacto de la Teoría del Apego, El Psicoanálisis Relacional y la Neurociencia en la relación terapéutica y en el Análisis Bioenergético. Se expone el impacto de nuevos conceptos y se revisa la reformulación de los antiguos. El resultado es una visión enriquecida y nueva de la relación terapéutica y de sus procesos transferenciales/contratransferenciales donde el proceso terapéutico se convierte en un proceso somatosensitivo e interrelacional dentro de la díada terapéutica. Se muestran algunas viñetas clínicas.

### Portuguese

Este artigo conduz o leitor a uma jornada em duas partes. Na primeira, traz contribuições sobre o tema da transferência/contratransferência, trazidas por autores bioenergéticos, dando uma visão geral da riqueza e criatividade de cada autor. Na segunda, traz uma reflexão sobre o impacto da Teoria do Apego, da Psicanálise Relacional e da Neurociência. Mostra o impacto de novos conceitos e traz uma revisão do modo de pensar os antigos. O resultado é uma visão nova, enriquecida, da relação terapéutica e seus processos transferenciais/contratran-

ferenciais, onde o processo terapêutico se torna um processo inter-relacional e somatosensório dentro da dupla terapêutica. Traz também, algumas vignettes de casos clínicos.

## 1 Introduction

“I needed someone who worked with the body and recognized it as the energetic core of self-expression and source of the true self but, more than that, I needed a person who wanted to connect to me, not just a body, not just a problem, not just a character, not just an energetic system, but me, with all my weaknesses and needs.” (Hilton 36, 2000)

### Purpose

My purpose with this article is to provide a journey through the contributions on the theme of the therapeutic relationship through one of its most important manifestations, the transference/countertransference dynamics, from thirteen different bioenergetic authors, from the first published articles to the most recent ones. I've chosen the articles I could get access to and I apologize if I have missed any. I've tried to grasp the main ideas of each author considering the limitations of space allowed. We can see the richness of contributions, from more analytical views to more somatic and some more personal ones. The second part of the article revises the contributions of bioenergetic authors on the theme of the therapeutic relationship and its transference processes, incorporating concepts from a new paradigm and revising our understanding of traditional bioenergetic concepts under this light. I present concepts through the lens of our bioenergetic authors, in order to provide evidence of how Bioenergetic Analysis theory and practice have been impacted by them.

### Evolution

Bioenergetic Analysis has evolved from its beginnings until now without losing its ground and core beliefs. Throughout the years, the concepts of therapeutic relationship, transference and countertransference have evolved from a classical Freudian analytic view, to a Reichian and Lowenian body focused one, to one

enriched by the contributions from Attachment Theory, Relational Psychoanalysis and Neurosciences where the emphasis has been displaced by intersubjectivity and mutual somatic attunement. Some courageous bioenergetic analysts have opened the way to incorporate these new concepts without losing our roots. I would like to provide an account of this evolutionary process in Bioenergetic Analysis, how the vision we have about the therapeutic relationship and its transference and countertransference processes has evolved from the earlier “Body Structure to Bodies in Resonance”, a term I have taken from Michel Brien’s article which synthesizes this long and rich evolutionary path.

## History before Bioenergetics

In Classical Psychoanalysis the relationship is based on the patient’s transference to the therapist. Through transference, the patient feels impulses and feelings, has fantasies and defenses that have to do with his/her primary figures. The therapist, from his anonymous, neutral place seeks to amplify transference reactions to access unconscious material. In Object Relations Theory (Kohut), relationships are considered the most fundamental aspect in life. The relationship with the primary caretaker is internalized and structures the self. The patient internalizes the therapist as a good object and the therapist becomes a healthier model for the patient’s inner world.

The Relational Theory (Aron, Mitchell) aspires to integrate the previous ones. Compared to Classical Psychoanalysis where the patient is seen as someone dysfunctional who transfers to the therapist, Relational Theory is based on a dyadic system, two people co-participating and change happens when the two members solve the conflicts in their therapeutic interrelationship. The classical analytic position of neutrality and abstinence changes to one of mutuality, spontaneity and authenticity where the patient learns to have healthier relationships through the relationship with his/her therapist.

The concept of transference originated with Freud and according to him, what was relived in the transference was the relationship with the patient’s parental figures. Freud’s theory about drives and the unconscious was dominant in psychoanalysis and has had an impact on other therapeutic approaches. Reich expanded Freud’s ideas and introduced character analysis and the work with the body. Lowen followed Reich and continued basically with the same idea, that the neurotic behavior of the patient showed itself through his/her body armor and in the relationship with the therapist. Transference has been seen for a long time as the patient’s parental contents projected onto the therapist. To Lowen, working with transference meant working mainly with the repressed emotions and their counterpart in body blocks, and transference was seen as the main impediment in the therapeutic process.

## 2 Contributions of Transference/ Countertransference by bioenergetic analysts in chronological order

With the new research about trauma processes and earlier disturbances, bioenergetic analysis has had to evolve towards more efficient ways to work with the type of early traumatized patients that we find now in the therapy room. As we go through the different authors, we will encounter the richness and diversity of contributions and we will see how the transference processes in the therapeutic relationship have been evolving since their origins, body structure, to the present, bodies in resonance. I will present these contributions, some of which are focused more on the theoretical analytic concepts, others on somatopsychic processes and others are more experiential. I have followed a chronological sequence so we can see how the different authors address the theme.

### Stanley Keleman: Bonding (1986)

Stanley Keleman (he belonged to the IIBA and was a CBT) wrote *Bonding*, where he talks extensively about transference and countertransference as somatic phenomena and develops the concepts of bonding, somatic resonance and pulsation.

Transference includes the muscular response patterns by which the client bonds to the therapist and countertransference includes the therapist's somatic responses, the ways he accepts or rejects the client's emotional and somatic states. Transference and countertransference are viewed as poles of a relational continuum and the term bonding is used to refer to this continuum. He describes different levels in somatic transference following the developmental patterns from fetal life to adulthood: umbilical, mouth, breast, genital and body to body contact. Which developmental level the client functions at, determines the nature of the transference.

Transference processes define a relationship as an attempt to establish a somatic-emotional bond of communication. In this relationship the therapist needs to know how he/she bonds somatically. Pulsating is the basis of bonding and involves a continuous circulation and Keleman's goal is to re-establish the pulsatory continuum:

“This is a process of pulsation in which waves of somatic emotional expansion and contraction, projection and introjection organize fields of cellular activity into patterns of complex behavior.”(102)

Therapeutic bonding is a continuously shifting process that involves a complex organization and structures a relationship with many levels of experience. In

this process, transference and countertransference are organized by the somatic emotional attitudes of the client and the responses from the therapist. As the client projects into the therapist and evokes responses, a resonating process is established.

The therapeutic task will be to help a client create a container, deprogram past responses and form a pulsatory movement. What is central is the emotional response from the therapist for if he is not aware of his neural, emotional, and muscular responses, he tends to project them on the patient. Transference involves distortions of this pulsatory continuum and the key to solve it is to disorganize the initial structure. A client has structured his past experience and he needs help to de-structure it, to form new muscular-emotional patterns. Keleman writes, "To restructure obsolete bonds is what somatic therapy is all about" (104).

### **Virginia Wink Hilton: Working with Sexual Transference (1987)**

Virginia Wink Hilton has had the courage to address the issue of sexual transference, not an easy subject. In fact it is one of the few bioenergetic articles I found on this specific type of transference. She stresses the importance for the therapist to be aware of his/her own sexual issues and to work them through in therapy and supervision. Here we can see how the therapeutic relationship was considered in the 1980's:

"The nature of the patient-therapist relationship is that it is an intense, intimate dyad where the therapist is perceived as being in control and having the power. The patient is in a dependent position. There is no mutuality in that the therapist reveals comparatively little of himself." (216)

The fact that the patient projects onto the therapist the aspects of the longed for object, is seen by Virginia as, "the most powerful tool for healing and for righting the wrong" and at the same time, "it can also be the source of the greatest destruction" as she says, "it is difficult not to misuse that power in an attempt to repair one's own oedipal damage, as the therapist can seduce or reject in accordance to what he experienced as a child". (216)

There is the danger for the therapist of acting out and blaming the patient. One important statement from her is that transference only ends when it is worked through. She outlines our responsibility as therapists: "Our responsibility as therapists and trainers is first and foremost to understand our own unresolved issues and how these may manifest themselves in countertransference". (219)

There are two basic premises when working with sexual transference: one is the setting of clear boundaries and the second is acknowledging and affirming the sexuality of the patient. A child needs to hear from his parents: I-you are a sexual



person, 2-you are attractive, 3- your sexual feelings are good. As the child needs the parents to see and acknowledge his/her sexuality without getting involved in it, exactly the same is required from the therapist who must be connected to his/her own sexuality.

“When the patient through the therapy process is experiencing his or her sexual energy with that joyful, expansive feeling that accompanies it, we need to have the courage to be fully connected to our own sexual energy, to stay fully present and completely separate, wanting or needing nothing from the patient”. (223)

### **Len Carlino: The Therapist’s Use of Self (1993)**

Len Carlino prefers the term “the therapist’s use of self” rather than countertransference. Psychoanalytic thought distinguishes between a real relationship (interactions between patient and therapist that lack of unconscious projections and are based on accurate perceptions) and the transference-countertransference relationship which includes a repetition of the past that distorts reality. As it is difficult to make a clear distinction between the conscious and unconscious material of the therapist and since the distinction between a real relationship and a transference one is relative, the best option for the therapist is to actively use the countertransference: “The patient stimulates his disavowed affect in us in a hope we can tolerate the affect and respond to it.” (89)

The patient learns to contain and integrate his affect as the therapist beams it back to him/her. This re-learning experience must involve an emotional response from the therapist and the “emotional reality” between patient and therapist is, “the only reality”. (89)

Commitment is the most essential attribute for the therapist, “an unyielding commitment, a commitment to the truth to maintain the integrity of the relationship and the process and to being aware of how the transference molds the countertransference and vice versa.” (90)

Strong countertransference that cannot be recognized and dealt in the treatment will be acted out. The acting out can take many forms: keeping a non-therapeutic distance from the client, refusing to merge with him out of fear of being out of control, or obtaining some direct gratification from the patient. He proposes some guidelines for the therapist’s use of self:

1. The therapist must be aware of his own strengths and weaknesses (his character structure).
2. Any intervention should be for the patient’s cure and not for the therapist’s self-cure.
3. The use of self should be seen on a continuum in the therapeutic relationship.

4. The therapist needs to be grounded in his body and able contain a strong affective charge and able to express it.
5. The therapist needs to handle his/her feelings more constructively than did the patients' parents.
6. The most effective way to apply the use of self relies on the therapist being honest, direct and nonjudgmental.
7. The therapist needs to have stable boundaries for patients who do not have them and permeable boundaries when allowing for regressive experiences.
8. The therapist needs to be able to share the patient's early affects rather than observing them. The therapist must be open to experiencing uncomfortable feelings such as confusion, anxiety, craziness, despair, anger and sexual excitement.

He concludes that the more a therapist is grounded in his/her self-awareness and self-possession, the greater will be his/her ability for constructive use of self in the therapeutic relationship.

### **Jean Marc Guillerme: Contre-Transfert Corporel chez Freud, chez Reich, ... Aujourd'hui (1994)**

What does the body of the analyst tell the analyst himself? Jean Marc Guillerme comments how Searles needed to develop a "detective" task to make sense of his countertransference reactions. He takes us into his own body countertransference exposing a clinical case and referring to countertransference body reactions in Freud and Reich:

The client, a man with a persistent complaint, in a workshop makes a dismissing comment about Guillerme's work as superficial, and Guillerme's reaction is somehow inadequate and he has diarrhea and feels worn out and affected later on. The patient does not attend his next therapy session and the therapist suffers a terrible lumbar pain and needs days to recover his digestion and lumbar tension and to integrate the meaning of what had happened: he had felt publicly diminished by his client's remark on his clinical capability, in his work as a bioenergetic analyst and as a person.

Lowen's feedback to Guillerme was that he was touched by fear of his own violence when he found out that his narcissistic need to be a super-therapist for his patient, (an impossible unconscious demand from the patient) had failed. Reich calls this unconscious demand a "Midas' finger", as if everything the analyst touches magically heals. The analyst becomes then the magical healer and his interpretations are magic presents for his patients, but these are muddy waters, as it leads to a false evaluation of patients and "to feel hostility towards the patient who does not succeed to giving his analyst the narcissistic satisfaction to have healed him." (129).

Guillerme goes through the vicissitudes of countertransference, its body signals, the therapist's wishes projected onto the client, the narcissistic ambition and its failures, and the difficulty of coming apart, which are all essential elements to understand what is played out somatically in the relationship.

At the same time he reflects on the physical symptoms Freud and Reich suffered because of painful break ups and separations. Freud had his first heart attack after his rupture with Breuer and the second after Abraham's death, while his fainting related to a comment made by Jung. Reich developed tuberculosis after Freud coldly received his theory about orgasm and after his conflicts with his wife. He was rejected by Freud who did not agree to analyze him and was very hurt by his conflict with Freud, possibly resonating with his conflict with his father.

Guillerme provides a definition of body countertransference departing from Freud's definition of countertransference as an affect that comes to the analyst due to the patient's impact on the analyst's unconscious feelings. This view follows Lowen's comments about analysts not having confronted enough their own body structure and not having changed enough on a body level. Guillerme defines countertransference as, "a sudden body agitation, unpredictable, incomprehensible at first sight, before, during or after the session. This agitation gets manifested through a body symptom, a specific tension or dream material. In any case, it is related to the patient's body or to a patient's affect". (132)

Body countertransference is lived by the therapist, he says, as a kind of trauma that requires long self-analysis "detective" work and an emotional energetic discharge from the therapist, as well as tolerance and patience to not act out towards the patient and concludes saying: "Maybe our countertransference body reactions are like hieroglyphs that we, alone, cannot decipher".

### **Bob Hilton: Countertransference: An Energetic and Characterological Perspective (1997)**

Bob Hilton quotes Alice Miller on the two kinds of countertransference:

1. Subjective countertransference where the therapist gets from the patient the narcissistic supplies he was denied by his parents.
2. Objective countertransference, where the therapist, having worked his narcissistic needs, feels in his body the patient's experiences and with this somatic knowledge is able to build a bridge for empathic contact and move to a resolution of the transference relationship.

1. In subjective countertransference he distinguishes between the primal self, the contracted self and the adaptive self. The primal self is the basic psyche/soma self-expression in the world. When it meets negativity its energy contracts

and forms the contracted self that inhibits the life force of the primal self. The wish to die is invested in the contracted self and the survival needs develop an adaptive self.

The contracted self and the adaptive self find expression in the negative self, that gets expressed through negativity and the characterological self maintains equilibrium between those aspects. It is the form one has created to survive the prison in which one lives. When the primal self is recognized, a real self can take the place of the characterological self. Hilton goes through the different possibilities when these different selves from patient and therapist meet. He exposes how the patient can sense the narcissistic wounds in the therapist and how they can both collide when the patient does not reward the narcissistic needs of the therapist and how the therapist can withdraw according to his/her character structure, and how he can manipulate the patient in the same way he had to do it to survive.

It is important for the therapist to break this cycle, have supervision and personal therapy and build the foundations of the real self. He needs to acknowledge the failures of his characterological self, grieve his original loss and face the patient who needs to grieve the same loss and with this new awareness the patient can be heard in a new way and he gains a real person to help him grieve his loss.

2. The objective countertransference refers to the therapist's ability to be an open channel with his client. He is able to experience the feelings generated in him by the patient and allow them to be present. He has to stay grounded in his own reality and can be experienced as a genuine model for the patient. The therapist then "is able to use his body as a resonating instrument upon which the "music" of the patient is played. This resonance is what the patient did not have from her own family and now becomes the foundation for healing the narcissistic wound ... the therapist is now able to trust his intuitive response and is less likely to fall into the narcissistic trap led by himself and the client." (262)

Through transference and countertransference the therapeutic relationship fosters a mutual healing process where therapist and client both get healed:

"The countertransference process, through which the therapist must move for his own healing is the same transference process for the patient. The patient-child is in a constant process of healing the therapist parent so that he himself must be healed." (263)

### **Vita Heinrich: Physical Phenomena of Countertransference. Therapists as a Resonance Body (1999)**

Vita Heinrich introduces the concept of bodily resonance and shows us her creative way to work with intuition as a central body tool, using it to feel her body

and her client's body resonances. Transference and countertransference manifest as psychosomatic phenomena:

"I must get involved with my intuition, the examination of everything, instead of analytic dismemberment, my bodily sensations and pictures are as resonance towards the physical reality of the client". (20)

In the therapist-patient interaction, the unconscious and repressed traits of the patient and the split off parts have a direct effect on the therapist. She positions herself in the energy field of the client (20 cms distance) "eyes shut and instead of feeling selective tactile muscles I let myself be touched without touching". Positioning herself in the four positions (both sides, front and back) she explains:

"I let my body respond to the physical reality of the client: body sensations emerge: cold, relaxed, hunger, tired and as time progresses more complex feelings emerge (shame, fear, rage, sadness), coupled with physical signs: breathing rhythm, and muscular posture pattern. These feelings show something of the true self of the patient who communicates non verbally from body to body". (21)

To Heinrich, resonance can manifest through metaphors, images, body sensations, or feelings. They are bodily messages the client sends us. There is an energetic exchange from body to body that she finds is quicker than a verbal exchange, and an important source of communication. Being aware of our countertransference feelings will help us connect with the patient's feelings.

### **Ben Shapiro: Will Iceberg Sink Titanic? Avoiding Collisions and Collusions instigated by the Dark Side of Client and Therapist: A Bioenergetic Approach (2000)**

Ben Shapiro introduces us into the transference-countertransference issue with a metaphoric story. The iceberg and the Titanic represent client and therapist who can collide and collude. He takes us into what he calls the "dark side" of the therapist and client, that is, transference and countertransference's negative aspects.

The client stands on the iceberg calling out to be rescued from his stuck state, the top of the iceberg is the false self of the client and behind, there is his character structure. From the bridge, the therapist wants to help. He distinguishes the bright side of therapy and the dark side, the defensive aspects of the client: resistance, negative transference, acting out, represented by the underneath ice that threatens to sink the grandiosity of the therapist. There is also the dark side of

the therapist, his subconscious fears, and his tendency to suppress them. And he shows us a way to avoid the dark side collision:

Symbolically the therapist uses a zodiac to approach the iceberg, to see where the ice is dangerous and can make a humorous approach that helps, so the client can show his devils and they can be worked through. Then the client can join the therapist in the zodiac and both have scuba diving to address the most difficult aspects of the dark side. The dark side, being those feelings and impulses blocked by the character structure. Shapiro uses the metaphor of devil as the personification of our dark side.

### **Leslie Case: When Trust becomes Distrust and other Perils of Countertransference (2000)**

Leslie Case shares with us her very personal and intimate experiences and reflections on transference and countertransference on her long personal therapy journey, including her experiences with many therapists. She says “it took twenty six years of therapy with six bioenergetic therapists to be in this body” (67).

Throughout her journey she learned quite a lot about transference and countertransference challenges and what therapist and client feared:

“The mutual resistance to exploring the interactions prevented me from facing my deeper pains. I was afraid- of weakness and failure, inadequacy and insignificance. They were afraid too-of their own shortcomings. Each of us, protecting ourselves from the past, each of us, making our lives more predictable”. (72)

From her challenging and deep experience she reflects about the possible dangers that can interfere in the therapeutic relationship, which, summarized, would be:

a) not being understood, b) not being supported, c) being blamed, d) therapist trying too hard, e) being denied, f) therapist being too close or too distant, g) receiving double messages, h) being overpowered by therapist.

Describing her journey, using poetic imagery, I find her article a very courageous act where she shares with us her inner feelings, the darkness and the light, the connection and the broken bridges, the joy and the impotence, the attunement and the betrayal, Case shares all the intricacies of a therapeutic relationship as she delves into the depths of her soul and body. And she finishes with these words:

“The journey I just described took me on a very bumpy road. At times it was a very dangerous one. Filled with blind alleys and detours, dead ends and cloverleaves. The countertransference with my therapists created many of these obstacles, adding to the ones structured in my body. But, fortu-

nately, the truth and beauty of bioenergetic analysis was stronger than all our characters.”(80)

### **Michel Brien: Corps en R sonance (2001)**

Michel Brien develops the theme of the therapist-patient body resonance, how the therapist can sense what happens in the patient’s body. The body continually emits messages in the therapeutic process. It is as if the therapist’s body can sense the patient’s internal experience that he tries to grasp but it is not yet accessible to the patient’s awareness. The therapist’s body becomes an essential therapeutic tool we need to decipher, an essential part in the message that needs to be understood, a therapeutic revealing tool as important as words and listening which allows us to explore territories where words are not allowed:

“Could we think of the symptom in the therapist’s body as revealing the client’s dynamics? If we pay attention to it, the body speaks, continuously emits messages. It is as if the therapist’s body evokes the inner experience of the client that is not yet available. The body manifestations in the therapeutic context belong to a non- verbal message that must be understood. The body is a major part in this discourse that must be understood and it becomes the therapeutic tool exactly as do the words and the listening”. (2)

He quotes three authors who have made contributions to the issue of the client’s resonance in the therapist’s body. From Reich, he says that we keep the principle of functional identity, from Lowen we take energy circulation and from Keleman the bonds between the family environment of the client and the somatic organization that comes from it. This is the path he refers to as going from body structure to bodies in resonance. He exposes an interesting concept by Keleman: the client’s body as the therapist’s environment. The environment client is dys-regulated and needs help:

“In therapy, the environment the therapist is exposed to is the body of the client with its history, its expression, its way of contact. It is in resonance with the body of the client that the body of the therapist develops an answer.” (4) He uses a beautiful musical metaphor: “the melody that resonates in the therapist’s body is the music played within the client’s body. As with the music, the client emits a wave, carrying an emotion that affects the therapist’s body”. (5)

He quotes Sandler and his concept of “floating resonance”, and sees a similarity between listening to the body and the psychoanalytic floating attention listening

to words. Wallin, the attachment theorist who says “we are the tools of our trade” sees the therapist as a basic tool for therapeutic change, while Brien sees **the therapist’s body as this basic tool**. Energy circulation in the therapist’s body shows the therapeutic process in action in the client’s body. A tension in the therapist would signal a defense in the client. So tension is an indicator of conflict and inversely, energetic circulation shows life in movement.

Another beautiful metaphor he uses is the body as the ground where words get grounded. He stresses the need for the therapist to take care of himself so that the client can resonate with a healthy therapist’s body. Then, he says, we can be the land where the client can plant his seeds and recollect them later. And he ends with another musical metaphor to explain the healing interrelated process going on: “The body of the therapist offers a variety of resonances so that the patient can compose his piece and take the melody that is created in the therapeutic alliance.”(9)

For him, bioenergetic analysis offers the key access to the therapeutic use of the resonant body.

### **Louise Frechette: Countertransference, How to Use it Energetically? (2004)**

Louise Frechette quotes Searles viewing transference and countertransference as “attempts to cure, repair and make others whole” and countertransference as “a place for mutual growth”. (1)

There are two functions in therapeutic treatment, the primary function is to provide for the patient’s analytic resolution through insight and a second function would be the resolution of the analyst’s psychopathology only if it serves to further the primary function. In her teaching material she talks about some authors (Irvine, Stern) who distinguish two types of countertransference:

1. Countertransference that results from the analyst’s unsolved issues.
2. Countertransference as a response to the patient’s transference.

Complimentary transference “occurs when the analyst unconsciously identifies with the internal objects of the patient and experiences them as his own internal objects, activating the unresolved conflicts in the analyst” (2)

She develops the concept of projective identification and defines it as an unconscious interaction, independent of the analyst’s conflicts. It is the reaction of the therapist to the intensity and quality of the patient’s projective identification:

“When the therapist experiences an unfamiliar sensation, emotion, thought, something that feels “out of character”, that feels like a “false note”, which is hardly ever felt with other clients, chances are the therapist is struggling



with a piece that belongs to the client but he/she cannot own for the moment.” (4)

“Through the defense mechanism of projective identification the client puts that sensation, that feeling, that thought, into the therapist for him/her to “hold” until the client is ready to take it back and integrate it on a conscious level ... it is a piece that belongs to the patient but she cannot own for the moment”. (4)

But if the therapist experiences feelings known to her/him, or sensations typical of his/her somatic organization that are experienced with other clients, then it means the patient has triggered something in the therapist’s character structure. Examples of the therapist’s own issues at work might be problems related to boundaries (schedule, fees, time frame).

### **Bob Lewis: Projective Identification Revisited, Listening with the Limbic System (2004)**

Bob Lewis revisits the concept of projective identification under the light of neuroscience contributions. He looks at the clinical implications of Schore’s psychoneurobiological model of projective identification. To Schore it is a process used throughout the life span involving the non-verbal, spontaneous emotional communications within a dyad. Schore describes both healthy and disturbed patterns of emotional regulation in the early dyad as “conversations between limbic systems” and, Lewis adds that “When the dyadic conversations involve significant dysregulation and misattunement, a defensive use of projective identification is imprinted into the maturing limbic system”.

The therapist’s body needs to be available for the client’s dysregulated states like the empathic mother who matches her infant’s internal states: “it is the clinician’s body which is the primary instrument for psychobiological attunement.”(4). Lewis defines projective identification processes as somatosensory processes: “Since feelings and emotions are psychobiological phenomena and the self is bodily-based, projective identification represents not linguistic but rather mind-body communications” (4)

What can be done to not cut your empathic connection to your pain and to your patient’s pain and avoid shifting out of the right (feeling) brain state into a left (thinking) brain state? The key, Lewis says, is to hold onto this visceral state until images (visual, tactile, olfactory, etc.) come to us, though auditory and tactile material may occur without images.

To Lewis, body communications that are conveyed through posture, gesture, movement, are not often recognized in the therapeutic context. He specifically talks about the patient’s hands and how they can express the patient’s inner state.

We can decipher the patient's body messages with our right orbitofrontal cortex and what the patient communicates through projective identification is decoded by the therapist's right brain: "it is only the analyst's unconscious mind that can receive the message". He views the therapist as a holding container for the patient's dysregulated inner states:

"When I sit with my patient and direct his attention to his tone of voice ... my way of being present with him is holding his unconscious, somatosensory or otherwise un-integrated material ..." (11).

He finishes by saying that there are some things that cannot be explained very well, and projective identification is one of them.

### **Violaine De Clerk: Body, Relationship and Transference (1993, rev. 2007)**

The classical analytic relationship includes two aspects: the development of an analytic relationship and the resolution of transference and there is a third dimension in bioenergetic analysis which is the body: "body work is seen as the axis around which the other two dimensions of the process are articulated ..." (180)

Traditionally, bioenergetic analysis had two dimensions, verbal analytical work and body processes. There were two relational phenomena occurring in a therapy: a "real" relationship and a transference relationship and the transference-countertransference relationship was considered the whole therapeutic relationship.

Violaine De Clerk writes that Van Lysebeth proposes three relational phenomena that develop in therapy and places the relationship between therapist and patient as a major therapeutic agent:

1. the transference relationship, based on the patient's inner world, independent of the therapist. It stimulates a countertransference that is part of the process.
2. the relationship, in the common sense of the word, when the therapist colludes with the patient. It is determined by the blind spots of the analyst that must be worked through in therapy and supervision.
3. the analytic relationship, due to the transformation of the two previous ones and due to the analyst's attitude and interpretation. This one leads to a relationship that is real and promotes growth, where analyst and patient form an intersubjective bond. The three phenomena are present throughout the therapeutic process.

The analytic relationship would be at the core of bioenergetic analysis. In it, the analyst assumes parental functions, contains emotionally and is available for the

patient. From this perspective, there are three dimensions in bioenergetic analysis: relational work, body work and transference analysis which are mutually inter-related. Each of these dimensions produces therapeutic changes and each one affects the other two.

The development of an analytic relationship is at the core of the therapeutic process. The analyst repairs the impasses due to a deficit of self-development as a result of early traumatic attachments that can be healed through a relational experience and engages in building a relationship which is reciprocal. Body work in the transference and in the analytic relationship can precede, be simultaneous to, follow the transference analysis or be a help to it.

1. Body work and the transference relationship
  - a. Body work precedes transference analysis: “Only the emotionally connected insights produce release and therapeutic change” (192).
  - b. Body work as an auxiliary of transference analysis makes it more accessible as the physical interventions of the therapist can bring about transference reactions. The therapist acts as the transference object.
  - c. Transference analysis precedes bodywork.
  - d. Bodywork and transference analysis are simultaneous. It happens when the characterological muscular tensions embody transference emotion.

She concludes that, “the body interventions that serve the transference analysis are body equivalents of transference interpretation. It is the analytic dimension of body work.”(197).

2. Body work and the analytic relationship

The analytic relationship proceeds when the bodily self is developed but strongly disturbed: “the feelings and perceptions emerge from a “subject” but can be rigidified in relational impasses, determined by early relational experiences” (199).

For De Clerk, body work that unifies emotional experience develops the analytic relationship. When the therapist engages in an exchange, this contributes to developing the analytic relationship. The therapist makes repairs and creates bonds: “The bioenergetic therapist allows the interaction between patient and therapist to co-create a vibration, which represents for the patient a major corrective emotional experience engaging his whole organization and releasing his vital force” (200).

She ends up with some reflections about the “right presence” of the therapist in the bioenergetic setting: “the bioenergetic therapist engages actively in partnering in a relational experience, which allows an emotional exchange while maintaining an analytic position.” (202).

## **Guy Tonella: Attachment, Transference and Countertransference (2008)**

Guy Tonella distinguishes between two possibilities regarding transference:

- a. working with sexual conflicts (character analysis), based on a body-mind analytical process where you work with muscular tensions, defensive psychic patterns, and the relational patterns as transference.
- b. working with deficit and developmental trauma that requires an intersubjective system where the work is more nonverbal. The therapist is the safe base for the patient and there is a regulating system in action. In this case “the therapist is no longer somebody who knows, does a body lecture and interprets, but he is somebody who experiences, regulates, feeds-back and contributes in a co-creative way to give a sense about what happens.” (5). He quotes Fonagy who has contributed to develop this intersubjective dimension with his conviction that “when the patient experiences that he is felt and thought of by the therapist, he begins to feel and think by himself” (5)

Tonella distinguishes between the traditional concept of transference and attachment transference:

“What we call usually transference can be present through body postures, emotional expressions in the face, in the eyes, subtle tremors or spastic micro-movements, superficial breathing, thoughts, images, dreams and fantasies. The therapist is unconsciously considered, through projections, as the real parent of the patient. Working on transference means to help the patient to make conscious these projections and to release or transform the body and mind mechanisms that produce that “repetition”. (5)

But he distinguishes another aspect of transference, the attachment transference, when the client considers the therapist as the parent he did not have. In this kind of transference the patient doesn't consider the therapist as a parent who rejects his sexuality, but as a parent who can answer his primary needs. The patient does not hope to release inhibition but he hopes to meet the real person of the therapist.

In the attachment transference, the patient needs to internalize the secure, empathic parent he never had. The patient will interact with the therapist according to his unconscious attachment pattern, he will adapt, get frozen, feel threatened ... etc. These attitudes, Tonella says, belong to the bodily self, they are shown, acted, but maybe there are no words for them. “The patient uses his limbic memory without knowing”, says Tonella. This is a specific attachment transference, which “is not located in the linguistic memory, in thoughts with representations and words; it is located in the bodily self and in the forms of interactions with others” (6).

He sees some tasks the therapist has in this mode of transference:

- to explore the patient's attachment pattern which can show insecurity, fear of being ignored or not understood, dysregulated inner states, etc.
- to help the patient discover the origin of his attachment patterns sensing and feeling it through his limbic resonance. He will help the patient "to feel that state and no longer be that state".
- to help the patient understand how this attachment pattern impacts his love and sexual relationships. Sexual problems, Tonella says, can be consequences of insecure preverbal attachment.

Posing the question of what countertransference is, Tonella answers that "countertransference is an insecure attachment pattern reaction of the therapist in response to the insecure attachment pattern of the patient" (6). Depending on the therapist's own attachment pattern, sensory-emotional expressions from the patient will be allowed or dismissed.

### **3 Redefining Therapeutic Relationship, Transference and Countertransference: Contributions from Relational Psychoanalysis, Attachment Theory and Neuroscience through the lens of bioenergetic authors**

#### **3a New View of the Therapeutic Relationship and Countertransference from Relational Psychoanalysis**

Historically the therapeutic relationship has been seen as being asymmetrical. The therapist is supposed to know and interpret and the patient doesn't know about unconscious parts of himself that need to be disclosed. Countertransference has been seen as a hindrance to the therapeutic process due to unresolved conflicts within the therapist. But the concept has evolved in the therapeutic field and in bioenergetic analysis too. From relational psychoanalytic approaches, it is perceived in a radically different way, as an essential tool for the therapist. Transference and countertransference are viewed as an interactive matrix and aim to use the therapist's countertransference responses constructively. Therapist and client contribute with their subjectivities to the therapeutic alliance and the therapist is not interpreting anymore but participating and co-creating. Transference and countertransference manifest in body dimensions that enter for the first time in therapeutic approaches, which are not bodily based, mainly due to the contributions from these new theories. Relational analysts talk now of "embodied countertransference", recognizing the importance of body processes.

Relationality and Intersubjectivity have had a profound effect on the therapeutic encounter. The intersubjective experience of patient and therapist takes a prominent role as both therapist and client contribute with their subjectivities to build the therapeutic alliance. The shift involves moving the therapist's position from interpreting or administering treatment to one of participation. These analysts talk about the "intersubjective body" referring to the complex and unconscious interactions within the dyad.

One interesting contribution is from The Boston Change Process Group, a group of relational analysts and researchers (Stern, Tronick, Lyons-Ruth, and others) whose thought is affected by Martin Buber's philosophy. Buber's central idea is that all genuine healing implies an authentic encounter with the Other. Their definition of the therapeutic relationship is that there exists a relationship between patient and therapist that is real, authentic, and it is defined by Lyons-Ruth as:

"The intersubjective field formed by the intersection of the patient's and therapist's implicit relational knowledge. This field extends beyond transference and countertransference and it includes the authentic personal implication and perceptions about the ways to be with each other". (2007)

Another concept coined by this group is the "implicit relational knowledge" and it refers to the unconscious processes stored in implicit memory, which are revealed by unconscious material present in the relationship.

### *The Analytic Third, Intersubjectivity and the Relational Field*

"The analytic third" is a concept developed by Ogden and Benjamin, both relational analysts. In their view, there are two subjectivities in the therapeutic space and there is a bonding space between them. This intersubjective space is what Ogden and Benjamin call "the intersubjective analytic third", a kind of third subjectivity, which results from the interaction between the other two. The relationship between these two subjectivities, together with the bonding space between them, constitute a relational field or intersubjective system. In this system, there is a continuous reciprocating interaction between therapist and client. It is an ongoing psychic, emotional and somatic interchange, which is mainly unconscious. The analytic third would hold all the ideas, beliefs and fantasies created jointly and shared by patient and analyst.

For many relational theoreticians the concept of "mutual interaction" substitutes the traditional concepts of transference and countertransference in clinical practice, because transference and countertransference belong more to model one (Stark) focusing in the intrapsychic, that does not take into account the weaving of subjectivities. Some scholars propose to even abandon the concept of transference (Rodriguez Sutil) and others (Lachman) to radically redefine it.

Aron, a relational analyst quoted by Sassenfeld, points out the limitations of the transference concept, as the therapist not only reacts but also initiates interactions with the patient. For him the term countertransference minimizes the impact of the therapist on the patient. Diverse relational theoreticians criticize and abandon the analytic concept of projective identification for different reasons (Aron, Mitchell, Stolorow, Brandchaft and Atwood). Sassenfeld, a relational analyst, shows us this change of perspective:

“The classical model operates in only one direction, the analyst impacting the patient and not vice versa. The relational approach stresses a mutual influence in two directions that brings a mutual transformation, if the patient changes it is because the intersubjective system has been transformed and so the therapist has to change too. Aron says that there exists a relatively asymmetric mutuality, there is an impact on each other, though this influence is not equal nor are there shared roles, functions or responsibilities.” (58)

Sassenfeld introduces the concept of new “emergent patterns” that appear as a result of the interaction between therapist and patient, new patterns that did not exist before. “In this non-linear complex of dynamic systems, reciprocal interaction between the components can generate emergent patterns, forms and structures that are generated through the interaction”(58).

In this evolved relational psychoanalytic model, transference and countertransference are seen in quite a different way, as an interactional process, as Jody Davis, a psychoanalyst, shows us:

“We now recognize the transference-countertransference process as intrinsically and irreducibly interactive ... transferences are not distortions, but competing, oftentimes conflicting, organizing schemas or interpersonal fantasies laying at the foundation of each participant’s unique striving toward self-integration ... transferences are not necessarily displacements of the past.”(185)

Psychoanalytic theory, Angela Klopstech points out, has undergone a deep transformation from the Freudian drive model to the first relationship models (attachment theory, object relations theory, self- psychology) that aimed to provide some corrective experience, to the later relational models more based on the Buber (I-You) approach, focused on reciprocal interaction. The relational paradigm, conveyed by the Boston Change Process Group and other analysts, place the relationship as the crucial element for transformation and develop the idea that our sense of self is continuously transformed by our intersubjective relational experiences. Somatosensory experiences take a relevant place and they talk about a body memory, called the implicit memory, which is unconscious. The contents stored

in this implicit memory form the “implicit relational knowledge” (a term coined by the Boston Change Process Group), that can only be transformed through present experience.

Another key concept they use is the concept of intersubjectivity coming from phenomenological philosophy. Mind, body and environment are closely connected and interrelated and Descartes’s mind and body split is not acceptable anymore. From this approach, we do not have a patient in treatment anymore but two subjectivities interacting. As Jody Davies exposes:

“There are two participants coming together, attempting to create an optimal space in which to experience and process multiple aspects of who they both were, are, and might yet hope to become. We seek ways of reaching and touching each other, of nurturing, exciting, soothing, arousing, and ultimately healing the places that hurt. Within this intersubjective space, the analyst, too, wants to be reached, known and recognized.” (188)

### **3b The Impact of Relationality and Intersubjectivity in Bioenergetic Analysis**

Stern, a member of the Boston Process Change Group, stresses the importance of relationship as the core element in change processes:

“Most of us have been dragged kicking and screaming to the realization that what really works in psychotherapy is the relationship between therapist and client. We are all devastated by this reality because we spent years and a lot of money learning a particular technique or theory and it is very disheartening to realize that what we learned is only the vehicle or springboard to create a relationship; which is where the work happens.”(Stern quoted by Resneck, 2012)

In the 1980s–90s, the global psychotherapeutic field was strongly impacted by new discourses and findings coming from these new theories and some brave bioenergetic analysts start to explore, reflect and incorporate these new concepts that profoundly affect the vision and dynamics of the therapeutic relationship and the concepts of transference and countertransference. I intend to reflect on the evolution of the therapeutic relationship through the contributions of some bioenergetic authors who, without losing their connection to Lowen’s basic principles, have felt the need to connect with present mainstream psychotherapeutic approaches and have included some of these contributions to our bioenergetic theory and practice enriching it, finding new nuances and at the same time aiming to place bioenergetic analysis among mainstream therapeutic approaches. Res-



neck-Sannes (2005) gives us a historical perspective and views three chronological paradigms present in Bioenergetics:

- The first one, developed by Pierrakos and Lowen, viewed the person from the outside and can be stated as: “open the armor and you will be free”.
- A second paradigm with Keleman, Boadella, Boyersen, and Levine can be stated as: “not only is the outside structure important but the flow of energy into the body”.
- A third paradigm with Carlino, Finlay, Lewis and Hilton, and, I would add Campbell, introduces the neurobiological and attachment research. In this third paradigm the therapist is no longer a neutral observer reading the body. In recent years there is a shift towards a more relationship-oriented approach, for example the one and a half/two person model of Martha Stark, which will be explained below.

I would add, from more recent years, a fourth wave of bioenergetic analysts: Resneck-Sannes, Klopstech, Schroeter, Tonella, Scott Baum, Heinrich-Clauer, Clauer, Koemeda and possibly some others, with contributions from attachment theory, relational psychoanalysis, neurosciences, polyvagal theory etc. who revise bioenergetic concepts under the light of the latest research and open a new view and understanding of bioenergetic concepts. With that comes a new view of the therapeutic relationship, and of transference and countertransference being seen as a dyadic somatic and relational interaction.

Angela Klopstech quotes Stark on this evolution:

“Psychoanalysis has come a long way since Freud emphasized sex and aggression. The spotlight is no longer on drives or on the patient’s relationships, and no longer focuses on the relation between structures within the psyche, but contemporary psychoanalysis focuses more on the intersubjective relationship between the patient and her therapist”(44).

It is not an easy process, for us, bioenergetic analysts, to be open to new concepts while we find a way to keep our roots. Klopstech addresses the struggle to integrate new knowledge without losing our essence:

“Bioenergetic analysis from its inception retained quite a strong theoretical orientation by using the drive model of classical Freudian analysis and the Reichian model of character analysis as its foundation. But it has not adequately integrated the newer analytic theories that focus on the self or object relations or intersubjectivity. Attempts have been made by various authors ... but these have not reached a critical mass yet to provide a coherent change ... in the struggle to integrate psychoanalytic concepts, we, in bioenergetic analysis, risk losing our deeper connection to the energetic

and bodily aspects of our endeavors and becoming a school of psychotherapy with some body techniques thrown in. (46, 2012)

This evolution has brought a discussion within the therapeutic field about two models of therapeutic relationship, the “one person psychology” model, centered on the internal dynamics of the patient and the “two person psychology” model, centered in the relational aspects. Klopstech introduces us to Stark’s three models:

- One Person Model views the individual in intrapsychic terms as a closed system with internal drives and defenses. The therapist is an observer where the patient’s transference is projected. Countertransference is viewed as interfering with the therapist’s neutrality and must be eliminated. The curative factor comes from interpretation. (classical Freudian analysis)
- One and a Half Person Model (self- psychology and object relations approach) views the patient needing an empathic therapist to validate him. The healing factor is the corrective emotional experience the therapist provides.
- The Two Person Model (contemporary interactive and relational schools) is based in a mutual relationship where the therapist is an active participant. Transference is a dyadic process and countertransference is a response to the patient. The healing factor is an authentic relationship. She remarks it is advisable that therapists be able to cope with the three models depending on the situation.

To Klopstech, Bioenergetics starts from a one person model (therapist works on the emotional blocks and connects them to client’s childhood) and shifts towards a more relationship oriented approach, from one person to one and a half (the patient manifests his posture, the therapist is the empathic giver) and two person approaches (the therapeutic relationship as a central tool to heal the patient). In this last case, two authentic subjects are engaging in a relationship in the here and now. Models 1 and 2 are familiar to bioenergetic therapists, model 3 is a major challenge and we will tend to choose the model which is our home base, based on our character, Klopstech remarks.

Some quotes from Bob Hilton illustrate this relational shift in bioenergetic analysis:

“Our contractions are the result of relational wounds. They can only be “fixed” in relationship and no amount of “self-help” or “I’ll do-it-myself” will resolve or release them.” Hilton (198, 1984)

“The energetic dynamics of the body and its holding patterns were seen as an outer manifestation of an inner process. To effect change in the form and motility of the body was to alter the rigidity of the client’s inner psychic conflicts ... it was assumed that healing occurred by release of tension

and did not involve a relationship with the person facilitating the release.”  
Hilton (32, 2000)

According to Hilton, the classical bioenergetic approach was not enough, what was needed was a true and real relationship between patient and therapist, two bodies dancing a mutual dance. In this relational model, what heals and produces therapeutic change is the relational dynamics within the dyad. He writes,

“I needed someone who was committed to our relationship, someone who could weather the storms of my rage and disappointment, someone who never once thought that whatever happened in the therapy could not be worked out; someone who was committed regardless of the outcome. I needed someone who would fight for us” Hilton (37, 2000).

Relationality and Intersubjectivity have had a deep impact in bioenergetic analysis. The present vision now is one of two bodies, two minds, and two energetic systems interrelating and affecting each other. On one hand it can be more challenging for the analyst, as he can feel more exposed or less protected, on the other hand, the gains are considerable as the therapist can feel freer to be who he/she is and able to engage in a relationship that is real, where he/she does not have to be the ideal therapist but a real human being.

### **3c Contributions from Neuroscience to the Psychotherapeutic Field**

Neuroscience research has deeply impacted the understanding of the therapeutic process, independently of the approach. These theories provide a map of brain’s plasticity and how brain circuitry can be transformed by our emotions, beliefs and relationships. They confirm how the brain, the body and the nervous system get structured through their relationship with the environment. They have validated attachment theory and have developed a psychoneurobiological theory of emotional development in childhood.

It is an emotional revolution in psychotherapy, which had been behaviorally oriented in the sixties, cognitivist in the eighties/nineties and now emotion and somatosensory processes take a central place. The brain and emotional connections are exhaustively studied as well as the different functions of each brain hemisphere. Both Schore and Siegel incorporate attachment principles to brain functioning and their research validates that it is through emotional communication that attachment experiences organize the brain. The “I and Thou” are now substituted by “We”. These new theories incorporate the body in the processes of change, something we bioenergetic analysts have known and practiced for

a long time. Some bioenergetic analysts have introduced neuroscience concepts into their writings and in their practices. I thank these authors for their contributions and for keeping us connected to the mainstream psychotherapeutic world and for allowing us to acknowledge contemporary paradigms and not be isolated from them. I was interested to see how these new concepts have impacted and are present in the writings of our bioenergetic analysts and my purpose is to take you through those contributions, which have enriched bioenergetic analysis with concepts coming from these theories.

Klopstech (2008) advocates for the need to “rethink what we do bioenergetically in neuroscience terms”. Concepts such as arousal, self-regulation, mirror neurons, window of tolerance, somatic attunement, and others, are developed and incorporated, all affecting the understanding of the therapeutic process. Other concepts such as transference, grounding, catharsis, energetic charge and others are revised broadening our understanding of them.

### *Daniel Siegel's Concepts*

Dan Siegel and Allan Schore's contributions to a new understanding of the therapeutic relationship's dynamics are remarkable. Siegel, a resident psychiatrist discontented with conventional psychiatric treatments, went to listen to a talk given by Mary Main, the attachment researcher, and was deeply impacted by it. This encounter awoke in him an immense curiosity to know how attachment affected human neurobiology and how this could contribute to neural integration. In his approach, Interpersonal Neurobiology, he develops his view of how relationships shape our brain, how our brain can be changed and how this directly impacts the therapeutic relationship. In this neurobiological system, emotion becomes the central element, and it is through the communication of emotion that attachment experiences organize the brain in the baby and it is through shared emotions and experience between patient and therapist that new neural pathways are structured. As a result, both therapist and patient can be transformed.

He develops a new concept of the mind, a mind that is both embodied and relational. The mind is seen as a complex concept that integrates interpersonal processes, body processes and the functioning of the brain. The process named, “mind” is localized in our bodies and in our relationships. In his theory, an embodied mind is a mind that deals not only with what happens in our head, but what happens in our whole body. And the mind is relational, because we live within our relationships and our connections with people shape our mental and emotional processes. It is a mind that emerges from the encounter with other minds.

Interestingly, he talks about energy. There is a flow of energy and how energy flows through our lives shapes our mental and emotional experiences. Information is a flow of energy structured in a pattern and the mind is the emotional embodied process that regulates this flow of energy and information. To him, our separate

bodies become connected as energy flows from you (a smile) to me (I receive it). Closeness would be a kind of resonance between two interactive systems. The brain is a social process and emotions are its fundamental language. Integration among the different parts is a key concept in his theory as from integration emerges coherence and harmony and when integration is impaired chaos and rigidity ensue.

According to Siegel, the specific clinical approach used becomes less important than the attunement of the therapist. Attunement becomes a key word as the unconscious, intuitive, emotional interaction becomes more important than the verbal interaction, and reparative enactments of early experiences co-constructed by therapist and client are fundamental to healing. In this approach, the therapist needs to access the right (emotional) brain to fully experience the client's feelings and his own feelings. The therapist must keep a right brain-to-right brain connection to create an empathic attunement but also a left-brain-to-left-brain one to make sense of the felt experience. Wallin, a relational psychoanalyst, talks of "binocular vision" needed from the therapist, who engages in contingent communication with the patient and at the same time must be in contact with his own inner states to establish new pathways in the patient's brain and increase his/her capacity for self-regulation. For us who work with the body, this is all good news. We can somatically attune to our patients through our somatic and emotional clues and decipher their somatosensory clues and respond to them. Siegel coined the concept "window of tolerance", as different for each patient, that refers to the intensity of emotion and charge a patient can hold without being dysregulated.

### *Allan Schore's Concepts*

To Schore, a neuropsychologist, the therapeutic connection happens through a "relational unconscious", where both unconscious (therapist and patient's) communicate. To be empathic does not only mean the patient feels better, it means to create a neural activating state. He was the first to connect right (emotion) brain to right brain connections, seen in infant dyads as well as therapist and patient dyads. Schore places emotion in a central place and talks about an "emotional revolution" in the psychotherapeutic field. Clearly Bioenergetic Analysis has included emotional work since its very beginnings but we know it was not the case for most therapeutic approaches. Schore's relevant contribution is the integration he makes of biological and psychological models developing a theory of emotional development and self-regulation in childhood that can be applied to psychotherapy. His research in emotional regulation has had a profound impact on the understanding of the therapeutic relationship. Schore's contributions have influenced many different fields such as affective neuroscience and trauma theory. His research has dealt with the effects of early trauma on brain development and, as I have said, he has provided us with a deep understanding of the neurobiology of attachment, which has had a deep impact on the therapeutic field.

### *The Impact of Neuroscience Research in Bioenergetic Analysis*

From this new perspective, there is a reunification of body and mind, the mind as a complex system that integrates the body. We do not “get out of the head” anymore but integrate it with the body:

“Now is the time to focus on the body that lives in the mind ... no longer are we a mind versus a body, but the mind and the body are one functioning as an intricately related system transferring information regarding somatic states and processing verbal and cognitive events.” (Resneck-Sannes, 2005)

Bob Lewis wrote of his important work on cephalic shock, “In classical Bioenergetics the head/brain/mind were seen as blocking our deeper, more vital experience and the therapy was structured to get one out of the head and into the body. In 1976 I initiated a paradigm shift in bioenergetics, a shift that included the head and mind/brain as co-equal in importance. (Lewis, 2012)

Angela Klopstech shows that Schore’s research highlights the role of emotion in change processes and the key role of relationships to shape neural processes and self-regulation capacities. To Schore, there is a therapeutic connection that happens through a “relational unconscious”, that is, all the processes going from right brain to right brain. With his research in self-regulatory emotional states, he sheds light on these implicit relational processes:

“The therapeutic relationship can alter the patient’s internal structural brain system that consciously and non- consciously processes and regulates external and internal information and thereby, not only reduces the patient’s negative symptoms but expands his or her adapting capacities”. (Schore quoted by Klopstech, 2005)

To us, bioenergetic therapists, it confirms what we intuitively knew, that there exists a somatic resonance that develops from the right brain hemisphere interaction between therapist and patient that is mainly unconscious. Schore applies his research on infant-caretaker right brain to right brain communication to the therapeutic process. We know now that emotional and body communication is a right brain to right brain process and this leads us to understand that much of the healing in the therapy process is unconscious. Resneck-Sannes (2002) exposes Schore’s contributions and also reflects on the crucial impact these findings have in the understanding of the therapeutic relationship.

“Early attachment experiences are encoded in the right brain, they remain there unsymbolized and are available through communicating with the body in relationship ... Mother and baby co-construct a relationship and

the mind develops in this relational matrix and the structure can be damaged without appropriate empathic resonance from the mother. To Schore it is the self-regulation process between mother and child the clue to attachment". (Resneck-Sannes, 111)

Schore's self-regulation theory outlines the importance of the non-verbal experiences between patient and therapist and the capacity of the therapeutic relationship to regulate affects. Exactly as it happens between mother and baby, the therapist, through the relationship, helps to regulate the patient's dysregulated emotional states.

"The empirical research on the caretaker-infant interaction challenges the notion of a therapist who is separate from the client and who can from body readings provide necessary therapeutic interventions by reading frozen function. We are in a relational matrix at birth and therapy is about the mutual effect of client and therapist on each other's bodies." (Resneck-Sannes, 112)

The research about the important role of emotions in therapeutic change has been significant and has produced a whole revolution in the psychotherapy field though this aspect has always been quite known to us as bioenergetic analysts. We have always known the power of emotional expression and regulation for change processes. Yet, emotion currently takes a central role in therapeutic change as never before in the history of psychotherapy. Now there is scientific evidence for the close connection between emotional arousal and depth of experience and how both are linked to the therapy outcome. The role of catharsis is revisited and re-defined and the impact of intense affective experience is validated: "therapeutic change results from bringing the full capacities of the cortical brain to intense affective experiences." (Resneck-Sannes, 39, 2005)

"Deep authentic affective experience and its regulation through coordinated emotional interchanges between patient and therapist are viewed as key transformational agents" (Fosha quoted by Klopstech, 120)

Klopstech takes on Schore's concept of "dual hemisphere regulation". Regulation is seen as an interactional process. She finds this process relevant for the non-verbal body-to-body communication between therapist and patient which is the essence of our way of working. He distinguishes between an interactive person-to-person and a non-interactive intra-person mode and emphasizes that good therapy involves use of both modes:

"Schore's regulation theory suggests that implicit mechanisms lie at the core of major change processes. "Implicit mechanisms" means the "limbic

attunement” between patient and therapist and the body and emotional interactions that happen unconsciously.”(ibid.121)

The concepts of arousal level and charge are redefined in Bioenergetics under the light of these new contributions. We know now that some arousal level is needed for neural restructuring in the limbic brain to occur. Greenberg, a relational analyst, believes that intensity, expression and reflection are major agents of change. Siegel defines a “window of tolerance” as the optimal frame for arousal to process emotional material. This window of tolerance can vary from person to person but therapists should find what falls into the window of tolerance for each patient. A patient feels dysregulated if what he feels or experiences goes beyond his/her window of tolerance.

Klopstech writes that neuroscience proves, that how much charge a patient can hold depends not only on his/her character structure but on how one relates to this patient in this precise context. We bioenergetic analysts have advantage in the field of regulation within the therapeutic window with our knowledge of body reading and character structure. We know how to create low and high arousal and how to work with it, she says. From this perspective, grounding a patient would mean bringing the patient into his/her window of tolerance. Klopstech advocates having the neuroscience and relational frames present.” She says, “Having this multiplicity of frames has made me a more effective therapist.” (ibid.122)

### **3d The role of empathy and somatic attunement in the therapeutic relationship**

This new understanding from neuroscience redefines key aspects in the therapeutic relationship. Now we know that relational processes are at the core of healing. Empathy and attunement become core concepts, like knowing the importance what we feel when we relate to our patients and how their emotional states impact our body and vice versa. Resneck-Sannes states that in classical body interventions, empathy, attunement and congruence are missing and it has been proven that they are crucial. She outlines the importance of empathy and attunement in therapeutic processes and the emotional regulatory task of the therapist:

“An empathic therapist is neither under-stimulating (too removed, neutral, not there), nor over-stimulating (not modulating the material to prevent the client from flooding, dissociating or splitting off).” (Resneck-Sannes, 48, 2005)

“Research has been showing for years that clients report that neither insight nor body interventions heal by themselves. I am not saying that our somatic interventions should be discarded. Quite the contrary, they must occur



in the context of an attuned, empathic relationship. This means that the therapist must no longer be separate from the client, but now must enter the room as a human being. (Ibid. 49)

What really matters now is the therapist's ability to engage in a real, empathic and attuned relationship with his/her client and there is a significant change of roles as we have already seen. The relationship is seen as a shared regulatory process of mutual growth where each element is affected and transformed by the other. The focus of what healing is has deeply changed.

"The healing that occurs is primarily by the adept therapist being able to read the somatosensory cues from his client and providing the correct somatosensory communication in return". The therapist's right hemisphere decodes emotional stimuli and responds empathically and this allows the psychobiologically attuned clinician to act as interactive regulator of the patient's dysregulated internal states. The therapist is not only reading the overt behavior and its external forms but, like a "good enough mother" is adept at reading the client's internal state. He/she uses his own somatosensory process to be aware of the state of the client and aids him in processing these states." (Ibid, 115)

Clauer reflects on empathy as an energetic-emotional resonance process:

"Feelings and posture patterns can also be conveyed in the psychotherapeutic treatment situation via the physical resonance processes of empathy, the embodied countertransference. I understand empathy in terms of sensitivity towards and feeling into the other person as a process of physical co-vibration or a coming into resonance with the non-conscious reality and the feelings of another person." (Clauer, 84)

### *Mirror Neurons*

Lewis takes Lyons-Ruth's term "implicit relational knowing", to describe what goes on in the empathic process, a process which happens out of awareness. Concepts such as "mirror neuron pathways" help us to understand the phenomena of empathy and body resonance as key elements in somatic transference and countertransference processes. The mirror neurons system allows us to read the mind of others through nonverbal clues. We perceive an emotional state in another person and the same emotion gets activated in us. They are taken into consideration by bioenergetic authors.

"Mirror neurons are necessary for our attunement but they may not be sufficient. They may help us to see into the mirrors (eyes) of our client's

souls but we still have to be able to tolerate what we see in their mirror. What these neurons support is our “implicit relational knowing” ... they help us to listen to what comes to us intuitively in fleeting images, body sensations or sentences. I called this “listening with the limbic system ... I learned to quiet my mind and listen to my hands. They quite often knew where and how I should be touching my patient before I did.”(Lewis, 2012, 121)

“Mirror neurons recreate the experience of others within ourselves, allowing us to put on the shoes of another person and thus experience empathy. They are located in the premotor cortex and are connected to the limbic system, the brain’s emotional region. When my mirror neurons fire in reaction to my patient it triggers empathic emotions or limbic resonance in me”. (Klopstech, 2008, 131)

### *Lewis (2005) on empathy, implicit and explicit memory*

Lewis sees the therapist’s body as a crucial instrument for change. To him, we are empathic when we respond to the patient’s needs and when we receive the projective identifications of our clients. Lewis talks about implicit and explicit modes of knowing which take different neural pathways. We know that implicit memory is the emotional and procedural memory out of awareness and explicit memory is conscious organized information.

He proposes a dyadic, non-linear systems view of therapy, where each member of the dyad is seen as both simultaneously regulating itself and the interaction. He quotes Fogel, “In a systems model, all behavior is simultaneously unfolding in the individual while at the same time each is modifying and being modified by the changing behavior of the partner”. (Lewis, 11)

To Lewis the therapist’s body is an essential tool, “we ourselves are the unique instruments that attune to the other’s psyche and soma”. He quotes Schore, “The attuned, intuitive therapist, from the first point of contact, is learning the moment-to moment rhythmic structures of the patient and is relatively flexibly and fluidly modifying his/her own behavior to fit that structure”. (Ibid, 17)

The important evidence from neurological research, Lewis states, is that traumatic experiences from the first years can be accessed implicitly on a body level. He stresses in many of his writings that we must not forget we are wounded healers and how from this basic wound we have limitations and strengths in our empathic contact with our patients.

As somatic therapists we are trained to be aware of our internal body processes, we are aware of our muscular tensions and our somatic signals show what’s happening in our own and our client’s bodies. In a therapeutic process there will be moments of attunement, moments of impasse, moments of disconnectedness

and ruptures, but the important fact is the reparation. If we can repair the broken bridges, through empathy and attunement, the process will go on. Schore uses the concept of disruption and repair, which is extremely important in psychotherapy but also in all relationships.

“Breaks in attachment activate the therapist’s limbic system which produces a somatosensory resonance throughout his or her body. Somatically trained therapists are taught to focus on the information from their own bodies and to use the data to examine the relational qualities of engagement and disengagement occurring in therapy. (Resneck-Sannes, 116)

T. Warnecke, a body therapist, provides us with a description of the complex process of somatic transference processes, phenomena that ranges in a continuum from empathy and attunement to intersubjective processes, re-enactments and transference issues at the other end of the continuum:

“Two people meet and two sensory motor systems and two autonomic nervous systems begin to respond, relate and interact. Somatic transference is facilitated by limbic resonance and by our sensory motor system ability to feel movements, postures and affect states observed in others. Mirror neurons form part of an action resonant system that evokes neural motor representations by movement observation (Pineda). Mirroring is a pre-reflective, intuitive and spontaneous process. Kinesthetic and limbic resonance enables us to co-experience and assess the intentions of others and form the basis for inter-personal phenomena such as empathy, resonance, bodily synchronicity and transference.” (Warnecke, 234)

## **4 Implications for Psychotherapy**

The patient’s and the therapist’s somatosensory emotional experiences meet and get affected in this intersubjective field. The body of the therapist becomes a central tool that resonates with the patient’s internal states. Resneck-Sannes explains this change in Bioenergetics:

“The focus is shifted from the client as a pathological character to the mutual influence of client and therapist on each other’s states of physiological arousal, desire for contact and intimacy and mutual regulation. It confirms our experience that instead of being a neutral observer who can read frozen function, two bodies are in the room together who by touch, mutual gaze, and words, set up a resonance. Implications of infant research state that our attention must be directed to our internal somatic states ... the therapist at-

tends his own somatic experience and uses this information to understand what is happening interpersonally.”(Resneck-Sannes, 116)

Bob Hilton talks extensively about this shift from the initial idea that the body heals itself if tension is released and emotion facilitated by physical movement is expressed, to the idea that without excluding the initial one, the relational dynamics between therapist and client are crucial aspects for the healing process:

“The therapist and client eventually create an I-Thou relationship wherein each is taught and renewed as a whole person by the other. The therapist in this process is constantly attempting to integrate the interpersonal self-needs of the client along with his own limitations to meet those needs. As the therapist accompanies the client on his journey back to the origins of his interactional failures, the therapist must know and understand her own relational failures and the solutions she sought for them. This dynamic interplay and all that is implied in it becomes the healing process for both therapist and client.”(Hilton, 42, 2000)

This creates a significant shift in the therapist’s role when what really matters is his/her capacity to attune to the body/emotional movements in the client and his/her capacity to be empathic and respond to them. Resneck-Sannes expresses this shift:

“Attachment theory showed that what mattered most was the therapist’s capacity for emotional attunement – the ability to hear, see, and sense the client’s verbal and nonverbal cues in a way that the clients felt genuinely seen and understood. Attunement or “contingent communication” as Siegel names it is a highly complex interpersonal dance between two systems” (Resneck-Sannes, 45)

Somatic attunement, necessary for infant attachment and for any therapy process becomes a key concept. The healing role of the relationship in psychotherapy takes central stage and much of it is an unconscious process. The therapeutic connection happens, through Schore’s “relational unconscious”. From this new perspective, the therapist’s role is evolving deeply.

“The therapist needs to be attuned so that the material is within the “therapeutic window. We then become the mirroring, empathic, attuned other that will begin to live inside our clients body/mind and support them in being vulnerable, needy, scared, angry”. (Ibid, 48) Somatic attunement becomes crucial to process emotional material. “Our knowledge of breath, of grounding, of ways to form somatic and energetic boundaries and our

knowledge of affect containment enables us to be sensitive to flooding ... body interventions are necessary but not sufficient for healing, they must occur in the context of an attuned, empathic relationship.”(Ibid, 48)

## 5 A new view of the body: the Relational Body

Klopstech (2009) provides us with an interesting historical overview on the issue of the body in therapy. From Freud privileging language over body to Reich developing a model of body/mind interaction that was expanded by Lowen, how do the new paradigms affect the view we had of the body?

The body finally comes to the stage in the psychotherapy field due to the central role emotion takes in the new paradigm, the body as a depository of emotions. The relational-neurobiological paradigm has affected too the view we had of the body in bioenergetic analysis, it is no longer a body which has to be analyzed but two related bodies in a co-created dance where two subjectivities meet and impact each other.

“In addition to the traditional focus on the more fixed and defended characterological body, the focus is now equally on the bodily experience in the immediate interaction in the therapy dyad, the body “in action” within the interaction, the body in the present moment, the communicating and interacting bodies of patient and therapist in the therapeutic dyad”.(Klopstech, 19)

The concept of the relational body takes space. Intersubjectivity is not only about two minds, but about two bodies. Siegel and Schore highlight the role of emotion and because of this, the emotion-expressing body takes a prominent place. It is not a single body anymore but a body in relationship. Klopstech’s clearly expresses the shift in our perception of the body:

“The body in modern psychotherapy needs to include the objective physical body with its emotional and energetic dynamics, with its history and character structure but it also needs to be viewed side-by-side with the subjective and intersubjective body that allows for communication, co-creation and enactment and there needs to be room for the interactional body (the body in action and inter-action). The complexity of multiple bodies is awesome and we need to select which is our comfort zone” (ibid 20)

Despite the body taking more space in the therapeutic field, Resneck-Sannes provides a useful reflection about the limitations of neuroscience research as neuroscience has worked a lot with face-to face and eye-to eye contact, but there is

little mention of holding and touch. Instead, the emphasis is placed on mind-to mind interactions and little importance is given to what happens below the head. An important contribution in the bioenergetic field is Vincentia Schroeter's recent article (2016) where she explores bioenergetic techniques from a neuroscience point of view with the entire body working with the nervous system.

“While the emphasis has been to mobilize the organism away from defensive, destructive processes and toward emotionally healthy processes, it is polyvagal theory that sheds light on the inner workings of the nervous system in a way that helps us understand more deeply the mechanisms of defense and healthy emotional communication on a body level.” (Schroeter, 12).

Margit Koemeda-Lutz (2012) synthesizes well the complexity of our present moment, complex, exciting and challenging at the same time:

“Integrating brain mind and body means to perceive our clients and interact with them on several different levels, most of them beyond our conscience. There are biochemical, cellular, behavioral and psychological changes in each of the participating organisms involved. None of these levels is more essential than any of the others. Processes on each of these levels influence each other, bottom-up and top-down and evolve parallel in time. Most perceptions are processed unconsciously and our nervous system initiates or triggers many psychic and somatic reactions without our awareness.”(64)

## **6 Clinical Vignettes**

These brief vignettes show some of these new concepts in action taken from different therapy sessions.

### **1. Vignette**

L. comes in excited and ecstatic at the prospect of visiting her new boyfriend who lives in another city. Her face and body look really alive. I feel a sensation of warmth and a feeling of joy coming to my chest (empathic attunement) as this relationship is the outcome of a deep process to heal a wound by an abusive father. She feels happy after having endured a long gloomy period. We both share in her aliveness and I try to help her to ground it having her feel her feet and legs and feel the breath in her chest going down to her pelvis and we breathe together and share this moment of bliss. In the next session, after the meeting with her new

boyfriend went well, she comes in anguished and afraid. She feels her emotions are too intense, she is quite afraid to let her heart be opened and get hurt. The result is anxiety and fear of not being able to hold all this intensity without feeling lost. I sense her anguish in my chest and I intuitively feel that working with breathing and contact will help her ground and contain this dysregulated state to move to a more regulated inner place. We have built a good therapeutic alliance and I try to touch her with my words and I propose to her that we have physical contact with her feet on mine while she breathes. She agrees and little by little her breathing gets deeper and calmed and she regains a place of inner self-possession she had lost. She leaves feeling more relaxed and understanding what caused her to feel dysregulated. I feel relief and relaxation in my back.

## 2. Vignette

N. stays hieratic (immobile) in his face and body and keeps his immobile eyes fixated on me. When he talks, his cheeks and mouth are almost frozen, and his eyes are tight, hieratic and fixed. Often, at the beginning of the session, I have an awkward sensation, a tension in my chest and a feeling of being invaded by his penetrating look that often dysregulates me. His voice is monotonous, flat, with no emotional quality in it. I do not find him an easy client and I often feel tension in my back as I do not feel completely safe. Somehow, I have to keep on guard. My somatic countertransference gets easily activated. I can go from feeling empathy to feeling really irritated as many times, physical movements are mechanical and useless. There are times I have the fantasy of shaking him as he leads me to visit a place of impotence inside myself. This correlates with the same impotence he feels toward making any movement in his life towards a different direction and toward an embodied movement in the therapy session. He feels a permanent dissatisfaction in his life, in his job, in his relationship and, obviously, in his therapy with me. He is unable to make any movement in his life towards a more satisfactory position and sometimes, I feel countertransferentially trapped in his immobility. Creating a mutual bond is not an easy task but quite a challenging process where we move in an often disharmonic dance of coming a little closer, (he is less tense and more open), followed by a disruption (he withdraws from the contact) that leads us apart. I feel him distant and I haven't found yet how to create a bridge to his steel-armored chest. He rarely feels or expresses an emotion and often goes back to the fortress in his head. Nevertheless, we both try to go on with all this complexity. Sometimes I can feel a little closer, I breathe and relax a little, other times I am unable to contact him, to find even a little fissure to approach his fortress. I use my somatic attunement, an empathic attitude towards this shocked little boy who saw his father threatening his mother with a rifle, and with my eyes, a soft and calm voice and body posture, I try to send him

the message that he is in a safe place and I am not going to damage him while we try to go on.

These vignettes are small examples of how embodied processes of transference and countertransference interact, how bridges can be built, how they can get broken or damaged, and the most important part, how we, as therapists, use our somatic and empathic attunement in our attempts to repair those broken bridges.

## **7 Conclusion**

We have made a long journey and the process continues. The bioenergetic view of the therapeutic relationship and its transference/countertransference processes has been transformed and expanded by the impact of these new concepts and theories without losing what defines us. We cannot see the patient anymore as only an energetic system whose blocks must be released. We know physical blocks are the manifestation of repressed emotions and we find it is crucial working with them, but it is the way we deal with them that has changed. From this new perspective, we do not see the patient as an isolated energetic system but we see patient and therapist engaged in a somatosensory intersubjective system mutually affecting each other and getting both affected and transformed by it. The role of the therapist is to help the patient regulate his/her inner states through the relationship and also be regulated by it. For patients with early pre-verbal issues, focusing on somatosensory cues can be extremely helpful and sometimes, the only possible way. We can now consider our bioenergetic tools and understanding validated by research. We know now how our work in an embodied relationship can change a person's neural circuits, his/her perceptions, emotions and position in the world. We have known for a long time how emotions can be contained and regulated through physical contact in a therapeutic relationship, now we have scientific research that validates our understanding.

Transference and countertransference involve all those somatopsychic interactions that we already know but within an intersubjective field that happens in the here and now of a real relationship. We need to learn more about how we as bioenergetic analysts can use our own body and emotions as therapeutic tools to resonate with our client's bodies and emotions. As Bob Lewis says, we need to recognize more these subtle body messages that many times go unrecognized. We have come a long way and it is not finished yet, from the single body to the relational body, from body structure to bodies in resonance. I have taken you on a journey that now reaches its end, from the contributions of bioenergetic analysts to the theme of the therapeutic relationship and its transference/countertransference processes, to the contributions from the new theories and their impact on Bioenergetic Analysis. I hope you have found it useful.



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