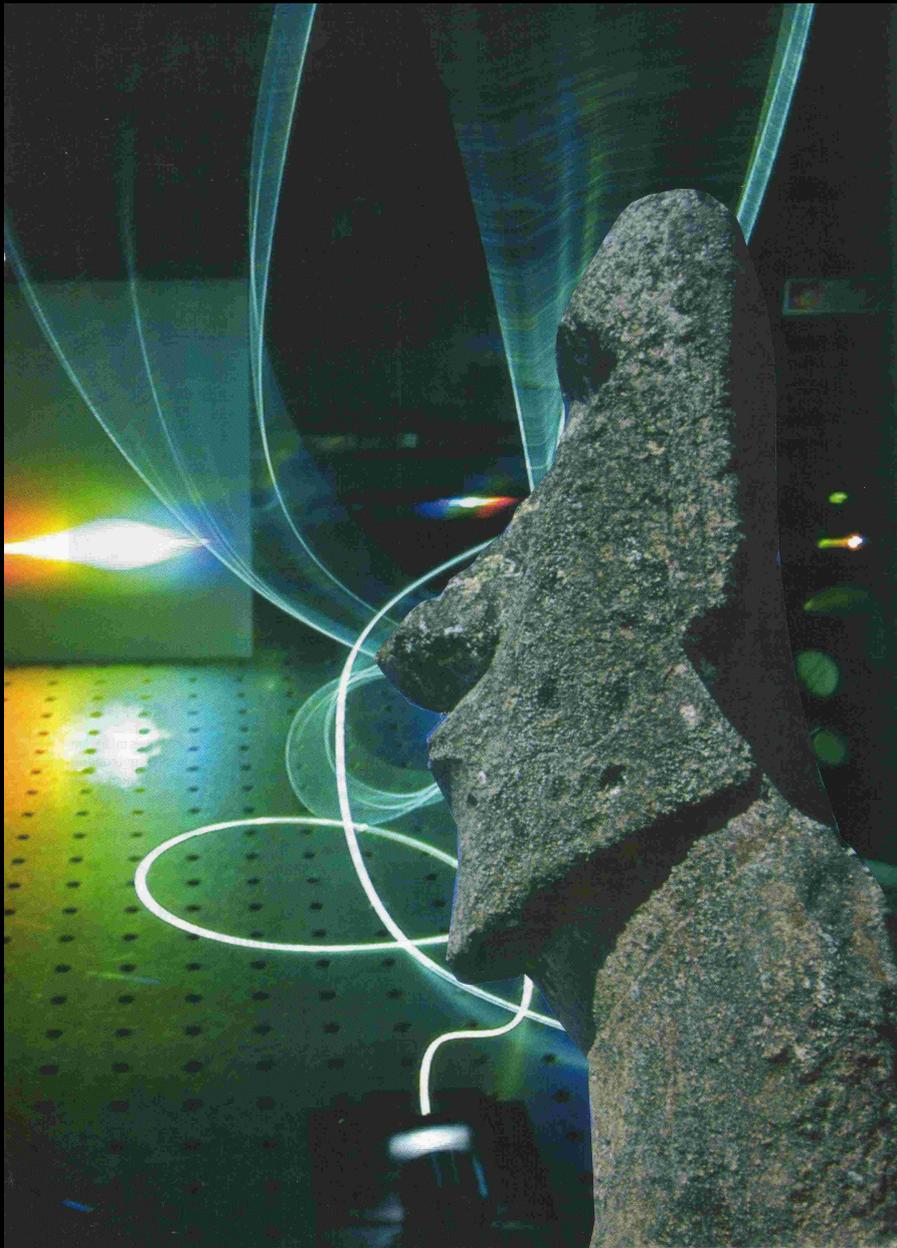


# **Paradigms for Bioenergetic Analysis At the dawn of the 21st Century**



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## INTRODUCTION

When he founded bioenergetic analysis half century ago, Lowen initiated a movement of a great amplitude. His personal charisma was an important factor. He also benefited from a vast sociological movement, in the Western hemisphere, that was seeking body experiences, expression and freedom. Back in those days, the hippie era was in full swing, all kinds of personal growth experiences were being made at Esalen, the development of humanistic psychology, a “vitalistic” orientation in psychotherapy was picking up speed. Bioenergetic Analysis was moving at the same time towards international expansion. It was seen as a form of psychotherapy, but it was also considered to be a preventive approach and a way to foster healthy life habits, in particular through “bioenergetic exercises”.

But what is happening today?

The “need for vitality” is still strong. But in our contemporary world, where brain imagery graphically reveals healthy vs. pathological processes, we, bioenergetic therapists, must demonstrate the relevance of our therapeutic practices. Lowen was not inclined to promote scientific research. He once wrote to me: “There is no need to justify: clinical proofs are enough”. Often times, the perception people from outside have about Bioenergetic Analysis is a simplistic one: “crying, hitting, screaming”.

We all know that Bioenergetic Analysis is much more than that and we must continue to build from the legacy of its creator:

- we must modernize or actualize its basic concepts while taking into account the present state of scientific research in the fields of neurobiology and psychophysiology;
- we must integrate in our reflection the various developmental theories of the child and the adult that have been clinically and experimentally confirmed ;
- We must take into account the evolution of psychopathologies and the necessary evolution of Bioenergetic Analysis methodologies:
- We must take into account the evolution of the needs of our populations with regards to public health, while knowing that sociological and geopolitical contexts marked by growing problems of violence and social inequities demand that we become creative, which may mean getting out of our offices. Our Brazilian members are proposing stimulating models with regards to that.

At the dawn of this 21<sup>st</sup> century, all of this demands of us that we stimulate an adjustment of our paradigms, a renewal of our Bioenergetic Analysis theoretical model. Our credibility, our “readability” (*Note of the Translator: "readability" in the sense of "aptitude to be understood by others"*), as well as our efficiency is on the line. But even more important than that, it is the very identity of Bioenergetic Analysis that is at stake, that on which we found our common identity, that which enables us to see ourselves as bioenergetic therapists and that which gives the International Institute for Bioenergetic Analysis a shared meaning.

## OUR HERITAGE: BASIC PARADIGMS IN BIOENERGETIC ANALYSIS

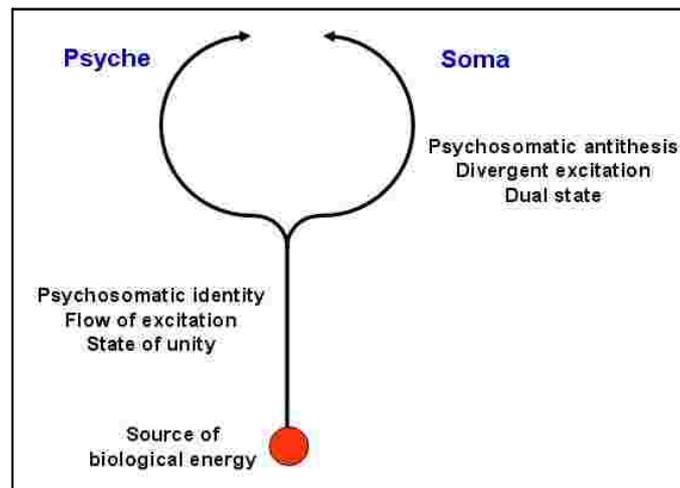


I would like to underline the essential paradigms Lowen bequeathed to us as a model for bioenergetic analysis. They are the major concepts (theory) defining the clinical models (therapeutic practice). They are those that I learnt during my training (1978-1981).

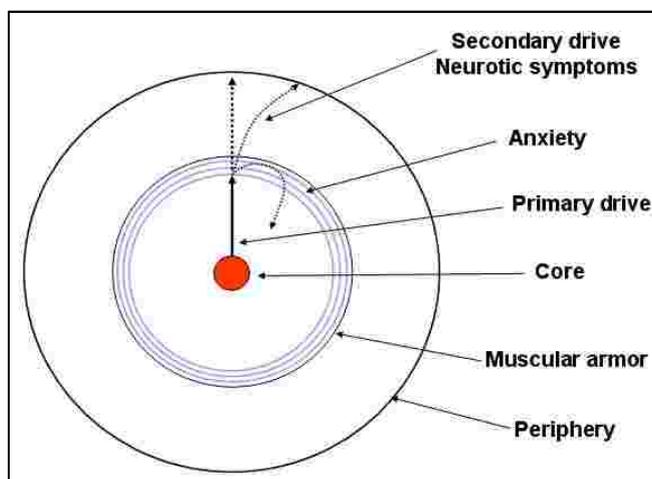
### Paradigm 1: psychosomatic functional identity

In “the Language of the Body” (1958), Lowen reaffirms the paradigm “of psychosomatic functional identity”, as stated by Reich:

- 1) The biological aspect is: energy is the *functional* common denominator for psyche and for soma;

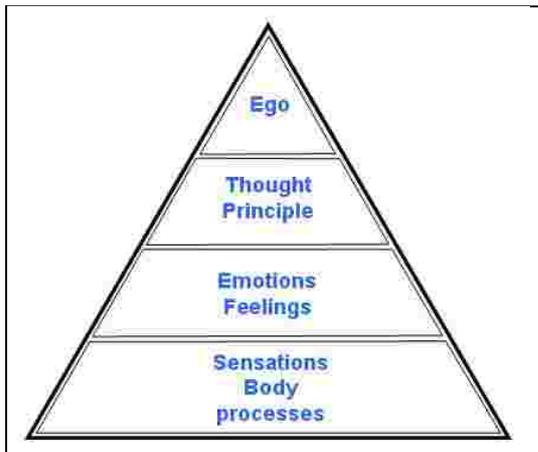


- 2) The defensive aspect is: when energy is blocked, it is by two *functionally* identical mechanisms: muscular tension and rejection of the neurotic psychic representations;



- 3) The clinical aspect is: these two mechanisms *functionally* inhibit emotional expression.

### Paradigm 2: the Self is a mind-body continuity

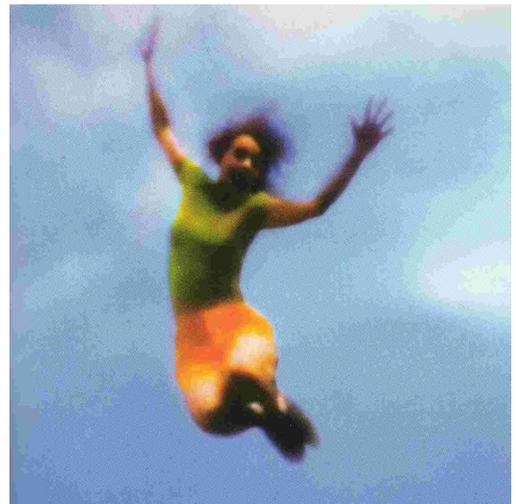


In his first monographs, Lowen uses the concept of Self (1965, 1968). He uses it again in “Narcissism” (1985). The Self is defined in terms of psychosomatic continuum: it includes the body experiences (feelings, emotions, movements) and the psychic experiences (perceptions, images, representations). He says, “we have a dual relationship with our body. We can have direct experience through our feelings or we can have an image of it” (pp. 29-30). Self is defined as mind-

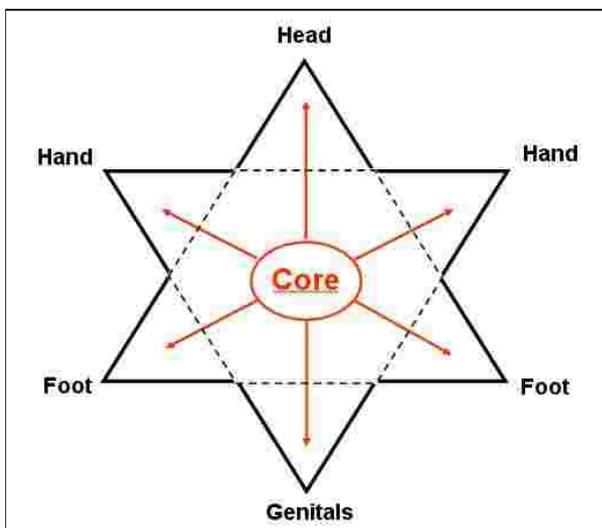
body continuum.

### Paradigm 3: finality of the Self is spontaneous expressivity

Lowen based the practice of bioenergetic analysis on the awakening of self-awareness: through motility, movement and expression. In one of its first monographs (1965) Lowen comments: “The self-awareness means (...) to feel the flow of feelings which joins the fact of breathing. While passing in the body, respiratory waves activate all the muscular system (...). Being entirely alive means to breathe deeply, move freely and feel fully”. The expressivity of oneself is related to a person’s degree of energetic charge.



### Paradigm 4: the therapeutic model is character analysis



Spontaneous processes can be blocked. In Bioenergetics (1975), Lowen clarifies the pathogenic diagram: “Lead to pleasure → privation/frustration → anxiety → defensive reaction”. He adds: “It is a general outline explaining all the problems of personality” (p.120). The sexual etiology of problems of personality is posed as well as the therapeutic method: freeing the repressed sexual instincts being opposed to vitality, expression and

pleasure, by releasing muscular tensions which are at the origin”.

This method is called ***character analysis*** which combines verbal and body processes:

- 1) body process in order to release the muscular tensions,
- 2) verbal process in order to understand the significance of the representations at the origin of the conflict.

### **Reformulation of the paradigms and new paradigms**

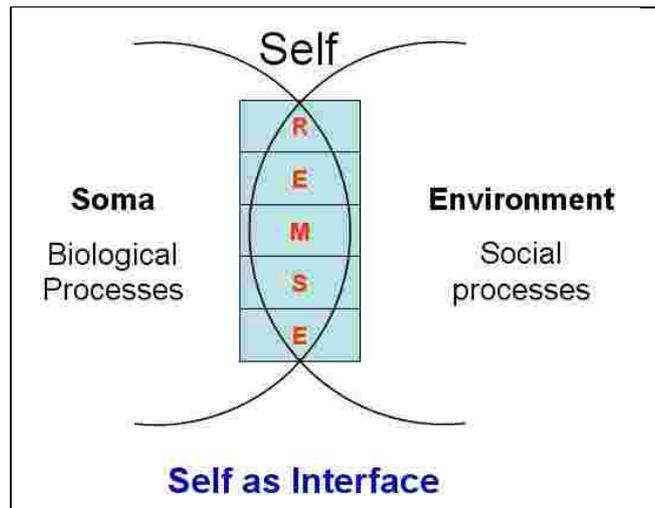
I will try to formulate those paradigms in a language that would not be understandable only within our bioenergetic community, but also understandable and attractive for our colleagues from other analytical and psychotherapeutic fields, for our colleagues from Universities, and for researchers. I believe that doing this effort is essential if we seek a new expansion at the dawn of this 21<sup>st</sup> century:

- 1) Reformulation of the concept of Self: this concept is still relevant and is shared by almost all psychotherapeutic approaches;
- 2) Reformulation of the energetic dynamics of the Self: his adaptive motility, his sexual motility and his attachment motility;
- 3) Formulation of the working methodology of traumas differentiated from the methodology of character analysis;
- 4) Formulation of a therapeutic relationship model giving a major role to the psychotherapist's intersubjective involvement;
- 5) Finally, I will propose a sociological paradigm for bioenergetic analysis, based on the principle of *shared vitality* for a *shared world*.

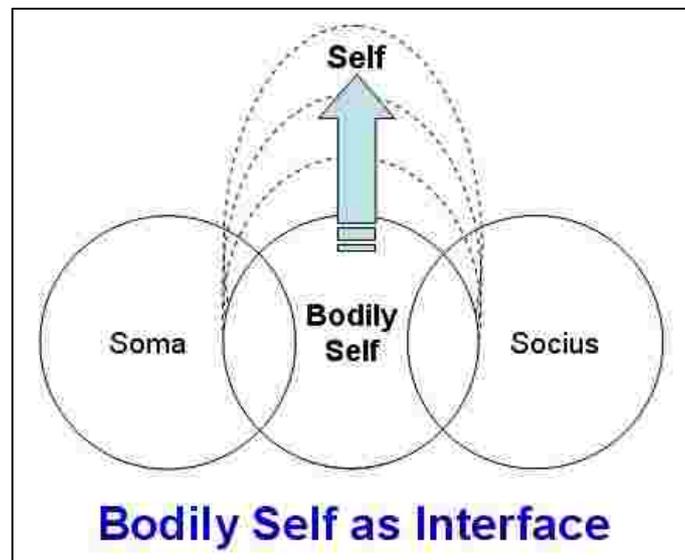
## PARADIGM I THE SELF, A BODY-MIND CONTINUUM

### The Self as an interface

The Self is an interface between the biological and the social. It is built with cross biological processes which substantiate it and interpersonal processes which make it subjective. The Self is the phenomenological place of convergence between instinctual and sociocultural phenomena.



The bodily Self is the first manifestation of the emerging Self. It is the first subjective reality of the Self and the foundation of development.



For example, the infant's sleep regulation as well as his feeding, physical and emotional expression regulation, are immediately subjected, on the one hand, to hereditary neurological mechanisms, and on the other hand, to the subjective social norms of his/her parents.

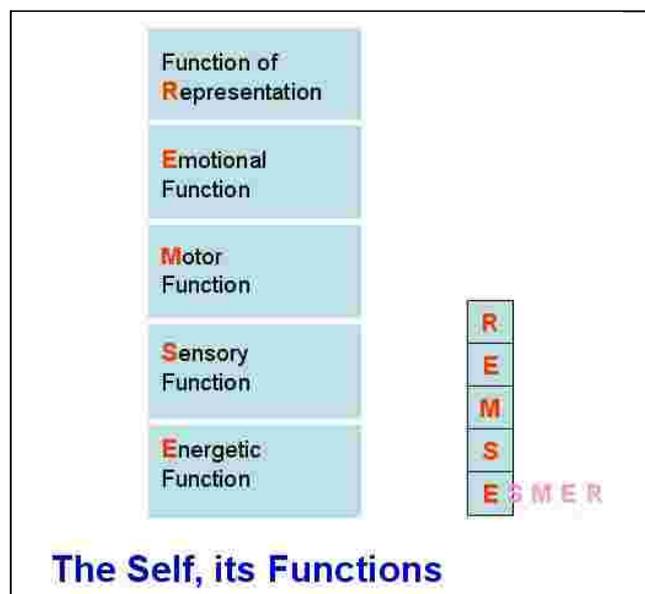
Blake (2002) shows that, conversely, these first social modelling modify neurobiological somatic processes: they cause structural and functional changes in neuronal connections. Concretely, the emotional experience modifies hippocampus cells, most sensitive to the emotional experiences,

and they improve the effectiveness of synapses. On the other hand, working with attachment modifies fronto-limbic circuits, implicated in the patterning of “sensitivity”. As Jeannerod (2005) demonstrates, this stimulates the emergence of new behaviours. For Kandel (2001), this constitutes the permanent dialectical process of exchange between soma and social, stimulating the neuronal “plasticity”, that is, in its turn, transformative of the Self.

We, bioenergetic therapists, are specifically dealing with the patient’s bodily Self. This bodily Self is an energetic reservoir where instincts are transformed into socialized, regulated drives which are the source of motility.

### Functions of the Self

So, how to redefine the concept of Self? The Self is defined as a functional whole made of the co-integration of five *functions*: the energetic function, the sensory function, the motor function, the emotional function and the function of perception/representation.



Each function of the Self supports the other. The variations which occur in one of the functions of the Self cause variations in the whole, like a moving wave.

*The energetic function* is the seat of quantitative variations in excitation. Those variations stimulate the motility and vitality of the Self, through pulsations and vibrations. The modulation of energy flows produces phenomena of activation/deactivation. They are regulated by biological needs and patterned by family environment.

*The sensory function*, through its qualitative manifestations, plays the role of primitive consciousness. Its expression is regulated and modelled by the family environment: for example, both pain and pleasure are subjected from the start to an expressive, approving/disapproving regulation.

*The motor function* has a double function. Through the adjustments of postural tone, it gives the Self the sensation of having a “tonic envelope” or conscious “boundary”. Through the adjustments of its muscle tone, it prepares the Self for action and expression. Motor function

supports the construction of patterns of action as well as postural patterns specific to a person, which are both shaped by interpersonal interactions.

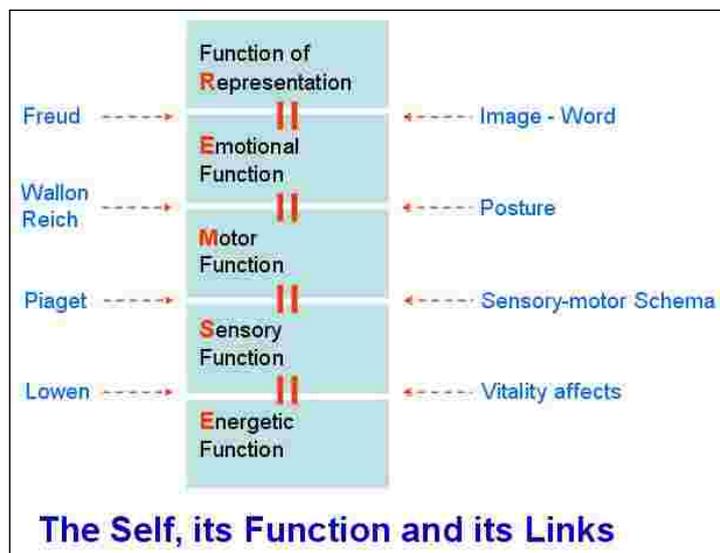
*The emotional function* plays a role in expression and subjective communication with the social environment. Through its emotional bodily manifestations, it plays a cathartic role in the regulation of the Self. Through its affects, it contributes to the psychic elaboration of cognitive information.

*The function of representation*, through its system made of images and linguistic signs, gives a meaning to the energetic, sensory, motor and emotional experiences. It encodes and symbolizes them, making them communicable. It ensures the capacity of the Self to think and reflect upon oneself.

Each of these functions participates in self-consciousness, from the most elementary level (vital sensation of physical existence) to the most complex level (awareness of having a spirit of one's own). However, the integration of the Self depends upon the links that are built between those functions.

### The links between the functions of the Self

The first half of the 20th century opened up a new fields of research, which brought clarity to the specificity of each one of the links connecting each of these functions, as well as their process of "subjectivation" (*process by which the experience becomes subjective*): Freud (1887-1902; 1915a; 1915b; 1926), for the link between affect and representation; Reich (1933) and Wallon (1934), for the link between emotion and motor function; Piaget (1936) for the link between motor function and sensation and Lowen (1965, 1968, 1975, 1985) for the link between sensation and energy.



*The link Self - ground* - constitutes a primitive system participating in the regulation of the energetic functioning of the human organism. This is the principle of "grounding" developed by Lowen (1958). However, before the baby meets the ground on which he will stand and to which he will be connected, it is in the body of his mother that he will initially ground.

*The energetic-sensory links* manifest through affects of vitality. It was Lowen's fundamental theoretical and methodological contribution during the 20<sup>th</sup> century. It focuses on motility of the Self, energetic circulation and sensory awareness. The work on breathing holds an important place in this contribution.

*The sensorimotor links*, as was demonstrated by Piaget, manifest through the elaboration of sensorimotor schemes. Many “bioenergetic exercises” proposed by Lowen involve the elaboration of sensorimotor schemes that facilitate self-assertion through regulated and coordinated action.

*The emotion-motor function links* manifest through postural and behavioural patterns as Reich and Wallon have demonstrated during the same period of time, Reich in relation with the adult and Wallon in relation with the child. Lowen has developed other “bioenergetic exercises” that facilitate the expressiveness of the Self, particularly through the use of movement and emotional expression.

*The emotion-representation or affect-representation links*, theorized by Freud, manifest through cognitive representations (close to perception) and through fantastical representations (by-products of imagination). Those representations coexist, consciously or unconsciously, and constitute the contents of the mind. They are the subject of verbal analytical process.

These links between the various functions of the Self are conducive to the *integration of the Self*.

Motility and integration of the Self are being expressed at three levels:

- at the level of adaptive motility
- at the level of sexual motility
- at the level of affective attachment motility.

Starting at 2 years of age, the Ego progressively and essentially will have to co-integrate and co-regulate the adaptive, sexual and attachment motilities.

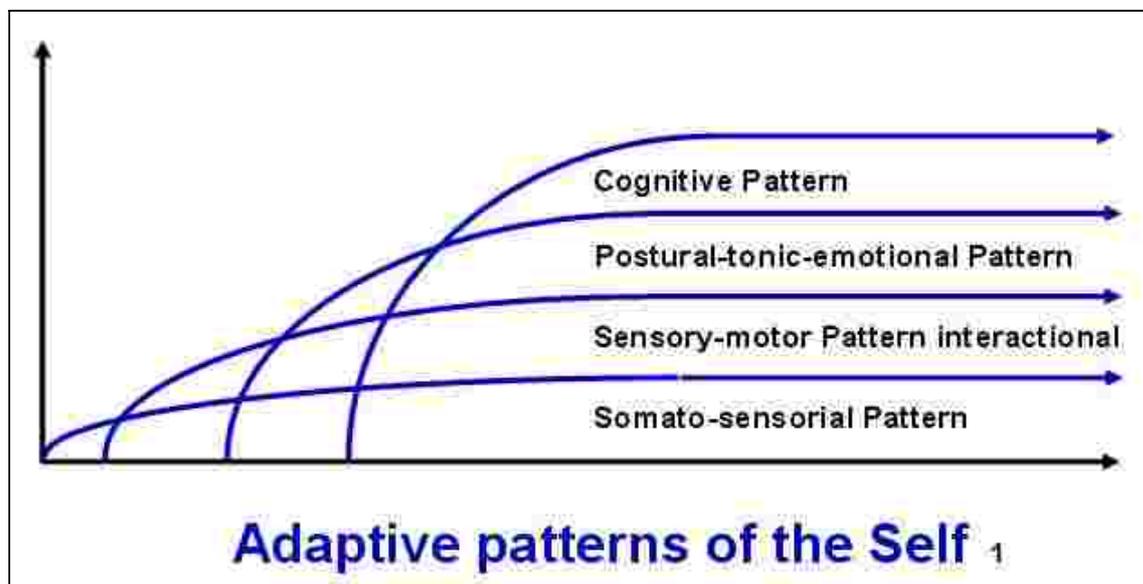


## PARADIGM II

### ADAPTIVE MOTILITY AND ITS PATTERNS

Throughout life, the Self is constantly obliged to adapt to external reality and to its modifications. In order to accomplish this, it counts on its life preservation instincts, as Freud, and later Lowen, have emphasized. Those instincts become the adaptive motility of the Self as it engages the environment on various levels: domestic (*Note of Translator: in the sense of "family"*), cultural, ecological.

The function of adaptive motility is to maintain the Self in a state of homeostatic vitality (a vitality that is energetically regulated) and in a state of perceptive consciousness (of itself and of the environment). It progressively organizes itself into adaptive patterns:

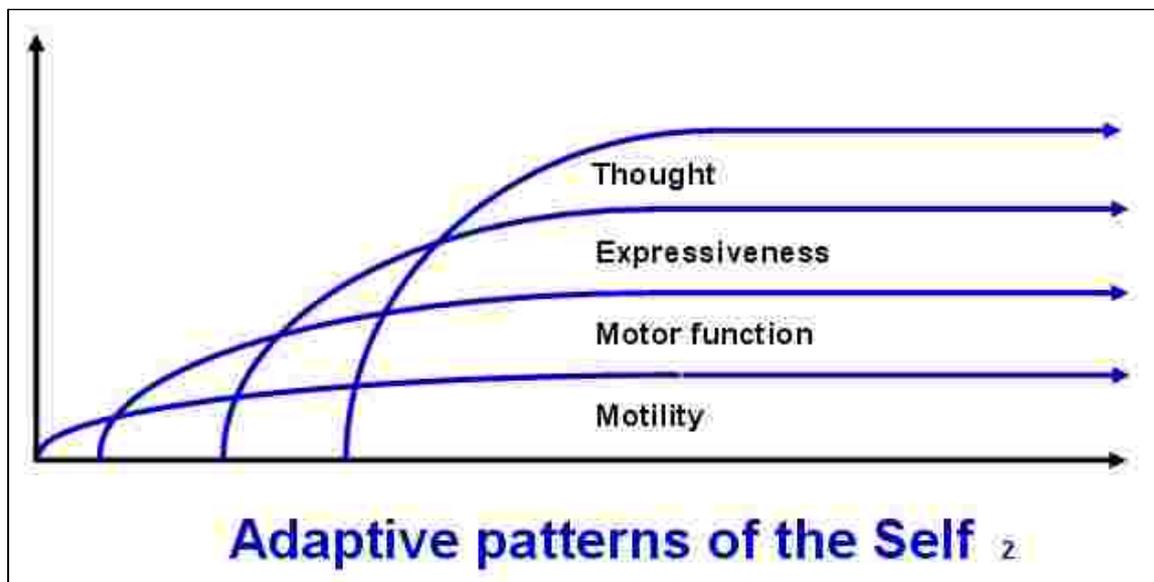


*Somatosensory patterns* organize and regulate the motility of the Self: sleep/awakeness, activation/deactivation, pleasure/pain, activity/passivity, expression/inhibition patterns, as well as multiple other configurations of vital expression. They are essentially coded in procedural memory but can be retrieved within the therapeutic context when bodily processes are emphasized, like during a piece of work on breathing or on sensory awakening. ***Those patterns ensure permanent regulation of the vital existence of the Self.***

*Sensorimotor patterns* are built on the usual sensorimotor schemes and they organize the motility of the Self. Very early on, they are permeated with affect and according to Bowlby's expression (1969, 1973, 1980), they become "Internal Operative Models" (IOM) that organize attachment and interaction behaviours. Those IOM are encoded in procedural and episodic memories and are apt to be retrieved in therapeutic contexts that facilitate their evocation. The more presymbolical the IOM, the closer a context to the initial coding context will be needed in order for it to be recalled, which supposes a sensory, affective and motor activation. ***Internal Operative Models ensure a regulated permanence of the interaction.***

*Tonic-emotional postural patterns* are built out of expressive interpersonal interactions and they organize the expression of the Self. For Wallon (1934), they have a socializing value: they communicate the affective experiences of the Self to the environment. For Reich (1933), they have a biological function: they express pleasure/displeasure of an instinctual/sexual nature. Finally, for Ainsworth (1978), they support a behavioural function that manifests itself by secure/insecure "attachment patterns". In all cases, *those tonic-emotional patterns play the role of invariant affective expression of the Self*.

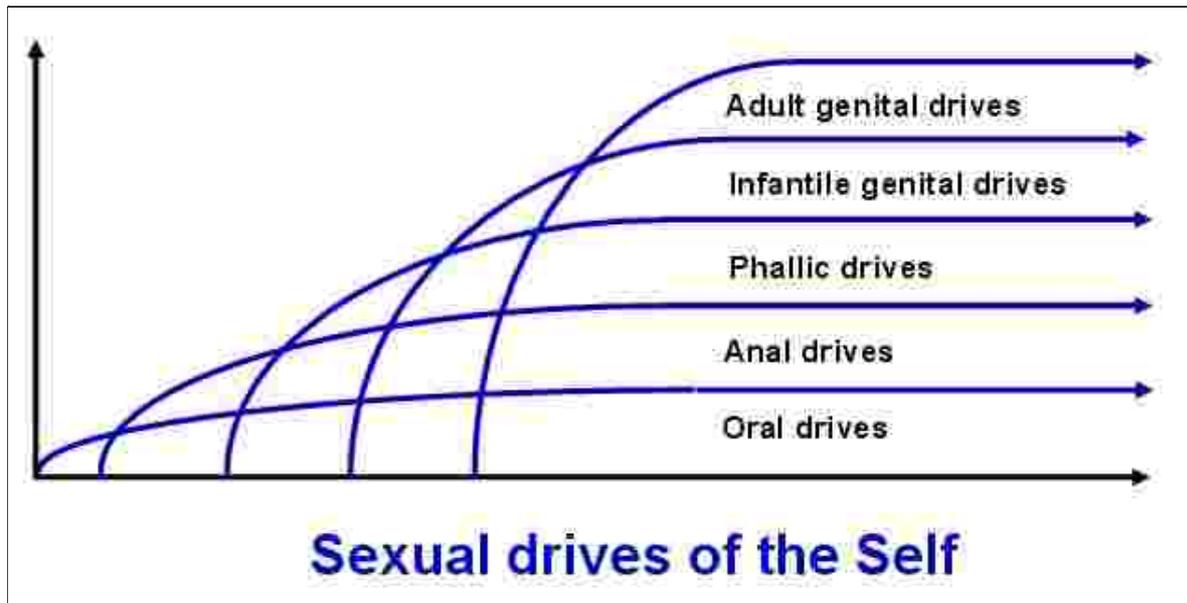
*Cognitive patterns* are built from perceptual images of self and of the surrounding world, both physical and human. They suppose mind processes and affective processes that facilitate adaptation to the environment. *They play the role of semiotic invariants (through images and words) within the Self*.



Those various patterns are adaptive because they continually activate motility, motor function, expressiveness and thought in a regulated, homeostatic way, nourishing what Damasio calls "The feeling of what happens" (1999).

## PARADIGM III SEXUAL MOTILITY AND ITS PATTERNS

We are used to a model based on sexuality in Bioenergetic Analysis and I will be brief regarding this. On this matter, Lowen (1958, 1965, 1968, 1975, 1985, 1989, 1990, 2004) was Freud's (1905), then Reich's (1933, 1940) heir. We usually describe sexual motility in terms of oral, anal, phallic, and genital impulses, first infantile, then adult genital drives.



Following Reich's footsteps, Lowen has demonstrated how each type of primitive drive is operating on a body level: their energetic dynamics in a particular part of the body that turns it into an "erogenous zone".

It may be useful to mention that in a child, the activation of erogenous zones is closely related to mother-child interactions, hence to a mutual attachment relationship. A lack of or an excess of erogenization of the bodily self of the child has direct consequences on the organization of its sexuality, both present and future. A lack of erogenization (erogenic body sensations) can lead to erotic compulsion (sexual compulsion) as if it could bring erogenic sensations and fulfill that need.

From this point of view, *the experience of attachment (conflictive/traumatogenic attachment) during childhood determines adult sexual patterns*. Conversely, the therapeutic experience of attachment by building a more secure Self can have a direct impact on the transformation of adult sexual patterns.

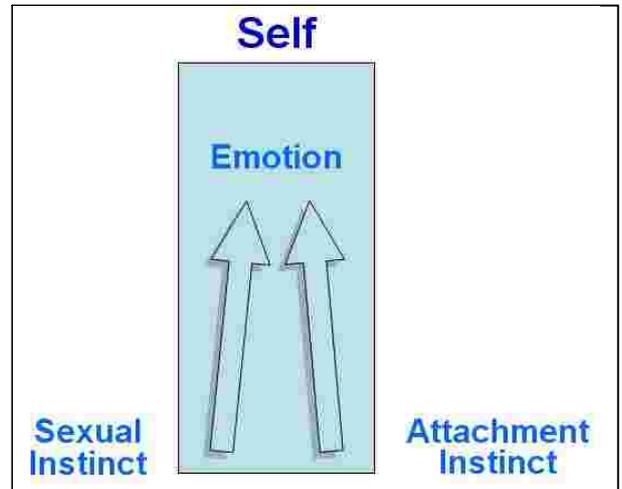
## PARADIGM IV

### ATTACHMENT MOTILITY AND ITS PATTERNS

Following Freud and Reich, Lowen in 1958 places sexual instinct and sexuality at the core of bioenergetics' practice. At approximately the same time, Bowlby (1969) formulates the attachment theory.

Emotional expression then takes on two possible meanings for the child: either it is a signal of sexual pleasure/displeasure (Lowen), or it is a safety/distress signal (Bowlby).

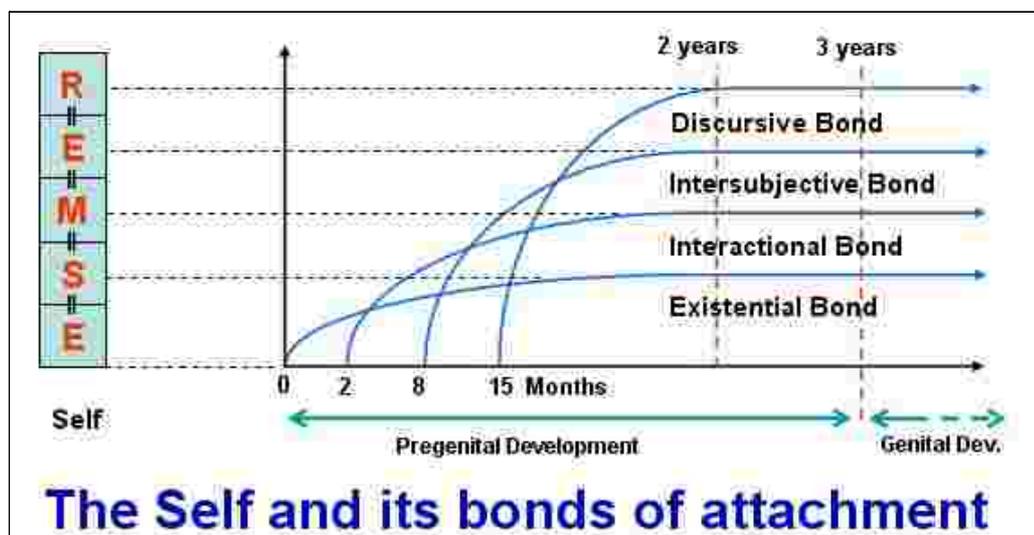
Contemporary Bioenergetic analysis has gained by trying to integrate attachment theory as it acknowledged that *instinct of attachment exists at the beginning of life and is a structuring force as present and active as sexual instinct.*



The second half of the 20th century opened a large field of research that saw theoretical elaboration regarding attachment and interactive bonds so essential to the construction of the Self. If D.W. Winnicott and M. Malher were precursors, let us mention as well the first theoreticians of attachment theory: Bowlby, Ainsworth, Main, as well as the work of Wolf, Emde, Anders, Sander, Cassidy, Stern and others. They all contributed to the following demonstration: the Self, as a subjective identity-in-development, cannot be built without bonding and that bonding is the work of both partners, by their *mutual attachment* and their *interactivity*. I believe that this is true for the elaboration of the bonds between mother and baby, I equally think that it is true for the construction of the bonds between therapist and patient.

#### Attachment and interactive bonds

The attachment and interactive bonds can be found in four types that gradually emerge from the encounter with the care-giver, generally the mother.

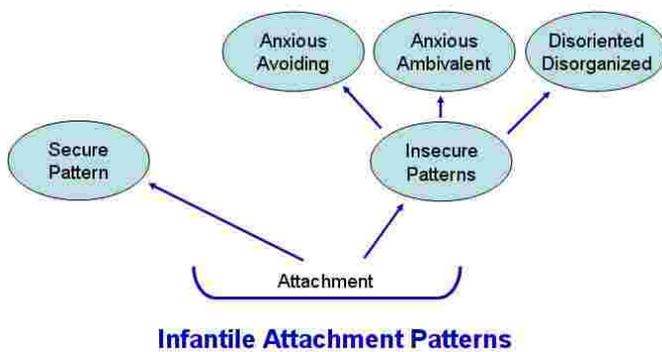


*The existential bond* participates in the emergence of the existential core of the Self, in the construction and afterwards in the secure reproduction of its somatosensory invariants. It is affirmed in the way baby and mother first look at each other, and is confirmed in their subsequent interactions that contain the organic excitation of the child, that shape his vitality and needs for contact. ***The existential bond promotes and validates the phenomenological base of the living-being-that-exists (“l’être-là-vivant”) throughout life.***

*The interactional bond* participates in the emergence of the sensorimotor invariants that become the sensorimotor Internal Operational Models (IOM). Those models are initially activated by the needs for attachment and the needs for the exploration of the environment. The regulation of committed actions is related to the stimulation or the inhibition of sensorimotor IOM, according to adaptive needs. ***The interactional bond ensures trusting reproduction of sensorimotor Internal Operational Models.***

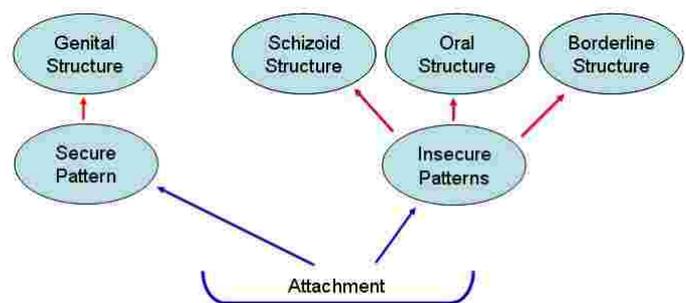
*The intersubjective bond* facilitates the emergence of personal subjective states, and helps to make conscious that they are different from subjective states of another person. It is based in the capacity for attunement. ***The intersubjective bond promotes the possibility to express and share its own subjective states with others.***

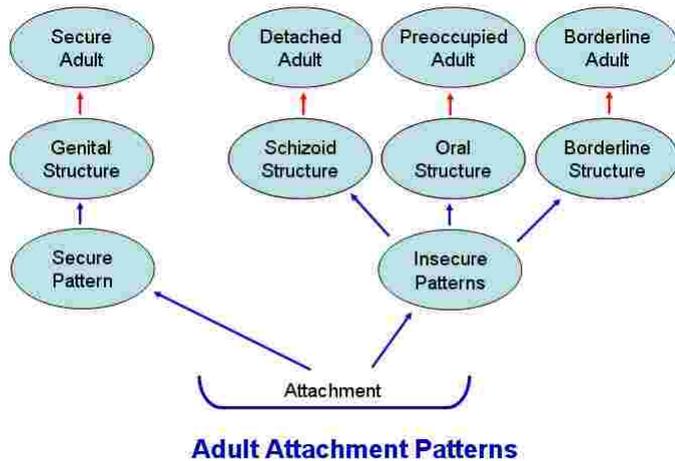
*The discursive bond* participates in the emergence of the capacity to reflect upon oneself, upon the relationship to one’s internal and external world, as well as their objectivation. It is based on a capacity for shared meanings from a system of verbal communication. ***The discursive bond promotes a coherent continuity between what is being experienced and what is being thought.***



When these bonds of attachment do not fulfil their organizing and regulating function, the child experiences anxiety. Ainsworth (1978), Main and Solomon (1988) show that he attempts to protect himself against anxiety by adopting three main types of attachment strategies: he can become “*anxious-avoiding*”, “*anxious-ambivalent*” or “*disorganized-disorientated*”.

We can establish bridges between these attachment strategies and our bioenergetic structures of personality: between the “detached” adult and the “*schizoid structure*”, between the “preoccupied” adult and the “*oral structure*”, between the “disorganized-disoriented” adult and the “*borderline personality*”.





If the child or the adolescent does not have the possibility to evolve and build a pattern that is more secure, he then retains his infantile pattern. He becomes an adult that is “*detached*”, an adult that is “*preoccupied*”, or an adult that is “*disorganized-disoriented*”.

Those conceptual links enable us to clarify during the therapeutic process:

- 1) the origin of prevailing pathology (conflict, deficit or trauma),
- 2) the type of transference attachment the patient actualizes, as well as the counter-transference responses of the therapist.

### Psychopathology of attachment

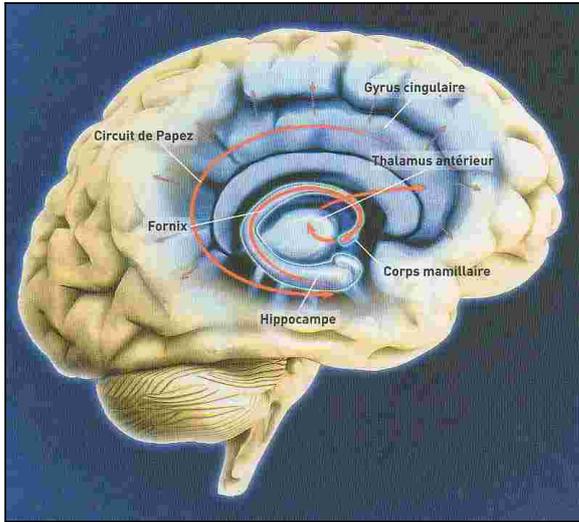
Relationships between psychopathology and bond of attachment need to be specified:

- 1) Attachment theory highlights the fact that the etiology of pregenital structures is not of a sexual nature but more of a deficit or traumatic nature.
- 2) The behavioural response to the deficit and the trauma brings into play a defensive organization that involves chronic muscular tensions. But if the bodily tensions that originate from the deficit and the trauma, and the bodily tensions that originate from sexual conflict are intermingled and sometimes merge, their function is not identical. They will be expressed through transference in a significantly different ways.
- 3) Sexual problems that derive from developmental trauma are the expression of a traumatic attachment pattern and not of a sexual conflict. If the purpose of *character analysis* is to dissolve defensive reactions against sexual anxiety, the purpose of trauma therapy is to *renegotiate functional activity, integrative links and bonds of attachment* with the human environment that exists in the present.



## Neurobiology of the attachment

Psychopathology of the bond of attachment is supported today by the investigations in neuroscience. Let me just give some examples:



Beaupère (2003) shows that when an infant has been mistreated and sees his perpetrator, his right hemisphere goes into survival mode. If this situation is repeated, it is registered into implicit memory, it shapes an emotional habit and determines a style of attachment. He then barely needs to see this threatening attachment figure to produce stress hormones. In the long run, this repeated hormonal production will modify the somatic development: the volume of the hippocampus will decrease and there will be an increase of the volume in the temporal gyrus.

Evrard (1999) shows that the limbic circuit dies out when a little child cannot renew substitutive bonds of attachment when he loses his primary attachment figure. The absence of stimulations explains cerebral atrophy, the atrophy of the neurons that play an important role in the circuits of the memory and the acquisition of the emotional aptitude, in the hippocampus. Except in extreme cases, this process is reversible.

After the death of the Rumanian dictator Ceausescu, Ionescu (Ionescu et al., 2001) wrote a report where he demonstrates that, in some forty institutions, children that were abandoned and deprived of attachment were found to be suffering from serious biological, emotional and behavioural disorders that are irreversible.

However, for the adult, disappearance of a loved one can cause a traumatic wound as serious as that of the infant who loses his mother. Parkes (Parkes et al, 1993), who has studied the biology of mourning, demonstrates that when an adult is attached to his/her partner in an anxious-insecure way, in the months that follow the loss of the partner, a peak of cardiac disease, pulmonary diseases, cancers, diabetes and mental confusion can be observed.

## Clinical conclusions

We are shown that attachment traumas are at the origin of specific pathologies that can deeply affect the Self, its construction, its bonds and its motility. ***If conflict has functional consequences, trauma has functional and structural consequences.*** We have to affirm and promote the existence of two different methodologies in bioenergetic analysis:

- 1) The methodology that consists in working with conflicts using character analysis;
- 2) The methodology that consists in working with traumas, which is quite different. Several of our bioenergetic colleagues have contributed to the development of the latter: Robert Lewis, Maryanna Heckberg, Helen Resneck-Sannes, Michael Maley, David Finlay, David Berceci as well as others.

## PARADIGM V

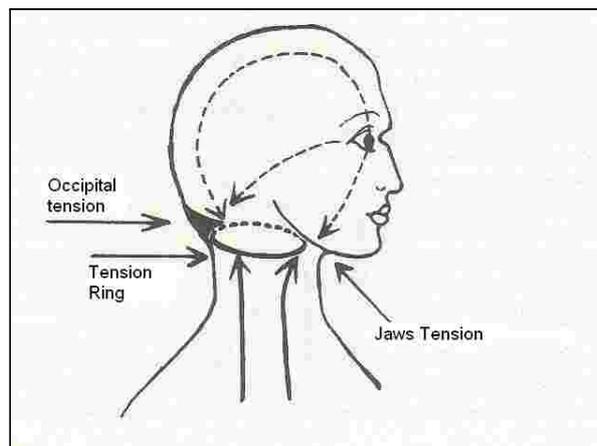
### A METHODOLOGICAL MODEL FOR TRAUMA

In addition to the model of character analysis reserved for conflict issues, we now have models that help us understand and therapeutic practices that help us deal with issues related to trauma.

#### Therapeutic models related to trauma

With his “cephalic shock” concept, Bob Lewis proposes a comprehensive model for developmental trauma (1976, 1984, 1986, 1998) which I will briefly summarize. This type of trauma originates in a non-empathic and dissonant holding and handling of the baby on the mother’s part. The cumulative effect of repeated experiences of shock constitutes a traumatic experience:

- the infant develops strong muscular tensions in the nape of the neck, at the base of cranium: the perception of the head becomes dissociated from the perception of the body;
- by having to compensate for an inadequate mother, the infant *prematurely* holds his head up, thus *prematurely* developing a state of vigilance and an anticipatory perception. He *prematurely* develops his mental activity.



Thus the Self grows from a mental core that is dissociated from sensory and emotional experiences. There is a Self, located in the mind, in the thinking self, dissociated from the bodily Self. Such a child grows into an adult that lives in his head and by his head, in the literal as well as in the figurative sense.

The therapeutic process aims at re-establishing a secure therapeutic attachment relationship, allowing the patient to relax his head as well as the nape of his neck, which is dissociated from his body, so that he can work through his primitive anxieties in order to be freed from them and to build a secure Self.

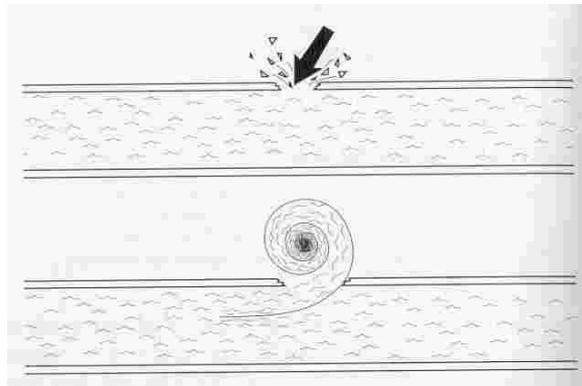
Maryanna Eckberg (1999), a bioenergetic therapist who has worked with political prisoners that were tortured, described her own methodology of traumatic shock treatment, inspired from Peter Levine’s approach. Levine (1997) has proposed a general model with regards to trauma. He describes three types of defensive reactions in the face of a traumatic aggression: 1) attempt to

fight against the aggressor (*fight*), 2) attempt to flee from the aggressor (*flight*), 3) faced with the failure, the organism freezes.

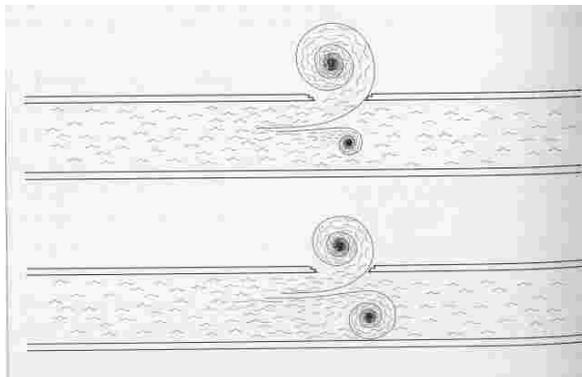
In this last case, the intense energy produced by the danger at the somatic level can neither be discharged nor metabolized. A breach has been opened in the envelope of the Self and functions like a “traumatic vortex”: it attracts all the energies of the Self that are being is engulfed by this vortex. The usual somatosensorial patterns do not function any more, the feelings and perceptions do not acquire meaning any more. One is then confronted with bodily terror and the unthinkable at the psychic level.

Levine makes the assumption that a “healing counter-vortex”, coming from an opposite direction, can be developed that could counterbalance the traumatic vortex allowing those people to experience a resilient co-integration.

#### **Birth of a traumatic vortex**



#### **Birth of a healing (counter) vortex**



In an article published in 2003, Bob Lewis has discussed Peter Levine’s approach. He considers that this model is not complete enough to help us understand and treat developmental traumas because Levine does not integrate the lessons from attachment theory in his method.

Berceli (2003), a bioenergetic therapist, has developed a large group approach, based on his experience with populations that have been traumatized by wars, massacres, rapes, attacks, during NGO missions he was part of. He focuses his work on accessing tremors in body, a natural somatic reaction that enables the body to release enormous quantities of energy that have been generated by a traumatic event.

### Body approach to trauma : A specific methodology

All the authors insist on 3 aspects: 1) the excessive quantity of energy mobilized by the traumatogenic situation could not be discharged and metabolized, 2) usual somatosensorial and tonic-emotional patterns do not function any longer, 3) representations of the traumatogenic situation cannot be expressed.

The methodology that is being used is quasi diametrically opposed to that of character analysis:

1) Regarding regulation “titrage” as opposed to catharsis:

*Titration*, a concept that has been borrowed from chemistry, means meticulous regulation of the quantity of discharge energy at every moment, in order to control the return of traumatogenic experience, and in order not to replace a renegotiation of the traumatic experience by a traumatic cathartic replay.

2) Regarding a “window of tolerance” as opposed to maximum intensity:

Seigel (1999) defines a window of tolerance that facilitates sensory awakening by allowing the return of sensory information (paralysis, feelings of numbness, rigidity, hyper-agitation, irritability, turbidity of wakefulness/sleep), in a modulated way, without waking up terror associated with the traumatic experience.

3) Regarding “micro-movements” as opposed to full and intense movements:

Slow work allows a person to become aware, to explore, to disentangle issues, to recognize, to integrate, associate. The slowness of the work facilitates the analysis of each feeling, image or affect. This work makes it possible to leave the frozen response, of frozenness of the organism’s underlying structures, to gradually get involved again in defensive and orienting responses.

4) Regarding containment as opposed to “letting go”:

The containing function of the therapist is essential because the patient’s capacities to contain his/her feelings, to think and to act were exceeded during the traumatic experience. The aim of the work is to reconstitute a membrane that is at the same time tonic and flexible, that will be experienced as a containing and protective boundary for oneself. It goes beyond that and becomes a kind of psychic boundary apt to contain perceptions, images and representations.

5) Regarding re-initialization of defenses as opposed to releasing defenses:

The aim is to help the patient re-mobilize reactions that were repressed at the time the traumatogenic situation happened, to reconnect with the defensive and orientation responses that could not be expressed at the time, and to enable those reactions to surface.

This methodology to work on trauma is now seen as an essential therapeutic tool today:

- 1) in response to developmental traumas that are forever increasing. They originate in the sociocultural evolution: mothers involved in a professional activity, the atmosphere in the family that is defined by poverty, unemployment and anxiety, urban violence, the uprootedness, isolation, etc...
- 2) in response to factual traumas that are on the rise, due to delinquency, violence, rapes, attacks, etc...

***Finally, character analysis turns out to be relevant to treat genital conflicts as well as for regressions to pregenital positions that are triggered by conflicts generated by the Ego and the Superego, while psychotherapy of traumatic shock turns out to be relevant for the treatment of developmental traumas and the structural then functional distortions that they generate.***

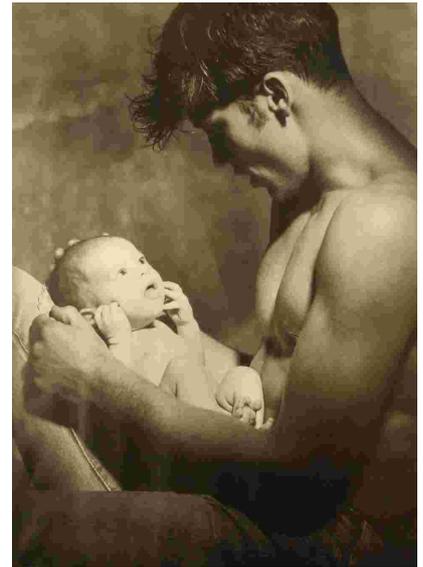
## PARADIGM VI

### A CLINICAL MODEL FOR THE THERAPEUTIC INTERVENTION: THE INTERSUBJECTIVE RELATION

#### Intersubjective attunement

In 1985, Stern highlighted the concept of “attunement” in the relationship between mother and child. This attunement regulates the subjective states of the child and allows him to understand that his mother has a “spirit” different from his.

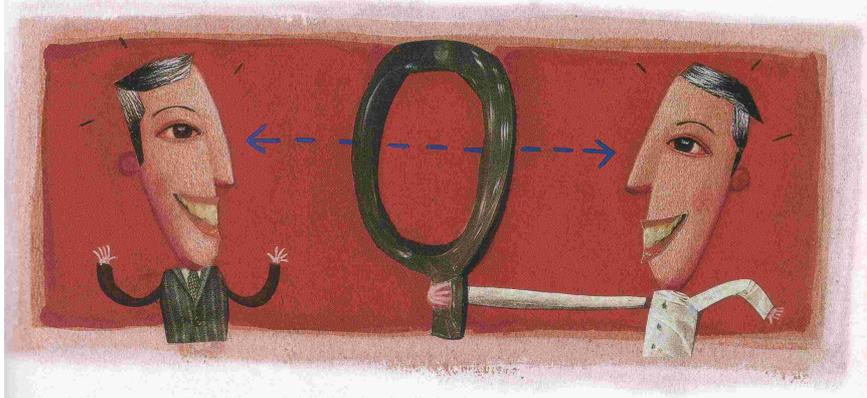
Fonagy (1994, 2000) has operationalized this intersubjective dimension in the therapeutic field. It is the therapist’s Self, with its containing, feeling, thinking qualities as well as its capacity to express subjectively that is therapeutic, which the patient internalizes. The empathic therapist feels and imagines the inner states of his patient and he reflects it back to him through nonverbal as well as verbal answers. By “meeting himself in the other” the patient develops his capacities to feel, to contain and to elaborate his own subjective states. Experiencing that he is felt and thought by the other, one feels and thinks by himself.



I remember my first session with **Rafaël**: he is seated in front of me, he looks at me without seeing me, immobile, frozen, hardly breathing, terrified, I guess. I look at him quietly, affectionately. I ask him what is going on for him, but he does not hear me, or he cannot answer me. At the end of a long moment of silence, I say to him with kindness, but also with sadness: “I feel lonely ... And you?” He looks at me, amazed, quiet, with some tears in his eyes. Then he says to me in a sad voice: “So do I ...” He will reveal to me much later that he felt at the time that I was human, that I had access to feelings of loneliness, and that I could understand him. For sure, that feeling was not strange, my inner child had kept a memory which had found a companion in **Rafaël** and had signalled it to him.

### Somatosensorial empathy

Schore (2001) highlights earlier somatosensorial attunements. By cerebral imagery, he shows that somatosensorial and emotional regulation of the child by his mother is organized from a body communication system recorded in a direct and unconscious interaction right brain - right brain.



Schore extends this discovery to the therapist - patient relationship, organized around the somatosensorial signals emitted by the patient, signals which the empathic therapist interprets from his own somatosensorial system, and to which he answers by attuned interventions.

I remember, in a hospital context, a schizophrenic young woman who held me by the hands, who was experiencing unthinkable anguish because she could not perceive where my hands “began” and where hers “finished”. She was oscillating between terror of contact and irrepressible need for contact. Her psychotic anguish was founded on the absence of somatosensorial patterns giving her the clear sensation of a separate physical existence (Tonella et Al, 1989; Tonella, 2006).



All the preverbal structures have problems of empathy. On the neurological level, Green (2004) found that they expressed a deficit in the amygdala activation. We, therapists, are amygdala activators. Because we have empathy, we invite our patients into a world of shared humanity.

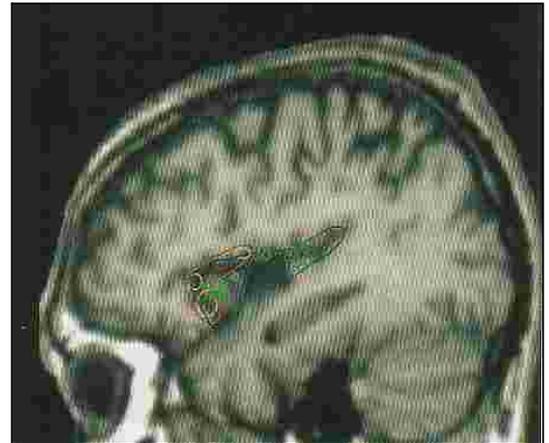
### Neurology of empathy

Empathy is more than a clinical concept, it is a neurological reality.



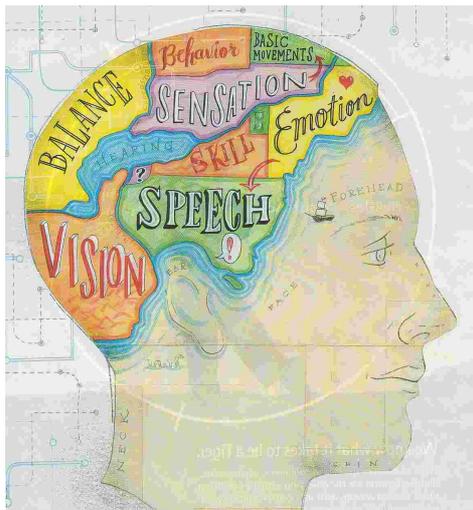
In 1996, Gallese, Fadiga, Fogassi, Rizzolati highlighted the existence of “mirror neurons” in the brain, that are in charge of the empathy. The therapist’s occipital area, the part that processes images, sends the information that has been perceived to the fronto-temporal cortex, another part that prepares for action, thus alerting mirror neurons. The therapist, simply by perceiving and feeling without acting, can assess the emotional and subjective state of his patient.

In this brain imagery graphical, the red colour line shows the activated neurons in the experiencing person (the patient); yellow colour shows the activated neurons in the person (the therapist) in relation-ship/observing the first one having the experience. One can observe that the same areas are activated within the limbic system (in green colour) of both patient and therapist. The therapist's mirror neurons (the activated yellow area) allow him to "rebuild" and feel the experience of the patient.



This year, Rizzolati, Fogassi, Gallese (2007) have shown that mirror neurons are missing among autistic patients. This has initiated a new therapeutic approach based on mutual imitation between the autistic patient and the psychotherapist, imitation underlying the development of the capacity for empathy.

### Neurology of transference - countertransference



However, how do we explain that we do not respond systematically by action when our mirror neurons inform us of a state of distress or suffering in the patient? Grézes (1998) shows us that, although the temporo-frontal area needs to be activated in order to act, the prefrontal area responsible for inhibition of action is also activated. This double message activates a left ascending frontal cortical area responsible for the language. The answer of the therapist can then be formulated in words. We have here a first neurological draft of transference/counter-transference. Therapists could learn to dis-inhibit their body responses, whereas others could learn how to contain their impulses and transform them into verbal language.

### Therapeutic process and resilience

Evrard, Marret, Gressens (1997) show that the fronto-limbic circuits are involved in the patterning of "sensitivity" since early infancy but they can be improved later on, prompting biological markers of stress to evolve (for example rate of serotonin transported by the 5-HTT Long versus 5-HTT Short proteins). This evolution rests on the possibility of rebuilding secure and trustful attachments. Psychotherapy must integrate this parameter in its setting, offering to the patient the occasion to reconnect with secure and decontextualisable therapeutic attachment.

### Criteria of competence of a therapist

Ainsworth (1978, 1979) has described the criteria of competence for the mother so that she (the mother) can offer her child a secure attachment that enables him to develop a secure Self. It seems that these same criteria apply to a therapist who can help a patient develop a secure Self. This is confirmed by current research in the neurobiology of attachment. Let me remind you of these criteria:

a) the development of trust in oneself requires three criteria of competence on the part of the therapist: 1 - a therapist attached to his patient in a non anxious way; 2 - a therapist who is available to his signals; 3 - a therapist who responds to him in an adequate way;

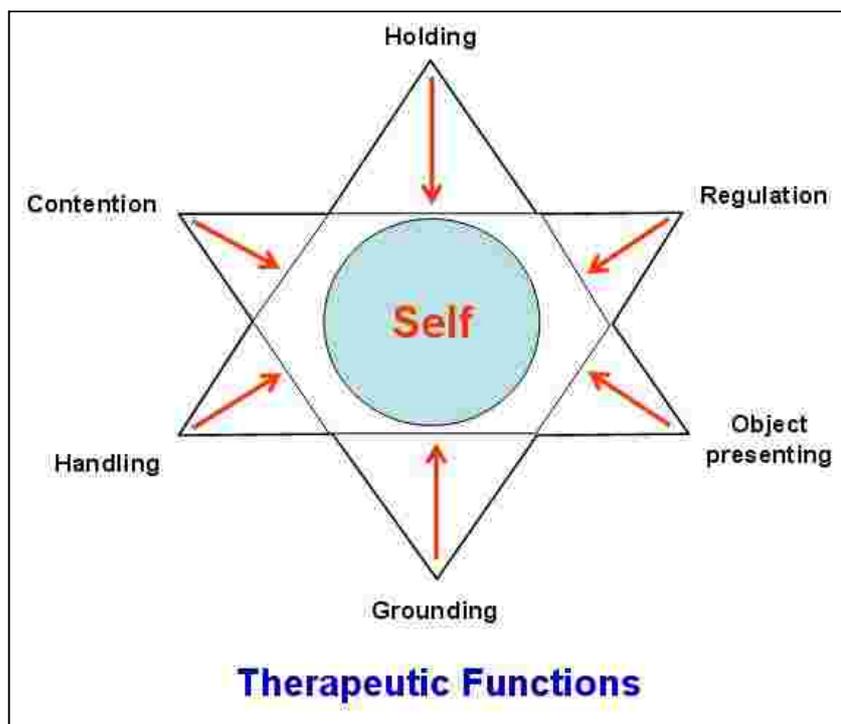
b) the development of self-confidence supposes: 1 - a therapist who allows himself to be used by his patient when he tries to recreate something he has just discovered so as to help him succeed, 2 - a therapist-patient dyad in which the same causes bring the same consequences so that constancy and permanence become organizing factors in the interaction;

c) the development of self-esteem demands that the therapist confirms to his patient that his new capacities for action, expression, attachment and interaction have value. It facilitates reproductive assimilation.

The adult who suffers from attachment disorders harbours a little child who is still waiting for someone who can surrender to him so that he can regain confidence in his own existence and value. To possess and be possessed, this is the name of the game for children who need to develop the deep-seated belief that they are loved and that they are capable of love. It is what gives all its meaning to the phrase “To hold someone tight” in psychotherapy. The imprescriptible needs originate, after all, from the time when, as Winnicott says: “Love can be shown only in terms of caring for the body”. It is, I believe, this experience that many patients are waiting for, secretly.

Many among us have already stressed the importance of intersubjective bonds: R. Lewis, 1976, 1986, 1998; R. Hilton, 1988/89; D. Campbell, 1991, 1995; M. Eckberg, 1999; D. Finlay, 1999, 2001; V. Heinrich, 1999; G. Tonella, 2000; H. Resneck-Sannes, 2002; M. Doess, 2004.

Finally, here are the therapeutic functions that enable the Self to become sufficiently secure:



## A COMPREHENSIVE CLINICAL MODEL

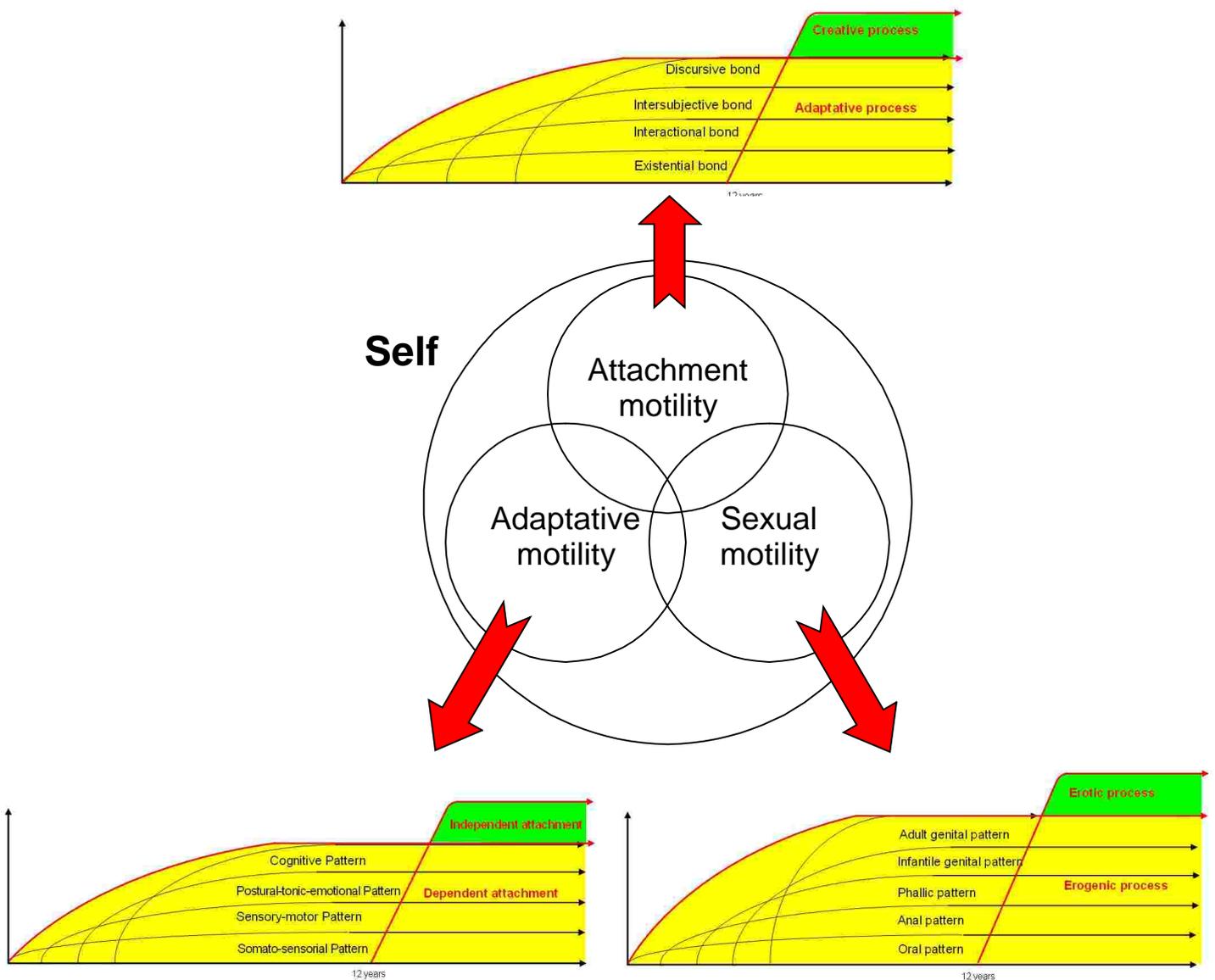
Let's see if we can now combine those various paradigms and their models, which we have just presented, in order to have a global vision of the theory and practice of Bioenergetic Analysis.

### GLOBAL THEORETICAL MODEL

This model concerns the dynamics of the Self that is:

- oriented towards adaptation because of adaptive motility
- oriented towards interpersonal relationship because of attachment motility
- oriented towards sexuality (or the sublimation of it) because of sexual motility

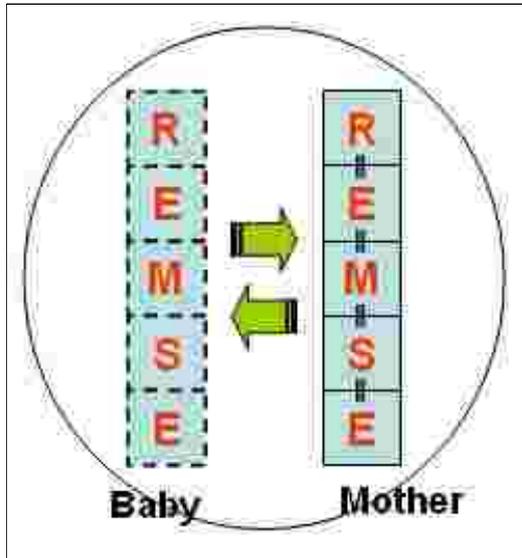
Each of these activities of the Self gets organized at the very beginning of life into structuring and permanent patterns that are apt to evolve depending on life circumstances including psychotherapy.



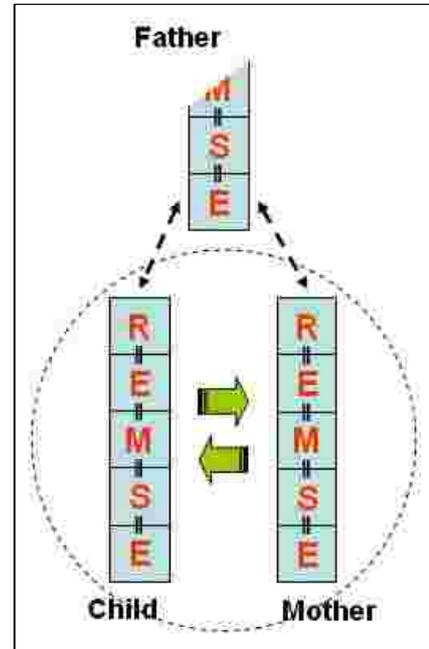
**DEVELOPMENTAL MODEL**

The development of the Self, in its adaptations, in its sexuality and in its attachments can be described according to those four phases:

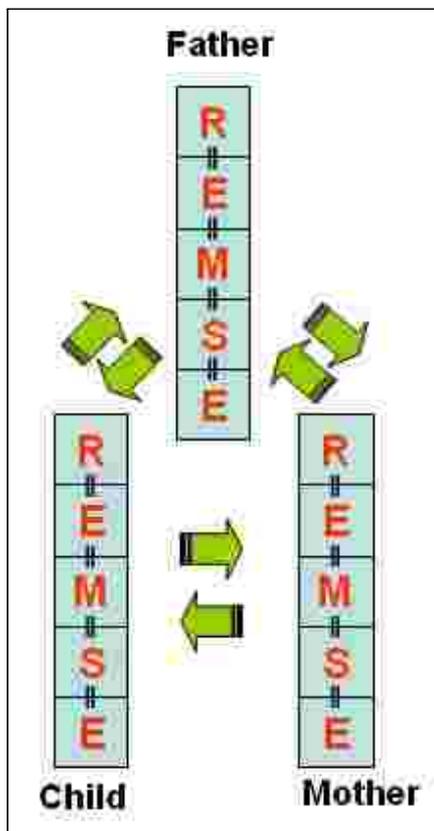
1- Oral phase of symbiotic attachment



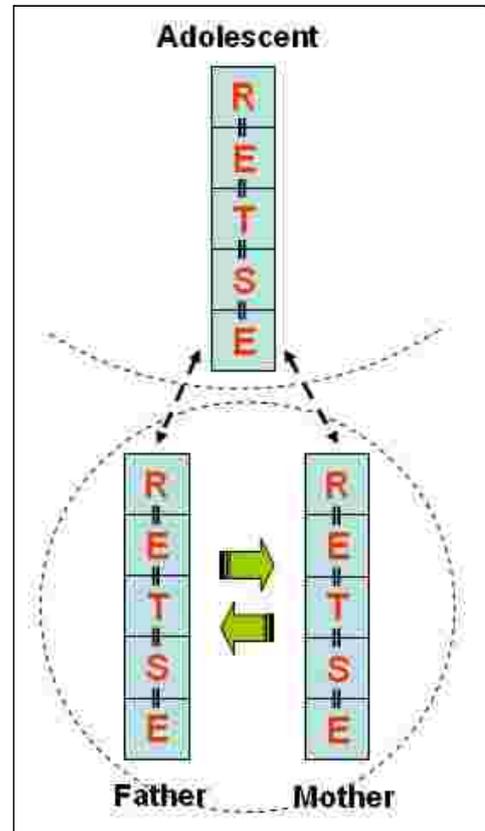
2 – Intermediate phase of individuated attachment



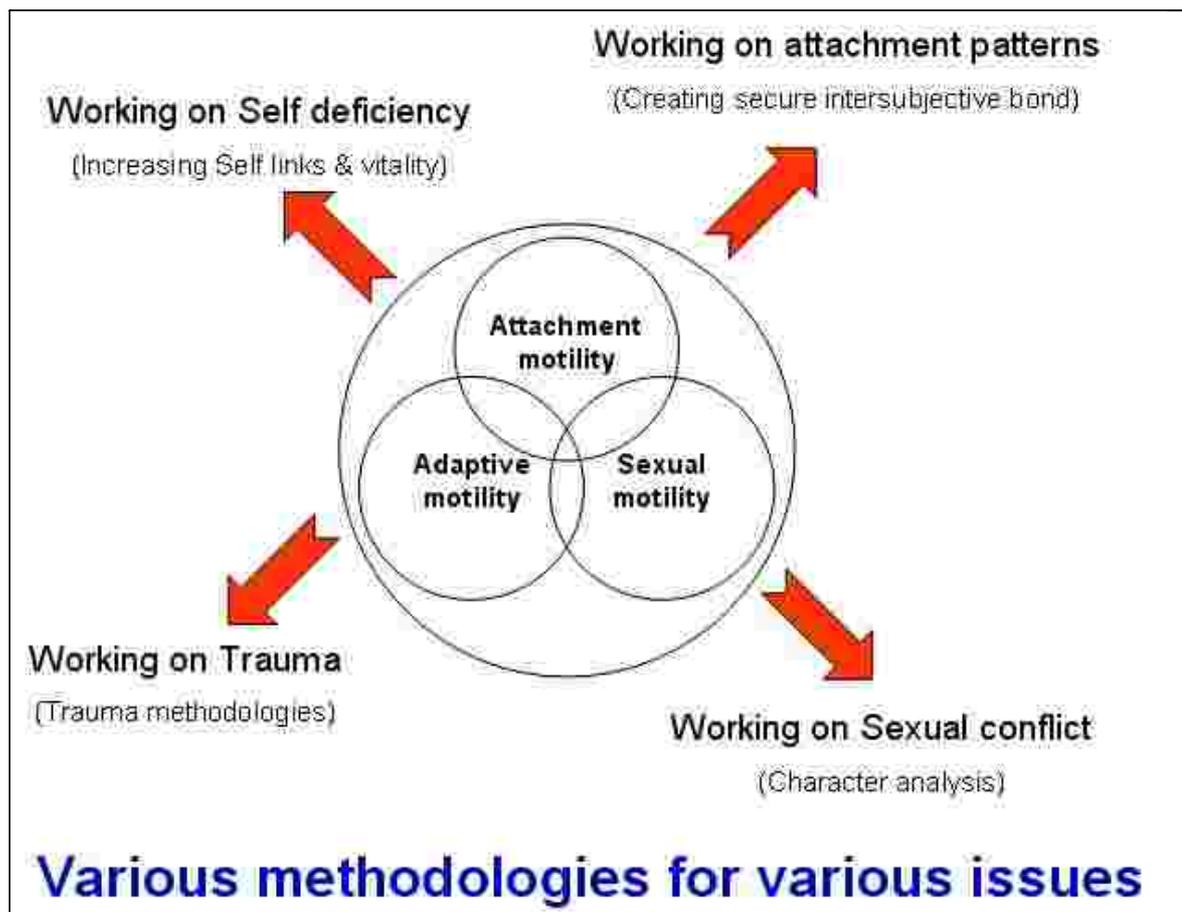
3 – Genital infantile stage of reciprocal attachment



4 – Adolescent stage of independent attachment



## METHODOLOGICAL MODEL



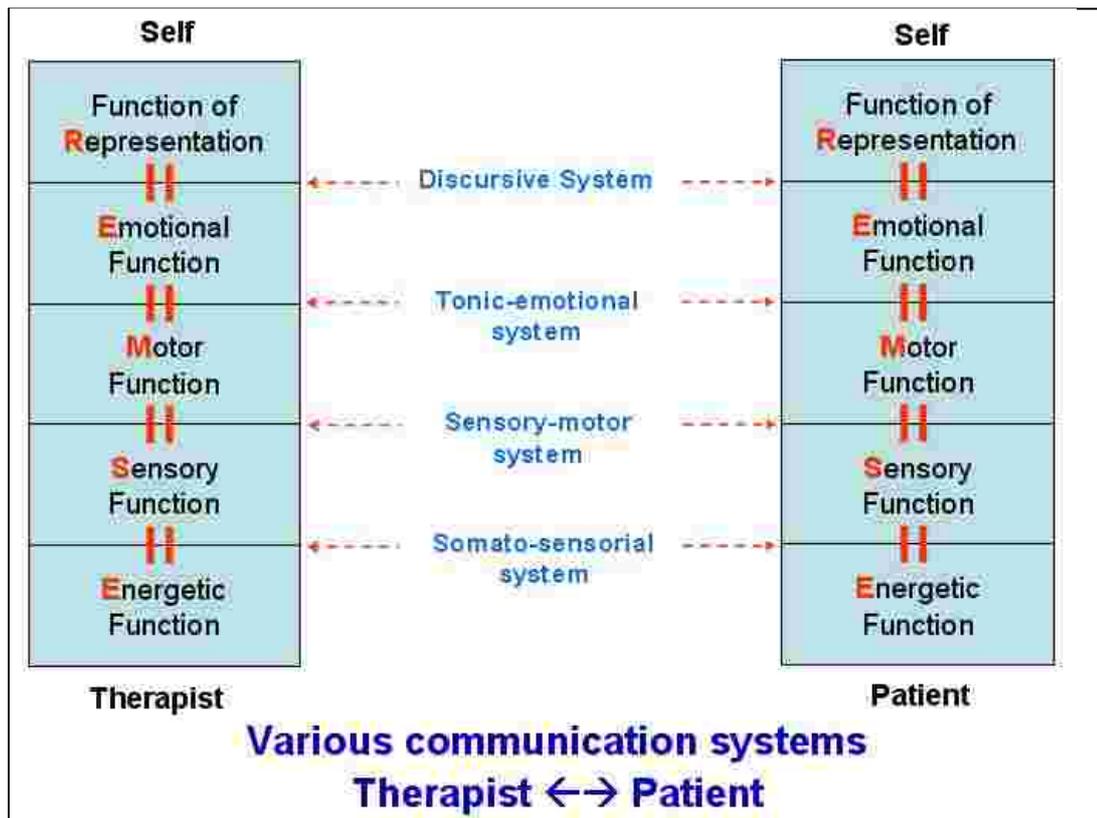
The advantage of this model may lie in its capacity to help formulate a therapeutic strategy that is specific to each patient:

- by emphasizing attachment motility and the construction of a secure attachment relationship when the patient's insecure attachment pattern acts as a major resistance to any therapeutic intervention (distress, terror, paralysis);
- by emphasizing adaptive motility (energetic charge increase, movement, emotional capacity for expression) when the vitality of the Self is in deficit;
- by emphasizing sexual motility and the resolution of sexual conflicts when they inhibit vitality and the Self's capacity for expression;
- by emphasizing re-initialization of the patterns of the Self when trauma damage or destroy it.

A therapeutic process obviously involves the total Self, but we can certainly argue that some people cannot work on themselves without having previously established a sufficiently secure therapeutic bond, which takes time. We can also argue that some sexual conflicts are nothing but the expression of an anxious attachment pattern and that the development of an enough-secure attachment during the therapeutic process is likely to resolve in part or totally the sexual issue.

## RELATIONAL MODEL

Our relational model is marked by intersubjectivity, which means the interactivity between therapist and patient. Therapeutic process is a co-creation between two persons. Various interactive communication systems contribute to it:



Each of these systems facilitates specific dimensions like:

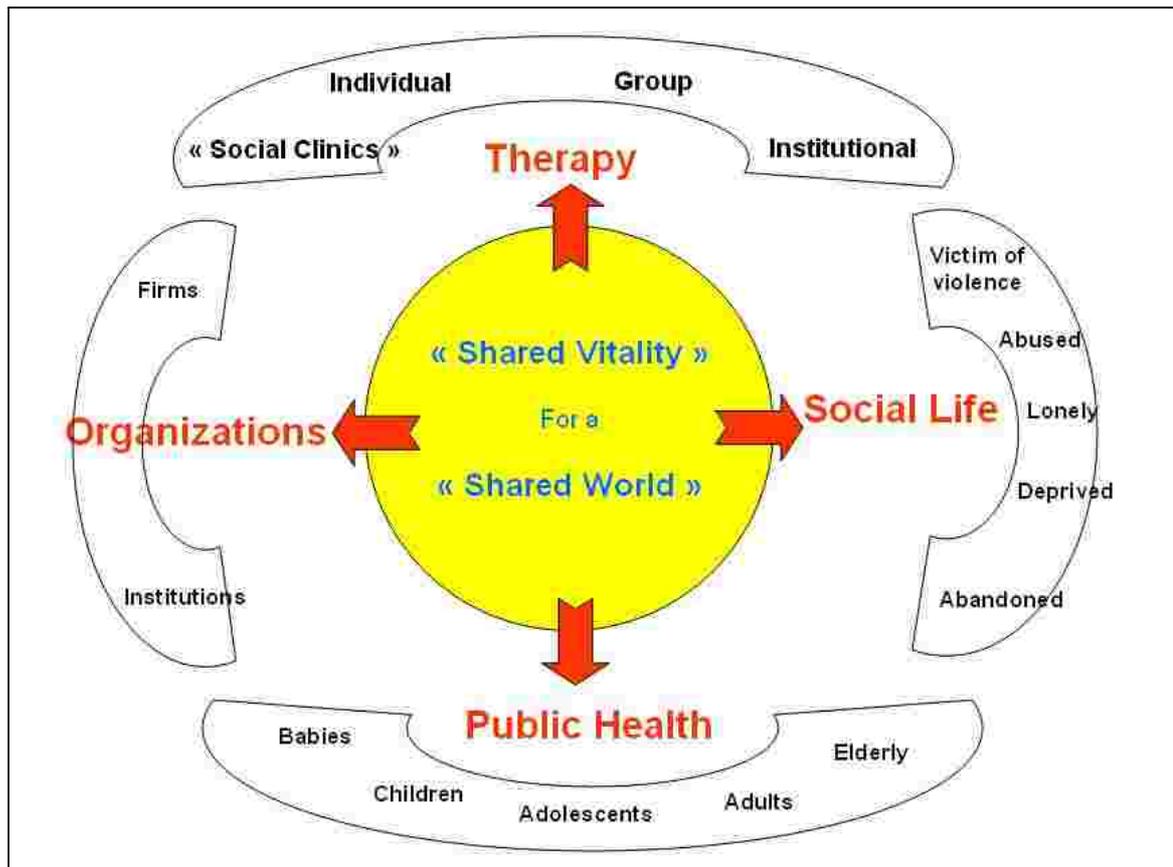
- interpersonal contact between two subjective Selves
- access to information of different nature (sensory, emotional, tonic, cognitive ...)
- activation of specific memories containing this information (procedural, episodic, semantic)
- regulation of the Self that refers at the same time to self-regulation and interpersonal regulation
- elaboration of these subjective states so that they gain meaning and enrich the Self.

The time has come for reconciling once and for all the individual experience and the interpersonal experience within the therapeutic process. We must nevertheless clarify that interpersonal experience does not mean “being in relationship” but means “being personally involved in a subjective relationship that is mutually shared and talked about”.

## PARADIGM VIII

### A SOCIOLOGICAL MODEL BASED ON THE PRINCIPLE OF “SHARED VITALITY”

Bioenergetics was a pioneer in initiating the work with vitality. Can it live up to that standard again? It can if we take into account the actual sociological evolution and the underlying demand of a “shared vitality” for a “shared world”.



A new creativity is emerging, particularly in Brazil: new applications are already being developed by many among you:

- [in public health](#) in relation to problems created by the sedentary way of life, the fast food culture, the traumas that disorient the Self: its functioning, its boundaries, its signals, generating somatic and relational malfunctioning;
- [at the micro-sociological level](#) for those forgotten minorities that face poverty, inequities, emotional separations that generate violence; places where vitality is not shared;
- [in business organizations](#) that are confronted with problems of communication, stress, loss of human contacts, robotization.

We, bioenergetic therapists, must become “readable and visible”, seen as qualified professionals in all these fields. We suffer from the secrecy in which we maintain our reflections, our methodologies and our experience. We do not publish much; we are not on display in the bookstores, in professional journals, in regional or international Conferences.

Our approach is not taught in Universities, where most of the teachers ignore its existence. Our creativity is sometimes plundered or counterfeited. If we remain in the shade, we will disappear like those prehistoric animals that did not adapt to the changes in their environment and we will remain with the stereotyped image I was referring to, at the beginning of my talk: “Bioenergetics is about shouting, crying, and kicking on the mattress”. As a result, it becomes harder and harder to fill our training groups, at least in the United States and in Europe.

We are the bearers of relevant answers; contemporary scientific research validates our work. We are qualified to take up certain challenges today’s world is confronting us with. It is difficult to take up challenges of this nature individually, on our own, but a whole community can succeed if it is alive, if it takes care of its *vitality* through its interactions, through its professional meetings, through its shared productions. This is exactly why we need to maintain these international meetings, beyond the barriers of language and distance.

## CONCLUSION

Talking about the individual, Alexander Lowen used to speak so often of the importance of the heart. An organization also lives through its heart. I wish for all of us in the IIBA, the capacity to preserve and defend our values of *solidarity*, *fraternity* and *co-operation*. We are more than ever in need of these three institutional paradigms at a time when the world is being torn apart and faces “broken times”.



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