DEVELOPMENT OF MODERN BIOENERGETIC ANALYSIS

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ABSTRACT

The field of somatic psychotherapy has grown greatly over the past thirty years. Bioenergetic Analysis, founded by Alexander Lowen and John Pierrakos in the 1950s, was one of the first such modalities. Bioenergetic Analysis has grown and changed over the years, especially in the areas of attachment and attunement by the therapist, the understanding based on neuro psychology of the difference in working with clients with different levels of self-regulation, and the research into common factors that predict positive treatment outcomes. This article describes modern bioenergetic theory and practice with both a theoretical discussion and case vignettes.

THE DEVELOPMENT OF MODERN BIOENERGETIC ANALYSIS

The purpose of this article is to educate therapists about Bioenergetic Analysis and its potential value for clients. It is our experience that in the current climate approaches like Bioenergetic Analysis were dismissed but are experiencing a revival of interest due to the medical research related to the connection between the mind and the body. It is our hope that this article will pique your interest and lead to exploration into Bioenergetic Analysis and other body-oriented approaches.

Bioenergetic Analysis is a relational, somatic approach to psychotherapy (Tonella, 2015). This means that Bioenergetic therapists work with the body as well as the mind within a deep, connected therapeutic relationship. The basic theory states that sensations and emotions occur in the body and that we label and interpret them cognitively. Bioenergetic analysis states that energy exists in the body which becomes reduced or bound during the socialization process and the occurrence of childhood trauma (Lowen, 1976).

Psychology as a field postulates that there are cognitive defenses such as sublimation, denial, rationalization, etc. (Prochaska & Norcross, 2014) Bioenergetic therapists believe there is also a set of body-level defenses, for example holding the breath, tightening the jaw, constricting the diaphragm, or locking the knees (Lowen, 1976). These defenses develop over time in reaction to chronic environmental stressors and traumatic events. Unlike the cognitive defenses, the body-level defenses can be worked with directly through physical exercises, boundaried deep expression of emotion, the use of touch, and many other physical techniques.

Additionally, Bioenergetic Analysis is rooted in the analytic tradition which holds that problems in our current lives are related, at least to some degree, to relational childhood experiences and trauma (Prochaska & Norcross, 2014). As such, it is important to remember events from the past, analyze how they are affecting the present, and resolve them to whatever degree is possible. This article will discuss the history of Bioenergetic Analysis and recent influences which have led to the development of modern Bioenergetic Analysis.

Evolution of Bioenergetic Analysis

Bioenergetic Analysis was developed by Alexander Lowen in the 1950s (Lowen, 1976). Lowen was a student of Wilhelm Reich, who was a student of Sigmund Freud. Reich split off from Freud and developed the concepts about body level emotional experiences and defenses (Lowen, 1976; Reich, 1973). Reich also developed the concept of character structure where the client's history is reflected in the body. He was the first psychotherapist to work with the client's body directly.

Lowen broke with Reich in the early 1950s and, together with John Pierrakos, also a student of Reich, developed the initial concepts of Bioenergetic Analysis (Lowen, 1976). "…many of Reich's best books were burned in 1956. Reich was imprisoned around the same time and died in prison" (Boadella, 1977, p. 5). Due to the professional stigma associated with Reich, it was necessary for Lowen and Pierrakos to separate themselves from Reich. While they kept some of the basic theories of Reich, they developed their own concepts, insights, and techniques, and founded the Institute for Bioenergetic Analysis in 1956. They further developed Reich's concept of character structure which included identifying five different character types in a developmental model (Lowen, 1976; Reich, 1973). Additionally, Lowenand Pierrakos added the idea the concept of working with clients while standing, unlike Reich who worked only with clients laying down.

Lowen and Pierrakos also introduced the concept of grounding as a dominant principle of Bioenergetic Analysis (Conger, 2016, Lowen, 1977). They believed that in order to work effectively with the energy in the body that the client must first be "grounded" which is having the experience of connection to the earth, self, and reality. This meant that the client began each session standing so that most clients would go into various physical positions which led to being grounded with the energy moving more freely in the body. Pierrakos split with Lowen in 1969 and founded another type of body-oriented psychotherapy, Core Energetics which had a greater spiritual component than Bioenergetics (Pierrakos, 1991). There are many other forms of body-oriented psychotherapy, all of which developed by expanding on, or disagreeing with the work of Reich, Lowen, and Pierrakos.

Lowen, coming from a classic psychoanalytic background believed that the therapist is the expert and had information about the client that was unknown to the client. (Lowen, 1976, Stark, 1999), By reading the body he recognized muscular holding patterns that corresponded to developmental stages (Lowen, 1976). Additionally, he was the expert about the issues that needed to be worked through. Through the contributions of many Bioenergetic therapists this approach was reassessed in order to integrate new findings in the field of psychology. Throughout the years, other concepts of therapeutic relationship, transference and countertransference have evolved from a classic Freudian analytic view, to a Reichian and Lowenian body focused one, to one enriched by the contributions from Attachment Theory, Relational Psychoanalysis, (Object Relations, Self-Psychology), and Neurosciences where the emphasis has been displaced by intersubjectivity and mutual somatic attunement" (Pla, 2017, p. 74). Several second-generation Bioenergetic therapists, such as Robert Hilton in California and David Campbell in the Scotland, started writing and talking about the importance of the therapeutic relationship and attachment with the therapist in the deep emotional bioenergetic work being done. They wrote about how to work with transference and countertransference within the energetic, body-oriented approach. They brought the need for connection, nurturance, and safety to Bioenergetic therapy and eventually profoundly influenced Bioenergetic Analysis worldwide.

"Carlino, Finley, Lewis, and Hilton, and …Campbell… introduces the neurobiological and attachment research. …therapist is no longer a neutral observe reading the body. In recent years there is a shift towards a more relationship-oriented approach" Pla, 2017, p. 93. "I would add, from more recent years… Resnick-Sannes, Klopstech, Schroeter, Tonella, Scott Baum, Heinrich-Clauer, Clauer, Koemeda-Lutz, and possibly 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" (p. 93). These contributions, within the past two decades, have created the shift from "classic" bioenergetics to a more "modern" approach.

These concepts have been integrated into Bioenergetic Analysis without losing its fundamental principles (Pla, 2017). In the more classic Bioenergetic Analysis, the therapist "knew" things about the client from reading his/her body. This still remains. Bioenergetic therapists are trained in observing the energy and the holding patterns in the body. We still "read" the body and can recognize certain developmental needs that were not met which informs our work with our clients. What has changed is that there is a more relational matrix, so rather than focusing primarily on the client's projections onto the neutral or "knowing" therapist, the therapeutic relationship is seen as two people co-creating and participating in the relationship. Change occurs when conflicts are worked through and as the client is able to move away from defensive armoring to healthier affective processes.

In traditional talk therapy the cognitions and emotions are the focus, while in Bioenergetic Analysis we work with the muscular and autonomic nervous systems as well as the cognitions and emotions (Michael, 2001). Bioenergetic Analysis still holds that the body and mind are one functional identity. In the authors' experience another evolution of Bioenergetic Analysis is that in traditional Bioenergetic sessions the therapist was more directive in having the client take a particular position or action. For example, the therapist might have the person begin hitting or kicking to see what emotions or transference might emerge. Additionally, the therapist is attuned to the client and notices certain movements that the client is making spontaneously and invites the client to exaggerate or emphasize a particular movement. The therapist may suggest an addition to their movement to encourage more expression. There is more of an exchange between the client and therapist in determining how the bodywork progresses.

We have found that at the end of the work with the body it is important to integrate the experience into a narrative. One of the important aspects of this work, we have found, is that insight often follows a deep expression of emotion rather than the other way around, which is a primary tenet of talk therapy. It is one of the strongest reasons we believe that working with the body is such an effective way of deepening the therapeutic process.

Bioenergetic Character Structures

Lowen (1976) developed five-character types rooted in a developmental model. These are clustered according to developmental tasks, unmet needs, and developmental wounds. Everyone is a mix of these various types as no one gets their needs met perfectly in any stage of development. We each have one or two more dominate structures based on the caregiver's ability to meet the needs of each stage.

Johnson (1985) describes much of Lowen's concepts about character structure in his books. His works are utilized in many bioenergetic training programs because he is able to describe the character structures in a concrete and organized manner. Johnson states that "The Recian and Bio schools have become the most active in pursuing characterlogical notions, and I believe they provide the richest contemporary exposition of this focus… the valuable contributions of these charact views have often been written off or ignored… I think this is extremely unfortunate because in all of my explorations and meanderings from everything from classical analy to "radical" transformational movements, I have found nothing of more value" (p. 23).

The original character types are: Schizoid, Oral, Narcissistic, Masochistic, and Rigid (Lowen, 1976). A sixth type, the Borderline Character, was introduced later as the psychological community developed more awareness of this cluster of unmet needs and defensive patterns. The names of the character types originated out of Lowen's psychanalytic training. He did not mean them to be seen as psychiatric disorders or the names to be pejorative.

In modern Bioenergetic Analysis there is discussion of how these character types can be related to Mahler, Pine, and Bergman's (1975, 2000) object relations theory's developmental stages. Lowen did not write about this correlation. The following are brief descriptions of each character structure and its corresponding object relations developmental stage. Space does not allow a complete discussion of each.

The Schizoid character is the result of developmental trauma that occurs in the first three months of life and corresponds with Mahler's Autistic stage (Johnson, 1985; Lowen, 1980; Mahler et al., 1975). The trauma that creates the Schizoid character stems from hostility or coldness from the primary caretaker (Johnson, 1985 & 1994: Lowen, 1980). Issues related to the right to exist, trust, feeling safe in the world, and the ability to bond are all part of the Schizoid character's internal emotional world (Lowen, 1967). Underlying emotional issues may include terror, chronic anxiety or depression, spiritualization, dissociation as a primary defense, or lack of ability to bond or experience empathy. Examples of physical characteristics of the Schizoid character structure are eyes that look wide open and afraid, tension in the occipital ridge, an underdeveloped body and musculature, movements that appear disjointed and constricted breathing and diaphragm. These people are often described as living in their head.

The Oral Character is formed during Mahler's Symbiotic stage where the connection with the caretaker is inconsistent or weak, with the resultant issues related to fear of abandonment, high need for contact, low energy, and a tendency to depression and/or anxiety (Johnson, 1985; Lowen, 1973; Mahler, 1975). "The themes of need and dependency gratification are fairly common" (Johnson, 1994, p. 27). Physical characteristics include a collapse in the chest with resulting rounded shoulders, breathing in the chest but not the abdomen, constriction in the ankles, and underdeveloped musculature, although not to the same degree as the Schizoid.

The Narcissistic character comes from the response of the caretaker to the transition between Mahler's Practicing and Rapprochement sub-stages of the Separation/Individuation stage (Johnson, 1987: Lowen, 1985; Mahler et al., 1975). It develops when there is not enough support for the regression that accompanies the breaking of the natural grandiosity as the child moves from practicing to rapproachment. In the Practicing substage the child has a lack of fear when exploring the environment that is an essential part of that stage. If the regression that comes when the child recognizes that she is a small entity in this world of larger people and the need for closer attachment to the primary caretaker is not accepted, then the grandiosity does not break. Therefore, the child remains stuck in the stage where he believes he can do anything the caretaker can do because they share the same abilities. The emotional issues can include tremendous insecurity underneath the grandiosity, the need to be special, impairment in the ability to feel empathy, using others to meet his needs, and a drive to succeed. The physical characteristics include energy in the head, weak legs, a sense of holding up, broader shoulders, and narrow hips.

The Masochistic character also develops from the response of the caretaker to the transition between Mahler's Practicing and Rapprochement sub-stages of the Separation/Individuation stage (Johnson, 1985; Lowen,1971; Mahler et al, 1975). In this case the regression is accepted but the natural movement back out of the regression towards real autonomy is thwarted. The caretaker is intrusive and over-protective in areas especially around dressing, toilet training, eating and correction of behavior. The energy in this character is bound and there is a significant amount of negativity which is not openly expressed. "The masochistic body is often noted to be thick with powerful muscles which are believed to restrain the direct assertion and block the powerful underlying negativity. Characteristically, the masochistic character is overly pleasing and self-sacrificing while at the same time evidencing passive-aggressive behavior" (Johnson, 1985, p. 38).

In all of the characters described above the development of object constancy is incomplete (Lowen, 1976; Mahler, Pine, & Bergman, 2000). The failure to achieve the full ability to self-soothe internally can lead to anxiety, depression, and addiction, as well as other mental health issues. This is why these character structures are referred to as pre-oedipal.

The Rigid character is formed during Mahler's Oedipal stage (Johnson, 1985; Lowen, 1988; Mahler et al, 1975). These clients are more functional and successful but often have difficulty in relationships. Their self-esteem is based more on performance than on being.

They often have difficulty integrating sex and love and may be so focused on successful performance that the emotional side of a relationship is neglected. They often hold back their authentic expressions. Physical characteristics can include a well-developed body that is coordinated and flexible, and there can be a split between the upper and lower body which reflects the split between love and sex. They can also have a seductive quality to their presentation.

Although Borderline character structure was not part of Lowen's original character types it is currently an accepted additional structure as part of modern Bioenergetic Analysis (Johnson, 1985). Johnson termed this character structure as the Symbiotic Character. Johnson was greatly influenced by the work of Masterson and incorporated much of that material in his description of the Symbiotic Character. "The body of the symbiotic character tends toward underdevelopment and low charge, though there can be a tremendous energy in the blow-off which accompanies the panic occasioned by perceived abandonment or object loss. In general, the symbiotic's body is characterized more by lack of development than it is by the kind of chronic holding seen in the oral and schizoid structures" (p. 34).

Bioenergetic Analysis Vignettes

Lowen developed a multitude of exercises and stress positions designed to work on the issues related to the client's character structure (Lowen, 1977). It is beyond the scope of this article to discuss even a small portion of the exercises so we will discuss two different sessions as examples instead.

Touching clients is an integral part of bioenergetic analysis. It is as important to know when touch is contraindicated and can impact the therapeutic process negatively. "The use of touch has a long history in the field of body psychotherapy, and serves as a cornerstone for many of the forms of work that are practiced today" (Phillips, 2002, p. 63). "Many students leave their clinical training believing that it is illegal to touch a client. There is much written about inappropriate touch but most trainees and interns receive little to no education about the value and ethics of touch" (Parker & Guest, 2011, p. 58). The ethical use of touch is a powerful technique and considerable time is given to touch literacy in our formal training programs. It includes how to assess the client's capacity for touch, how to ask for permission, knowing who the touch is for, knowing how to touch appropriately, the impact of touch on the therapeutic relationship, how to address transference and counter-transference issues that arise, somatic tracking and resonance. This is a broad, important subject and beyond the scope of this article to discuss further.

Example Session One

Amy is a 35-year old woman who has come to therapy primarily because she has difficulty in forming and maintaining close relationships. She comes from a family where there

was little to no display of affection or emotional connection. She has been in bioenergetic analysis for over six months, has a positive transference with her therapist, and has participated in somatic interventions many times.

Amy comes in to the room, sits down and begins complaining about her relationship difficulties of the past week. Her therapist notices that Amy seems ungrounded and not completely present in the session. Consequently, the therapist invites her to stand up and begin grounding exercises. One of the basic tenets of bioenergetic analysis is that all emotions, interactions, or insights are best integrated when the client is grounded. Grounding also gets the energy moving in the body. Grounding exercises can also be used to charge the body, leading to discharge of emotion and energy later. Once Amy is grounded and more present the work on the current issue can deepen. The therapist asks Amy to close her eyes and picture someone she wants a connection with. The therapist asks Amy to extend her arms like she is reaching for someone and say "I want you" or "I need you" or any other words that fit. The therapist stands facing Amy with her palms open and receptive to connection but does not move towards Amy. The therapist's affect is neutral at first so that Amy experiences in the present moment the hurt resulting from the lack of connection in her earlier life. Amy starts to cry and says "no one is ever there for me". At this time the therapist responds by saying "I'm here" and extends her arms towards Amy. Amy grasps the therapist's hands and pulls the therapist towards her. The therapist is tracking Amy's responses and asks Amy where she wants her to be. At that moment Amy begins to talk to the therapist as if she was her mother and says "Where were you? Why couldn't you be there for me?". The therapist recognizes that the unexpressed anger that accompanies the hurt is emerging so the therapist clasps her hands together and invites Amy to wrap her hands around the therapist's wrist and either pull her closer or say "Where were you" again. Amy says this repeatedly and is able to express her anger about this for the first time. Then Amy releases the therapist's hands, starts to cry, moves toward the therapist who is receptive to Amy coming in for a hug and putting her head on the shoulder of the therapist. After Amy's tears begin to subside and she moves away, they both sit on the floor. The therapist asked Amy "what was different about this experience for you?" Amy states that her mother was not able to be present and comforting. She goes on to say what a relief it was for the therapist to be receptive and accepting of her need for physical contact and soothing. They spend a little more time integrating the experience and how it relates to her present-day life.

Example Two

In this case, the therapist is working with Ray, a masochistic 40-year old male client, who is having problems with being passive-aggressive and unable to express himself directly. Ray has reached the point in the therapy where the underlying aggression is now accessible at times. The therapist and Ray have been working on this for some time. Today Ray comes into the session complaining about a co-worker. To help Ray express his aggression the therapist invites him to bite on a towel, look at her and growl. This intervention is helpful

because so much of Ray's aggression is locked in his jaw and this exercise can help soften the muscular contractions which have been unconsciously held. Ray is standing during this intervention. Ray is also working on being able to vocalize his aggression. Consequently, the therapist invites Ray to take the towel in his hands and twist it, look at the therapist, and shout phrases like "You can't control me" or "I hate you." This allows Ray to begin to express his aggression and he can begin to experience what it is like if his energy is not so bound. Like in example one, after Ray appears to have completed his aggressive expression, then the analytic part of the work can be done to integrate the experience in a new way. This can be done standing or the therapist and client can return to their chairs and process from there.

These are two very simplistic examples of how a Bioenergetic Analysis session might happen. Obviously, elements such as the client's ability to experience strong emotion without dissociating, the ability to come out of the deep emotional expression and reconstitute within the time frame of a session, the strength of the therapeutic relationship, nature of the transference, trauma history, and many other aspects of the client's background enter into the decision about how to work with the client.

This work requires in-depth post-graduate training, in addition to the graduate degree required to qualify for licensure. Bioenergetic Analysts all subscribe to the belief that therapists cannot do deep healing work without a comprehensive understanding of their own issues. All Bioenergetic Analysts are licensed therapists and complete a minimum of four years of academic training in Bioenergetic Analysis, 140 hours of individual psychotherapy with a certified bioenergetic therapist, and 50 hours of clinical supervision with a certified bioenergetic supervisor. Once all of these required elements have been completed and a level of competency has been demonstrated, one can apply for certification.

Conclusion

As stated above, Bioenergetic Analysis has been in practice for over sixty years and has grown with the theoretical advances in the field of psychology. It used to be much more prevalent in the United States and Canada before the advent of managed care by the insurance industry. Due to the insurance companies-driven acceptance of the medical model, and insistence of the need for empirical data for any given therapeutic approach, many theoretical models that are more long-term in nature, more holistic, experiential, or body-oriented are not as readily accepted in North America any longer as they are in Europe and South America. Another aspect of this lack of acceptance is that the majority of empirical research in Bioenergetic Analysis to date has been done in Germany and Switzerland and thus is not available in the databases used in North America by that psychological community.

Messer and Wampold (2002) suggested that researchers should no longer place such an unwarranted emphasis on empirically supported treatments (ESTs) as they are based on the medical model which proposes that the specific ingredients of a therapeutic approach are in and of themselves, the important sources of psychotherapy outcomes. Proponents of ESTs

cite numerous studies indicating that they have successful outcomes in treatment. Wampold and Bhati (2004) have noted, however, that "The evidence-based treatment movement places emphasis on treatments when it has been found that the type of treatment accounts for very little of the variability in outcomes; on the other hand, aspects of treatment that are valued by psychologists and patients that have been shown to account for variability in outcomes have been ignored. If evidence were taken seriously, one could easily build the case that the attempt to identify particular treatments as privileged is unjustified." (p. 568). Furthermore, reliance on the ESTs approach has led to the discrediting of experiential, dynamic, family, body-oriented and other such treatments which have not been subjected to the same research protocols. The common factors approach would argue that while specific ingredients are necessary in therapy, their true importance lies in them being a component of a larger healing context of therapy and the meaning the client gives to their experience in therapy. Aspects such as the quality of the therapeutic alliance, empathy, therapist's and client's expectations for change, cultural adaptation, and therapist differences are some of the variables addressed in the common factors approach. The common factors proponents note that numerous studies indicate no difference in therapy outcomes due to specific therapy approaches, rather the common factors in therapy are what is important for successful outcomes. (Norcross, 2002; Wampold, 2001, 2015).

Norcross and Lambert (2011) discussed the polarization of the ESTs approach and the common factors approach where the specific treatment method is pitted against the therapy relationship. They noted that the American Psychological Association (APA) (2006) adopted a more balanced perspective by providing a neutral definition of evidence-based practice: "Evidenced-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 4). This task force expanded the typical findings of evidence-based therapy to include evidence-based therapy relationships. In this way, the importance of evidence-based therapy relationships is given equal standing to the importance of ESTs.

In expanding upon the common factors approach, Wampold (2015) discussed a specific common factors model called the contextual model, which proposes three pathways by which psychotherapy produces benefits. This model provides at alternative explanation for the benefits of psychotherapy compared to models assessing specific ingredients that are hypothesized to be helpful for specific disorders. The first pathway is the real relationship, which is defined as "the personal relationship between the therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" (p. 568). This involves establishing a strong therapeutic alliance. The second pathway includes the creation of expectations through explanation of the disorder and the treatment involved, in which the patient comes to believe that successfully participating in the tasks of therapy will be helpful in coping with his or her problems and that he or she will achieve the mastery to do so. The third pathway involves enactment of health promoting actions. In the contextual model, if the treatment elicits healthy patient actions, it

will be effective and the specific methods to do so will vary based on the issues and needs of each patient.

Laska, Gurman and Wampold (2014) have noted that more recent psychotherapy research has focused on how the common factors and the specific ingredients work together to produce the benefits of therapy. They propose that to be most effective in delivering mental health services, these two models of empirical inquiry should be integrated.

Future outcome research on Bioenergetic Analysis could provide this much needed integration of approaches. First, a scientific exploration of Bioenergetic Analysis would fit well within the contextual model approach. For example, Bioenergetic Analysis focuses a significant amount of the training program on developing the person of the therapist, in terms of their ability to see how and where change is possible, provide the holding environment for the exploration of deep trauma and emotional expression, as well as processing transference and countertransference.

Training in Bioenergetic Analysis also teaches therapists how to work with physiology which integrates much of the current work being done in neuro-psychology into sessions with clients. Additionally, Bioenergetic Analysts are trained to see holding patterns, contractions, and subtle body movements that inform the therapist about potential developmental issues and the client's immediate experience in the session. These areas could be assessed within the specific factors model.

One of the most effective differences between Bioenergetic Analysis and traditional talk therapy is the use of touch which requires a comprehensive understanding of its impact on both the client and the therapist to facilitate change. Few therapists have been educated on the value and ethics of touch in the therapeutic process. Few, if any, talk therapists even discuss the subject and may use touch without proper training, for example something as simple as shaking the client's hand or putting a hand on their back. This technique could also be assessed within the specific factors model.

In addition to utilizing the contextual model for Bioenergetic Analysis treatment outcome research, utilizing specific research variables designed to measure the impact of therapeutic touch and working with the patient's physiology would provide much needed data regarding their effectiveness in the treatment process. Taken together, this integrated approach would be a positive contribution to the psychotherapy outcome literature.

We also acknowledge the need for more empirical research to be done in the United States and Canada into the efficacy of this therapeutic modality.

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