Working with Trauma Without the Drama: Abused and still alive

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Abstract

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

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

INTRODUCTION

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

A simple non-trauma example of this is when a patient told me that she hadn't visited her brother for over 11 years even though she liked her sister-in-law and their children. It wasn't worth it to her because he was so difficult. She then told me, “Now I go there. I am not part of that theater play anymore.” We had never discussed this issue in therapy yet she resolved it alone. The problem seemed to evaporate and had not come back later or in another form. This seemed to be going against the basic tenets of psychotherapy: analyzing and understanding the problem, relating emotional states to the therapist, re-living dangerous events or emotions, using the therapeutic relationship for support, expressing repressed emotions, memories and movements.

It was particularly surprising when this same phenomenon happened with patients with lifelong traumas. In some cases, the patient had not mentioned the trauma and therefore

it was never worked on. For example, by the beginning of the last of a series of 9 sessions with a patient in a week-long workshop, there had been no revealing discussions, nor movements or emotions. He was lying on a mat on his abdomen and I was gently touching his back. He started crying quietly and deeply. He later explained that he realized his stepmother loved him. "I always thought that the things she did to me was because she didn't love me. Now I see that this was her way to show she did love me!" I didn't know his mother had died when he was a child. Additionally, in that session there had been none of the typical vegetative signs of trauma emerging: fast heart rate, hot or cold sensations, panic or fear, sweating, shivering, shaking or splitting off. Yet he worked on and cleared this trauma by himself. (Davis, 2012, p. 71).

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

THE PHENOMENON

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

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

> During the instroke exercise, I saw my dad. He died in my arms when I was 13. And that was the moment I lost the way back to myself and I did it on purpose. In the last days I remembered how my dad used to take me to a river, or up in the mountains when I was a child and we just sat in silence. He used to tell me that this is a way to find peace within, to find strength. He taught me how to listen to my inner voice, how to feel my body, how to find the strength in me. And when he died, I was so angry at him that I just blocked it all, I threw away the key for inside and started to live only by "going out".
>
> I have worked on my anger, and my sorrow and so many other emotions in my personal therapy. I do yoga and numerous kinds of meditations. And all I was looking for, all I was struggling to find is exactly that feeling of calmness and "it will all be fine" that I knew so well in my childhood. The insight that I just have is so powerful. I feel on the right path for the first time. I want to reconnect to myself. And this changes so much…"

In this passage we read the major themes of the phenomenon of what I have described. There was no specific focus on the traumatic event. (This was not even a therapy workshop.) There was no specific release or insight that happened during the practicing of the technique by the trainee with this participant. She already understood the concepts of instroke and the undamaged endo self, but until then it was merely an impersonal, intellectual experience.

There were also the classic signs of the endo-self state (Davis, 2014): all was fine, calm and peaceful and she already knew this state. She was returning to it, returning to herself as Merleau-Ponty pointed out: "At the root of all our experiences, we find, then, a being which immediately recognizes itself...not by observation and as a given fact, nor by inference from any idea of itself, but through direct contact with that experience." (in Pagis, 2009, p. 267).

Further she did not describe any panic, fear, or vegetative responses as a result of her re-organizing the trauma event. She was realistic, in the present moment and did not

idealize. For example, she took responsibility for her own actions: angry, "throwing away the keys", going away from herself. And, she acknowledged what a good and loving father he was by teaching her so many important things. In addition, she processed all of this *after* the workshop *by herself*. What is of particular interest is that she had already worked on her anger, sorrow and many other emotions in her personal therapy.

Colleagues have suggested that this transformation was a result of her previous therapy and other activities. But if this is true, then most patients who have long term therapy should engage in this sort of experience but to my knowledge, they do not. I had not seen this phenomenon for the first 15 years of my practice doing Encounter Groups, Gestalt therapy and then Radix neo-reichian therapy. It did not appear until I became proficient in helping patients mobilize their instroke process and deepen their contact with themselves. And in the example of the transformation of the stepmother, as with other patients, he was a "beginner" in therapy. It was clear to me that something else was happening that I had not learned about in my therapy trainings. Additionally, I have since trained other therapists who report a similar phenomenon some of whom had difficulty accepting that this was actually happening. In psychological terms, what we are witnessing is a complete re-structuralizing of a negative, life-long primary object relation or experience that is happening intra-psychically, sometimes alone, with no new input available to the patient. How is this possible?

To answer this question, we begin with the Gestalt principle of figure-ground discovered over 100 years ago. The neurologist Kandel (2013) described the self-referential nature of perception and how we create our own reality. Throughout his discussion of visual perception, he emphasized that “the eye is not a camera” (Kandel, 2013, p. 234) “every image is subjective” (Kandel, 2013, p. 200) and “there is no innocent eye.” (Kandel, 2013, p. 200). And this is true for touch, hearing, taste and smell as well. For emotions, empathy and the five senses, the brain engages in so-called hypothesis testing: guessing what is seen based on previous experiences. (Kandel, 2013). Our perception of the physical world is, “... an illusion created by our brain” (Kandel, 2013, p. 203). He pointed out that one can view the same painting over many years and see and/or feel different things each time. This can also be said about one’s varying response to

the same object/other.

This ability to re-formulate is the basis of how we can restructure a primary relationship years later with no new input and how the changes found in in-depth psychotherapy are achieved. The object remains the same. The story remains the same. It is the patient's *experience* that changes. Similar descriptions are found in the phenomenological point of view. "The learner remains unchanged. It is his experience of the situation which changes." (Syngg, 1941, p. 406)

With all sensory input, interpretation is inherent. A change of the interoceptive experience, changes the interpretation of the past just as with viewing the same painting repeatedly over the years. The painting only *appears* to change

To illustrate his point, Kandel (2013) used the Gestalt drawing that appears to be a rabbit or a duck depending on how one looks at it. The first point he made is that the visual data on the page doesn't change. What changes is the interpretation of the data. In therapy it is the patient's experience of the historic event that changes. The data/history is reorganized which in turn leads to a change of the experience of the exact same event.

His second point was that we "decide" what we see and these decisions are based on hypothesis testing grounded in a combination of our innate neural recognition patterns and our past experiences. It is important to note that in conscious perception, there cannot be ambiguity. It has to be either a rabbit or a duck. We cannot see both at the same time. Further, this principle underlies all of our conscious perceptions of the world. On the conscious, cognitive level, we have to make sense of everything

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

> Conscious thought works from the top down and is guided by expectations and internal models; it is hierarchical. But unconscious thought works from the bottom up or non-hierarchically and may

> therefore allow more flexibility in finding new combinations and permutations of ideas. While conscious thought processes integrate information rapidly, unconscious thought processes integrate information more slowly to form a clearer, perhaps more conflict free feeling. (Kandel, 2013, p. 469)

This helps to explain how the original data — the patient's history — can be re-organized resulting in a re-structuralization of a primary object or event with no new information added.

The same phenomenon was recorded in pupillometry.

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

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

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

"Our perception of the world is a fantasy that coincides with reality." (Kandel, 2013, p. 261) The fact that we are creating all these objects explains why we can continually misinterpret and see the same object "incorrectly" again and again, for

example, in transference or with a "bad" stepmother.

This idea is also supported by the neurological research of Raichle (2010) and Buckner, Andrews-Hanna and Schacter (2008) about the default mode network within the brain. Raichle has shown that there is a sub-cortical system involving different brain areas that unconsciously organizes all incoming information with no conscious awareness, and then informs cognition as to what it has "decided".

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

As we have seen from the perceptual point of view, the self creates the object. I have argued elsewhere that there is no objective object. (Davis, 2015 p. 14-18). For example, Campbell's Psychiatric Dictionary (2004) described introjection as: "The incorporation into the ego system of the picture of an object as *he conceives the object.*" ([Italics added] p. 348). Idealization is an extreme example of a self-created object. In idealization the internal object representation could have none of the characteristics of the "real" external object. This is a result of the earlier mentioned necessity for the conscious mind to organize and make sense of what it is experiencing. It also is the basis of the narrative the patient creates about traumatic historic events.

Investment

In creating our objects, the self gives significance to the object in the form of a specific quality, a charge of energy: need or desire. This is called investment. Most theorists argue that it is not the object qua object that is important but the investment made in the object by the subjective self. Mitchell (2000) commented that in the language of infant research, the mother and baby co-create each other. For example, taking the obverse position of Winnicott, Loewald suggested that objects: "…do not

exist independently of the subject. Objects are created by being invested with significance". (Mitchell, 2000, p. 38). Kohut (2001) took a similar view: "Narcissism is defined not by the target of the investment, but by the quality of the investment." (Kohut, 2001, p. 26). Research in social psychology showed that "It is the quality that determines functional significance rather than the particular event or object." (Ryan, 1991, p. 220). As well, in a quantum model of transformative processes: "The essential element is not the amount of energy involved but its quality; if it is able or not to trigger an information process of phase coherence." (Casavecchia, 2016, p. 10). As we have seen from this phenomenological, perceptual view, of all the incoming information, it is the subject that chooses what to focus on and to make sense of, depending on its own experience of the relationship. It is not so much about what was done to the patient by the other, but the patient's experience of the other/event.

Green (1999) criticized object relations theorists as being too focused on the object to see what he called the objectalizing function of the life drive. They over emphasized the object and do not appreciate the endo-psychic strivings, the *investments* by the self in creating objects and then relationships to satisfy itself. For Green, (1999) the object does not create the drive, it only reveals the drive toward the object. In this same manner, Damasio (1999) described the object as an emotionally competent stimulus, capable of meeting a response but not creating it. The object is a necessary precondition for the drive to be activated, but the drive is already there (Green, 1999, p. 85).

The role of the drive is:

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

He went so far as to suggest that the self will create objects in their absence! We create what isn't there out of our desires, needs and beliefs based on our own experience of events, not the external "reality" of those events.

Loewald brought this discussion to a final point:

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

Through the presented empirical results and their implications, the process of creation and therefore re-creation of (primary) objects becomes clearer, giving ground to mechanisms of change in psychotherapy. Objects don't change. We transform them. More precisely, when the therapy is going well, we transform our *experience* of them. This is also exactly what happens in a healthy development process. As the child goes through a progression of developmental stages, it continually re-organizes the representation of the mother object into adulthood. The mother is not so much changing as the child is experiencing the mother's various aspects as *he* transforms and develops himself further.

But Who is Transforming What?

The following is a typical representation of what an effective psychotherapy is based on no matter what the orientation or school of therapy utilized. "By confronting these fears from the past with open eyes in the now a person can find the strength to overcome most of his/her psychic and somatic dysfunctions in everyday life." **(**Adler, Gunnard & Alfredson, 2016, p. 8)

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

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

Further support comes from the Cambridge Conference on Consciousness (2012) when it was emphasized that there is subjectivity in the fetus before the development of cortical activity: before cognition, language and relationship. In the same tone, Solms and Panksepp (2012) identified an embodied, affective core consciousness in the brainstem and that higher cortical brain functions — cognition, language, representation and object creation — are built on and informed by this earlier emotional, embodied core consciousness. "The brain mechanisms of the internal body function largely automatically, but they also arouse the external body to serve its vital needs in the external world." "[…] in the sense that exteroceptive consciousness and learning reflect and serve interoceptive needs." (Solms & Panksepp, 2012, p. 155, p. 165). A core consciousness exists without cortical consciousness. The reverse is not possible. Perls said it more simply "[…] nature doesn't work by decisions, but by preferences." (Perl's, 1972, p. 30).

Experiences are lived not only below cognition, but without it. For example, it is possible to "traumatize" insects. Scientists selected a type of insect that shows maternal care of its eggs and young. They removed eggs from some of the mother insects and one set of eggs were cared for in laboratory conditions. The results showed that the females

not raised by their mother were not as nurturing and protective of their own young. "The researchers found that nurtured female nymphs matured into devoted mothers assiduously cleaning eggs and feeding and defending their young. In contrast, females raised without mothers did not excel as caregivers. They fed their offspring less frequently and were not as effective at protecting them from predators." Similar results were found with another set of eggs inserted into a "foster mother's" egg collection. (Scientific American, 2016, p. 13)

An interesting approach to understanding a core consciousness/endo self state through a quantum field theory (QFT) model has been developed by Tosi and Del Giudice (2013) and Casavecchia, (2016) with their concept of Minimal Stimulus. Their understanding is phases of "resonant relations" within the quantum field. The psyche houses the resonating phases within the field thus ensuring a unitary behavior of the organism. In terms of this paper, their description below describes in QFT terms the gathering force of the instroke —"concentration of internal energy"— and the endo self state —"reorganization of internal energy"—.

> These resonant relations …do not require a flow of energy, but rather a *concentration* of internal energy *already present* in the subject, which implies a decrease of its entropy. It turns out that the movement of the organism is not only a movement that requires a constant supply of energy from outside; it is rather a movement from within, based on the reorganization of internal energy and triggered by informational stimuli. (Casavecchia, 2016, p. 4, [Italics added])

Their concept of Minimal Stimulus also works below defenses, focusing on the emerging resources and not on the structural deficits of the defenses of the traumatized state.

> Resonating in the defenses, focusing the action on the structure of body armor, reinforces the functional forms of somato-psychic stratification of the adaptations to the trauma of loss and to the block of the bioenergetic flow. It consolidates the experience that produce the intra-psychic sense of rupture of the continuity of existence,

> Winnicott's "going on being" — in the block of pulsation, that has fragmented the self and organized the defense. (Casavecchia, 2016, p. 14)

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

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

Rewriting History

If we postulate an undamaged, embodied, psycho-emotional core called the endo self, we have answered the question of who is doing all the work of transformation. But the question remains, *how* is the experience altered with the same data? How do patients now access information that was there but not available to them before? The answer to this question lies in the dynamic of what Guntrip originally called the "dual nature of

transference" (in Buckley, 1986, p. 467), just as Reich had already differentiated between false positive transference and genuine transference and used it as the basis for his character analytic work (Reich, 1976).

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

A Duality: Need and desire

It is this dual nature of relationships that allows for the possibility to transform objects and historic events. As Guntrip pointed out, there are two movements flowing simultaneously. I have framed the dynamic of this duality in terms of need and desire, a dual flow of both need and desire within all relationships (Davis, 2015). Desire is the natural impulse towards contact. Using Freud's model, desire is the "universal characteristic" in all relationships. Need is frustrated desire adding another layer or element to this universal characteristic creating the neurotic's "intensification" or Winnicott's "rupture of continuity" and thus distorting the natural flow towards relationship resulting in the creation of distorted need states.

Typically, psychotherapists refer to the needs of the patient. Even Maslow (1968) wrote of a "hierarchy of needs" from safety to social to self to altruistic on to transcendence with the "lower" needs having to be satisfied before the later ones could be engaged. To differentiate between desire and need changes the theoretical landscape. Need arises when the desire is not met. Need is a state of difficulty, a sense of deprivation with a goal implied – usually at a distance. In psychotherapy terms this distant goal is the other. Desire suggests mutuality, a give and take dialogue by placing a

"request" to respond upon the other to whom the desire is expressed. It has an impervious quality, a request that must be responded to (Crabb, 1917). Desire is a request. Need is a demand.

Thus, need is unmet, distorted desire. A desire to be in contact is a different state than a need to be in contact; they have a different purpose and outcome (Davis, 2014, p. 14). Need originates from desire, but just as the ego emerges from the id, the ego then has different intentions and outcomes than from whence it came. There is a rupture between id and ego. If the desire is not met, then it "sours" and becomes need – a lack state. The "pushy", "gluey", shrill quality of the need state is a symptom of the unmet desire. A need state is symptomatic of a lack, what is missing. In reichian terms, needs are emotions from the armor that have lost their pulsatory contact with the core. Again, there is a layered effect: defensive emotions about unacceptable emotions about more primary, unmet emotions. It's an archeological dig.

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

Another differentiation between need and desire is that in a desire state, in contrast to need, there is no tension that has to be discharged as in drive theory. The "tension" that does exist within a desire is an energetic excitement, a concentration of internal energy, that acts as a spontaneous, natural, mobilizing force towards object relationships and is well within the tolerance levels of the organism: Freud's "universal characteristic". It is pleasurable (Libido means "it pleases").

Surprisingly Piaget spoke directly to these twin themes of flowing out towards the other and the pleasure found in this movement. Piaget described development as "[t]he very nature of life is to constantly overtake itself" (in Ryan, 1991, p. 208), to extend itself outward even further. And this striving outward, what Piaget called intrinsic motivation, is merely for itself. There is a pleasure in mastery, in effectance, in experiencing merely for

its own sake. For Piaget this is a "basic fact of psychic life" (in Ryan, 1991, p. 209). Fifty years later the neurological research of Ramachandran verified that the wiring in our brain ensures that the very act of searching for the solution is pleasurable (in Kandel, 2013).

Immutability

Additionally, it should be noted that satisfying needs only creates the *possibility* that the desires will be met, which brings up the all-important theme of the immutability of the desire of life to "constantly overtake itself" (Piaget in Ryan, 1991, p. 208) , to go beyond itself into contact and relationship. And herein lies the nature of the duality in relationships. I have argued for the humanistic model of an inexorable movement towards development, growth, contact and relationship (Davis, 2014). This is desire, also known as: investment, Freud's universal characteristic, Green's objectalizing process, Guntrip's dual nature, etc.

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

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

renovation.

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

Schore (1999), like Kohut (2001), emphasized this continuing search for completion, this immutability. Echoing Guntrip's subtle dual nature he wrote:

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

Bowlby reflected this when describing attachment. "While especially evident during early childhood, attachment is held to characterize human beings from the cradle to the grave" (in LaPierre, 2015, p. 86). Casavecchia as quoted earlier also referred to a duality when working with patients: to focus on the emerging resources (what I call desire) and not on the structural deficits (needs).

In an earlier formulation of this same understanding, Reich (1976) emphasized that analysis could not proceed without reaching a level of "genuine transference" with the patient; "…the glimmerings of rudimentary genuine love"; again, a subtle dual nature (Reich, 1976 p. 143). Reich understood that the original desire for the object is still intact but obfuscated by false positive transference. Genuine transference is desire for contact and relationship, rooted intra-psychically in the endo self. False positive transference, Guntrip's transference, Schore's deregulated state and emotions from the armor are need and lack rooted in dysfunction and defense and sought externally in the object.

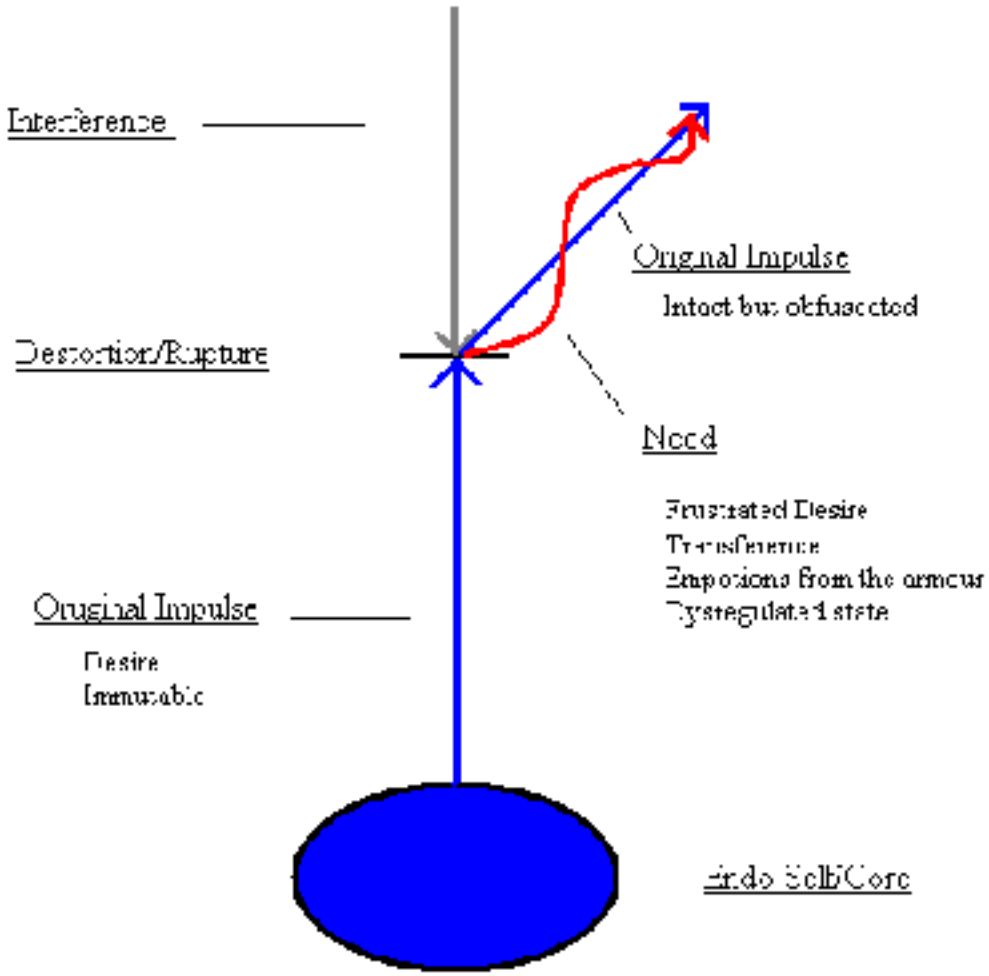
It might be of interest to body oriented therapist that there is also a dual nature to the central nervous system that might have something to do with the effectiveness of touch in psychotherapy. Becker (in Oschman, 1997) has shown that there are two nervous systems within the central nervous system. The one is the well-known system of nerve fibers and synapses that carry electrical impulses in an alternating current. These nerves are surrounded by an insulating layer of connective tissue — the myelin sheaths just as electrical wires are insulated. The impulses are carried *within* this sheathing called the perineurium. In fact all the major systems have this same sheathing: the perivascular system, the perilymphatic system, the periosteum, and the myofascial system. Why this is a duality is that the external, insulating sheathing *also* carries a current, a direct electrical current throughout the whole body! What makes it even more interesting is that this current is the same as the brain waves.

> Becker describes the properties of the connective tissue layer surrounding the nervous system, called the perineurium. Every nerve fibre in the body, down to its finest terminations, is completely encased in peri-neural cells of one type or another. Becker recognized a 'dual nervous system' composed of the classical digital (all or none, alternating current: AC) nerve network, the focus of modern neurophysiology, and the *evolutionarily more ancient* peri-neural system which operates on direct current (DC). The peri-neural system is a distinct system. It sets up a low voltage current, called the current of injury, that *controls injury repair*. Oscillations of the direct current field, called brain waves, direct the overall operation of the nervous system, and *may regulate consciousness*. (Oschman,1998, p. 41, [Italics added])

It is tempting to speculate that possibly touch effects the peri-neural systems throughout the body, therefore contacting direct primary processes and repairing injury both physical and psychic. It might be a physical way to understand how it is possible to reach the deep levels necessary to get below the trauma.

The Diagram I below delineates the dual flow in all relationships.

Diagram 1. The dual flow in all relationships.



The continuation of the straight (blue) arrow past the rupture point represents the original impulse —the universal characteristic of Freud— from the self/core towards the other. The continuation of this impulse is embedded within the distorted need state represented by the irregular (red) arrow, revealing the still alive desire for contact and relationship that underlies all neurotic need states. Because both are there at the same time in all relationships, Guntrip referred to a "duality". And because both are there at

the same time in the therapeutic setting, the decision the therapist can make is which to focus on, the need or the desire; the "emergent resource", or the "structural deficits". Fairbairn (in Buckley, 1986) reported that a patient once said to him "I want a father." He deduced from that that the goal of the drive is the object. I am arguing that he is correct only when the drive is a need state, a ruptured desire. Differentiating between need and desire, the therapist can choose to work with the need for the "father" object, or the desire of "I want…".

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

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

Green wrote:

> […] what brings a subject to analysis is…a compulsive need [in terms of this article, what did *not* happen, desire] to rebuild his story in order to carry on with his life, a story that he neither knows nor knows how he wants it to be; and, by recreating it, to make it different, risking, in the process, to pay the costs of the fiction that he wants to turn into reality. (2005, p. 424, [Italics added])
>
> […] how far does what unfolds in the treatment involve a repetition of the past and how far does it concern not what has been repeated but, on the contrary, *what has never been experienced.*" (2005, p. 71, [Italics added])

On the other hand, without some sort of model as I am suggesting, as Strecker (2018) pointed out, we are left with a quite different position.

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

A FUNCTIONAL MODEL FOR REWRITING HISTORY

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

In discussing pupillometry I pointed out that perception and imagination are based on the same neural process and as a result what is happening in the imagination is actually happening and is not a memory. Neurological research confirmed this. As Cozolino (2002) and others have pointed out, all trauma is stored sub-cortically and in the present moment. Research revealed that traumatic events are stored in the more primitive regions of the brain stem and limbic brain with little cortical and left-brain involvement, resulting in the absence of localization of the memory in time. "Flashbacks are always in the present and total system experiences."(Cozolino, 2002, p. 272-273), reflecting the position taken in the Cambridge Declaration (2012): "The neural substrates of emotions ...are therefore "out of time".".

All of this discussion confirms Reich's earlier insight.

> There is no antithesis between the historical and the contemporaneous. The whole experiential world of the past was alive

> in the presenting form of the character attitudes. The make-up of the person is the functional sum total of all his past experiences. (1967, p. 121)

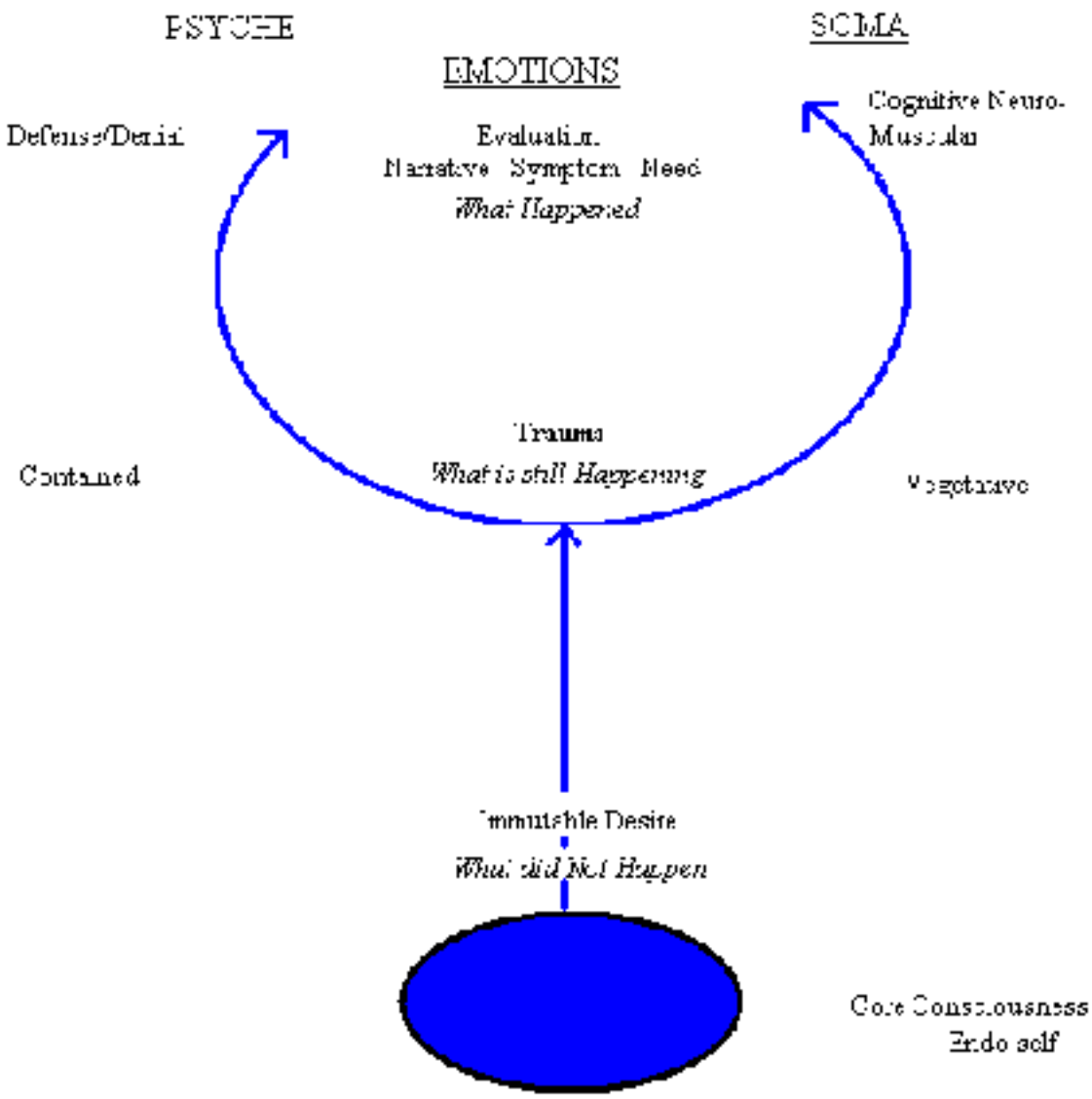
And,

> The schizophrenic does not "regress to childhood". Regression is merely a psychological term describing the actual, present day effectiveness of certain historical events. The schizophrenic does not "go back to the mother's womb"; what he actually does is to become a victim of exactly the same split in coordination of his organism which he suffered when he was in the deadened mother's womb; and he has maintained that split his entire life. *We are dealing here with actual, present day functions of the organism and not with historical events.* (1976, p. 492)

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

Diagram II

The psychosomatic level contains emotions and the central nervous system based cognitive and neuromuscular system. This level is the location of the body/mind defenses that protect the patient from the underlying trauma. Defenses in the forms of thoughts, emotions and muscular reactions are evaluative responses by the patient to what he is *still* afraid of re-experiencing from the historic event(s). In the case of trauma, it is a defensive, avoidance reaction to what has happened and to preventing it from being experienced again. Defenses are evaluative, decisions made to protect the patient from what they experience as dangerous. And of course, what is being evaluated is the horror of the trauma which lies *below* these defenses. The patient must protect her/himself from this abomination.



Herein also lie the symptoms and the narrative of how the trauma occurred and how it continues to negatively impact the patient's life. This is what the patient presents in the therapeutic setting. Or, if the trauma is unconscious, the narrative formed around this unacknowledged experience. According to Cozolino (2006), the vast majority of memories are unconscious (pre-cortical), but shape our emotional experiences, self-image, decisions, and relationships. He pointed out that the speed of the amygdala in processing information generates a physiological reaction before we are conscious of what is being processed. He calls this the "known and unremembered" (Cozolino, 2016, p. 130) just as Bollas (1987) had earlier referred to "the unthought known".

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

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

As we move down the diagram we come below the cognitive/neuromuscular, psychosomatic level to a pre-cortical, yet knowing state on the vegetative level: the unthought known. And here again we have evaluation. Below the cognitive-neuromuscular based defenses, the vegetative state is still out of balance because of the trauma. The organism reacts first to any shocking event on the vegetative level. If the shock is not released, the vegetative system stays out of balance: This is trauma. Not all shock is traumatizing. The cognitive/neuromuscular response is secondary, built upon an evaluation of the more primary response to danger on the vegetative level. The vegetative response is the active, living level. As pointed out, it is not historic. It is not a story of what *happened*, but what is still *happening*. This is why it must be defended against continually. If it truly was in the past, there would be no threat to the patient. The

problem for the patient is that it can happen again right now, because on this level there is no time. It is always now. It is always haunting the patient, threatening to happen again. The psychosomatic narrative level is about what happened in the "past" and the patient is desperate to keep it there. In reality, and understandably so, it is simply being avoided, split off from. Unfortunately, in the deeper vegetative level it is still happening. It is, hopefully, *contained* by the vegetative response, but it has not been eliminated. For example, it is more precise to speak of a schizoid *process*, not a schizoid *character.* Further down the diagram, represented in brainstem functioning, is the endo self, the level of what has not happened; the incomplete, immutable desire for satisfactory contact and relationship.

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

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

A recent session with a patient with a trauma history revealed the same qualities of the endo self state described earlier. Often in Functional Analysis nothing happens in the sessions and the surprising phenomenon described earlier of the release of the trauma and the object re-organization happens safely later. In this case, using an older

mobilization technique, the partial release of a deep contraction on the vegetative level allowed the whole body to be involved during the session. At that point, the patient began the gentle, gathering, curling movement of the instroke with her head and shoulders rising up gracefully from the mat. But suddenly she interrupted this natural, flowing movement with a strong contraction in the rhomboids pulling her shoulders backward, contracting her throat and preventing any further gathering, instroke movement. Instead of trying to undo this, I supported this defensive movement by placing my hand on her rhomboids and, for a few moments, I applied light pressure upward in the direction of the contraction. I then told her to stretch and move on the mat and then she described the interruptive, blocking quality she felt in the rhomboid contraction. After talking, and returning to the work on the mat, the same rising up movement came again but this time she did not interrupt it and gathering herself, she came into a curled-up ball where she felt satisfied.

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

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

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

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

HEALING BEGINS AFTER THE TRAUMA IS FINISHED

Healing begins after the patient finishes with the trauma. They can get on with

their lives and continue the still intact developmental track that was interfered with or more importantly, begin what was never given the opportunity to develop due to the restrictive nature of the defenses against the trauma. The patient must be accompanied through this new territory. Having thrown off the restrictions of the trauma, they are now able to mobilize their intrinsic motivation: To search for what has not happened. They should be supported just as we support a toddler learning to walk. We don't do it for them or lead them, we merely follow behind supporting them in exploring and becoming themselves.

The healing process goes through stages. Once the trauma has "finished", the event cleared, the perpetrator fading into history, there arises a sense of having been abandoned by others. There can even be a phase of blaming: Where were they? Why didn't they protect me? How could this even happen to me? (As therapists we too sometimes ask ourselves during a session "How could this have happened?") This can be seen as a negative, judgmental state. But in reality it is a nascent, emerging, self affirmation.

Then there is an acceptance — even a type of forgiveness. It is not merely a coming to terms with, an adult intellectual understanding, but a letting go of. The sign of this is when the patient begins to review the past and differentiate persons, events and memories from what was a dangerous, dark, tight, condensed, confusing tangle of people, places, events, memories and emotions. At this point, there is no blaming. There is a neutral quality to the narrative, sometimes expressing caring and tenderness towards others historically involved, even towards the perpetrator(s). And sometimes even acknowledging ones own contribution to the abusive behaviors.

The patient acknowledges the other(s) as not just an object but as a person. For example, three different patients commented similarly: "He is a sick man. I feel sorry for him." "It is sad my father could not enjoy my achievement." "He was a stupid man, and stupid men do stupid things. It wasn't against me, but I suffered." There is an adult to adult quality with all the imperfections involved in such a realistic relationship.

A surprisingly condensed version of this process happened during a series of four sessions in 2 days. In the third session, the patient came in with a dream from that

morning. He was in a mental institution and there was all sorts of bizarre behaviors going on around him. Among the melee he recognized a man who was shouting dangerously and a woman wrapped up "like a mummy" as his father and mother.

He saw this as the reality of his childhood home life and for the first time he could see the brutality of it all. What is interesting is that this *type* of dream was not new. He had worked on this theme in his previous therapy. What was new was that for the first time there was what he called a "clarity". Before everything was "like in a cloud", the reality of the brutality was too brutal to see clearly. Now it was not dangerous to accept that reality. He was safe in front of it. I asked him very much the same question I posed at the beginning of this article: "Where did you find the strength to overcome all of this?" The patient described it as: "Something was developed inside me so that I could face this truth. A biological process. I don't know what it is (as he unconsciously touched his abdomen tenderly) but it is a healing process. My own resource."

He then said he was grateful to his parents despite all the bad things that they had done. As he spoke there was a sense of an acknowledgment, acceptance and on to a freeing from guilt, a forgiveness of an offense: An absolution.

SUMMARY

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

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

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

The psychoanalyst Hans Loewald described this process:

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

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