

# **<sup>1</sup>CONTAINMENT, HOLDING, AND RECPTIVITY: SOMATOPSYCHIC CHALLENGES**

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*ABSTRACT: This paper is about some of those principles in the organization of the psychotherapeutic space. These are central, basic principles, which are necessary for the space to work as intended. A perspective derived from principles of Bioenergetic Analysis is shown to be useful in elaborating the dynamics of the space. This paper is also about the challenges posed by the requirement to establish an environment based on these principles. This construction demands a great deal from therapists. At the end of the paper I will propose that facing these challenges and the work to meet them offers a model for psychotherapy and also for relationships more broadly.*

## **INTRODUCTION**

A supervisee in the China training program in Bioenergetic Analysis tells me about her patient. His reasons for coming to see this therapist at this time are somewhat vague. He wants to feel his body, his insides, in an immediate and integrated way. The therapist tells me that he immediately reminds her of a friend, whom we both happen to know, a very tightly constricted man, very withdrawn into himself even when he is in contact with another person, who's mother also committed suicide when he was young, as this patient's mother did.

This patient came to see this therapist to avail himself of an approach to psychotherapy that also used active techniques stemming from an understanding of the subtle relationship between somatic structure and process and psychic

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structure and process. The therapist observes him and sees a man in his late thirties who is tall and thin. His shoulders stoop forward, his belly protrudes, and his legs are stiff with locked knees. His left shoulder is noticeably higher than his right. His head and neck are thrust forward in a way the therapist describes as a “goose neck.” Overall, he gives the impression of someone staving off imminent collapse.

The therapist offers him movements and postures that are expected to intensify his contact with himself and with the environment around him, movements familiar to bioenergetic therapists as part of increasing groundedness. This is done to meet his request to feel himself and the reality around him more. His reaction to the experience of himself standing in a more aligned posture, activating muscle systems that are chronically flaccid, is to become flushed with energy, overwhelmed by even the small effect of these quiet movements.

He withdraws and becomes silent. The therapist asks him what he is feeling or thinking. He says he is considering ending the therapy because he is making no progress. Nothing is changing. He also says that when he stands and feels the floor under him he wants to feel like a “cock” with the aggression and brashness of a rooster. Instead he feels tremendous tightness in his shoulders and neck.

The therapist tells me of the struggle to know what to do at this moment; with the patient and how to deal with the therapist’s feelings, which include some anger at the patient. The anger feels to the therapist a result of the patient’s unwillingness to take the therapist’s care, and offers of help. We talk for a while about whether it is the therapist’s job to ‘get’ the patient to take what is offered. We talk about the difficulty of caring for someone and wanting them to feel better, get stronger, and facing the limitation that the therapist cannot make those things happen. I suggest to the therapist that the anger felt by the therapist might be made up of two elements. One is a projective identification, the patient has evoked in the therapist his anger at not being enough for his parents (this fits with data we

already have about him), and that what he offered them as a child did not make them feel better. Second is the therapist's anger at not being received and appreciated. We talk about how the first vector of anger can be useful as a way to share with the patient the enactment of this relationship process. The second vector belongs in the therapist's therapy—she has similar feelings of resentment and anger at not being sufficiently cared about and taken care of by those in the early environment who should have done so.

In the session the therapist adroitly responds to the patient's needs in a very effective way. In response to his complaints about discomfort after the active interventions the therapist explained to him that he has been holding himself in these rigid somatic patterns for a very long time and that disrupting the patterns or challenging them results in discomfort. It is hard for him to feel the changes as natural. He responded to this by saying he was not ready to face the feelings that arose from the movements and postural changes. He reported a strong feeling of nausea that was more than he could work with.

He did relate the nausea to his feelings about his mother. He talked about a woman he has had as a friend for a decade who "also suffered with her family". She has a baby and from speaking with her he realized that "...those first two years of listening to their mother's language, connected with physical closeness to your mother, this is called mother tongue. You don't get this attachment you don't have a sense of identity." He said this made him aware of what he lacked.

His therapist and I talked at some length about what the therapist's job is. Where we left things, for now, is that the therapist's job is to create a space in which this patient can feel himself as deeply and fully as he can and wants to. In that space the patient can form a relationship with himself and the therapist that includes maximal freedom for self-expression, and the possibility of encountering himself as he is now, and stretching to be in new ways, to develop new forms. The

therapist accompanies him in this, and organizes the space along the lines of very specific principles.

This paper is about some of those principles in the organization of the psychotherapeutic space. These are central, basic principles, which are necessary for the space to work as intended. This paper is also about the challenges posed by the requirement to establish an environment based on these principles. This construction demands a great deal from therapists. At the end of the paper I will propose that facing these challenges and the work to meet them offers a model for psychotherapy and also for relationships more broadly.

## THE HOLDING ENVIRONMENT

Containment, holding, and receptivity in modern psychotherapy practice are concepts that describe basic functions of the therapeutic process. These terms are often used impressionistically, with a spaciousness that allows for inclusion of various significant elements. But sometimes there is not enough clarity without enough clarity or specificity to assure that the users mean the same things by their use of the terms. This is particularly significant because, as will be suggested in this paper, these terms refer to essential elements in the construction of the psychotherapeutic environment. Included in that construction are characteristics of the space, both material and conceptual; and characteristics of the therapeutic relationship, including therapist characteristics. Since the method for understanding psychotherapy process in Bioenergetic Analysis includes the examination of energetic forces at work within and between people, and also treats psychic and interpersonal phenomena as events observable in somatic processes and structures, it provides a very useful lens for focusing on the concrete meanings of these concepts and their operation in the psychotherapeutic setting.

One way to organize the group of concepts and functions represented by the terms containment, and holding, and receptivity, is to place them under the rubric of what is meant by a holding environment. The concept of a holding environment is a concept developed by Winnicott (1958) to describe the relationship between mother and infant, the qualities of which can be repeated in later life relationships. If the original holding environment was deficient emotionally and psychically it will be repeated in the psychotherapeutic relationship. If the therapist facilitates the development of a healthier and more constructive environment than in the original parental-child relationship the possibility for healing is engendered.

The conceptual framework represented by the idea of a holding environment has penetrated the consciousness of psychotherapists of many orientations (see Mitchell and Black, (1995), for an elucidation of this idea and its prevalence in the field). To some extent it has found a reception in the public at large, along with a general idea of the significance and importance of attachment processes in the formation of people's personality, starting perhaps in contemporary times with the work of Benjamin Spock, MD (1946) whose book on baby development and earlier relationships are among the most widely read books in the world.

Attachment forms a matrix in which the person is embedded, and which nurtures—or impedes—the development and emergence of her or his personality. This perspective on formative processes, the somatopsychic aspect of which is profoundly elucidated by Stanley Keleman (1985), and the particular role of early relationships, is the product of many influences and many theorists. Nowadays it has become conventional wisdom among psychodynamically oriented psychotherapists that it is the therapeutic relationship between therapist and patient that is the primary healing agent of the psychotherapeutic process. What this means exactly is somewhat unclear. There is a general consensus on certain

elements that ought to be present in the therapeutic environment, emanating from the therapeutic relationship, but not so much clarity and specificity on what those are, or why they work. This paper is an attempt to organize some of those characteristics of the psychotherapeutic relationship that operate in the holding environment, and enable it to function as a medium for healing and for growth. I will also illuminate what some of the challenges are if the ideas currently espoused about the nature and function of the relationship are correct.

## A BASIC MATRIX

A student in a class of creative arts therapists I taught made a comment that opened a way to a deeper understanding of the psychotherapeutic relationship than I had before, or that I had seen or heard previously. She said that she thought that psychotherapy was an evolutionary development brought about in response to the particular kind of healing possible in the environment created by this practice. Her comment stimulated me to begin thinking about what it is that makes the psychotherapy environment unique. And how that uniqueness might be part of its function, and, now I see, integral to its success.

The psychotherapy relationship is not just a better version of other, especially parental, relationships. In the relationship between patient and psychotherapist the patient is always, and forever, at the center of the process. In no other relationship is the focus on one partner so absolute. It would not be healthy was it so. In all other human relationships it is essential that the relationship be explicitly mutual. Giving and taking are reciprocal functions. Interdependency requires the needs of both (or more) parties in the relationship to be considered and for needs to be met in appropriate ways.

The psychotherapy relationship is a human invention, similar to a hyperbaric chamber. That is a device in which a person is placed that creates conditions of oxygen saturation and air pressure that do not exist naturally on earth. These

conditions facilitate healing from certain medical conditions—the bends, severe burns—that are not easily healed otherwise. Similarly, psychotherapy is not a better version of relationships that have come before. Or even an ideal version of relationships, a sort of paragon. It is a unique kind of relationship that we have created for the purpose of healing damage caused in other relationships. The central principle of that uniqueness is that the patient's welfare, autonomy, self-determination, and the patient's centrality in the relationship are always prioritized.

It is not a natural part of relationships to be so exclusively at the center of the relationship for so long a time as in psychotherapy without any demand that the needs and feelings of the partner in the relationship (the therapist) be considered in the patient's decisions about what to do in the matrix of the attachment. One thing we learn from early infant research is the critical importance of the mutuality that informs healthy early relationships, even in earliest infancy (Bowlby 1969). There is no time when the infant and parent is not a pair. No time when the dance does not include both partners. To dance effectively, creatively, passionately, happily, constructively, both partners have to be aware of each other, of each other's needs, limitations, and what needs gratifying and is gratified. This part of the dance is explicitly not required in psychotherapy.

The relationship that is co-created by patient and therapist specifically permits the patient to occupy the center of the relationship in whatever way, and for as long as is necessary, that the healing requires. And it specifically enjoins the therapist from impinging on that centrality in any way not absolutely necessary for the maintenance of the relationship (fee, scheduling, and the like), and certainly not to provide for the gratification of the therapist's needs to be loved, adored, admired, followed, served, deferred to, or otherwise to take the center.

This is the abstention that the therapist agrees to in order to create this unique environment that we have come to call in shorthand “the holding environment”. Once this specialized environment is constituted the therapeutic actions of psychotherapy can begin to take place. Many of these actions get subsumed under the general rubric of the holding environment. But they are specific dynamic actions each with their own structure and energetic impact. Just as, for example, love and respect are not the same emotional-energetic forces so each of the elements in the therapeutic holding environment are not the same. Bioenergetic analysis with its focus on energetic processes, and its refined approach to understanding somatopsychic processes gives us tools to examine in finer detail the nature and operation of these therapeutic elements and their actions.

## EMBODIMENT

It seems necessary here to ask what psychotherapy is for. The earliest emphasis in modern forms of psychotherapy was on liberation from repression and the freeing of personal autonomy, part of the political changes in Western civilization that began in the Enlightenment. More recently, there is a focus much more on anxiety and the reduction of suffering and on the possibilities for positive feeling.

One way to synthesize these two positions is in the concept of embodiment. Embodiment is another of those conceptual and experiential understandings that we have difficulty defining with specificity, although we kind of know, implicitly, what we mean. In modern bioenergetics embodiment refers to the capacity for deeply felt experience and strong expression of emotion. In this context embodiment refers to somatopsychic structure and capacity in an individual that holds that deep experience and powerful expression and the holding allows for continuous integration and refinement of the experience. Somatic oriented free-association, the following of one’s process in a profoundly attentive way, without



judgment, accepting of whatever arises, is made possible by the psychotherapeutic space.

From the moment of embodiment self-possession is possible, choice is possible, options for amelioration of suffering, if any exist, can be chosen. In this perspective one thing psychotherapy does is facilitate a person's capacity to be in reality. To be in reality means to be able to feel things and experience things as deeply as possible, to broaden awareness and understanding of ourselves and the environment, and to use as much of the information available to us as we can tolerate knowing and immersing ourselves in.

With this general view of what psychotherapy is for we can examine the ways that a holding environment creates and sustains a space in which this project can be undertaken. This paper is an analysis of the elements that constitute a holding environment. It is not my idea that this exhausts the analysis. Rather this is the beginning of an investigation using the tools of bioenergetic analysis that is designed to illuminate the elements both structural and procedural that make the holding environment the therapeutic envelope, and why it works as it does. I hope others will add to our understanding of it.

So far my analysis has led me to divide the functional elements of a holding environment into three general categories that I label containment, holding, and receptivity. Each of these functions has both structural and procedural dimensions. That is, there are aspects of each that are built into a successful holding environment, and there are dynamic parts that are behavioral, executed by the therapist.

## **I. CONTAINMENT**

Containment refers to all the elements of the therapeutic space that contribute to its therapeutic effect. This use of the term has nothing to do with modulation, or

suppression, or restriction, or regulation of affect. It has to do with the constituent elements in concrete material terms, in ethical and professional terms, and in characteristics of the therapist, of the therapeutic environment. From a bioenergetic perspective the therapist's space is an extension of her or his body. It is designed to contain, meaning to cradle, and to sustain, strong and deep emotional experiences of self. Some of the elements of a successful psychotherapeutic container are common to all psychotherapeutic modalities.

The common elements include structural elements of private and secure physical space. They also include the ethical and professional elements such as confidentiality, and a covenantal relationship, a bond based on faith and trust that the therapist will maintain the centrality of the patient, in which the interests of the patient take priority. And there are certain characteristics of the therapist—a non-judgmental attitude, and an ability to respect and appreciate the patient as an autonomous person, that are requisite for the containing function to operate properly. In bioenergetic analysis these characteristics extend to a physical space that allows for expressions that can be loud and unconventional by the standards of psychodynamic psychotherapy, and include emotionally evocative physical interventions that require the therapist to have mastered a discipline of direct physical contact and a tolerance for the ensuing emotional expression.

A clinical example of what I mean by this idea of containment comes from my own psychotherapy. Here is a moment from my psychotherapy with Michael Eigen, a therapy of many years duration now. One day, many years ago, I was on the bed he used as an analytic couch at that time, and I was in the throes of certain kind of unbearable tension in my neck. It is a maddening, demonic force in my body. It overtook me, and still does. I said to Mike: "I wish you could hold my head so I could scream." He said: "I wish I could too." This was an immensely important moment for me. He was not denying the validity of that way of working. He was saying, to my ears anyway, honestly what his limitations are. That I could accept. Those limitations of his have meant that I have had to do this, for me

lifesaving, work of strong, loud, emotionally intense expression, on my own, or occasionally with others who work in this modality. Learning that has reinforced my conviction about the importance of the characteristics of the containing environment for strong expressive work, and how that environment can be internalized by patients.

Mike has personal experience with bioenergetic work, and the forceful emotional expression does not seem to throw him. But once, when I began on my own to make too loud or intense an aggressive sound, I'm not sure the exact nature of the stimulus, he asked me to tone it down because he had heard complaints. From other residents, I assume. So I have had to monitor and modulate my expression. I am clear that he can receive the force of my emotional expression, but I cannot express myself as fully as I can. Luckily for me, by the time I came to him, I was experienced at working with explicit strongly expressed emotion. My first extended therapy was with Vivian Guze, a bioenergetic therapist who saved my life, and the work with her taught me how to stay present for myself in the throes of intense experience despite the possibility of decompensation. And, even more important, I had a life partner whose capacity for strongly felt and expressed emotion exceeded mine and who could therefore provide a holding environment greater than any of the others in my life.

In fact, when I left my therapy sessions with Mike—who, despite his familiarity with bioenergetic work, and comfort with it, was not working in that modality--I would always need to make time for expression of the rage that was mobilized in me. I have been doing this kind of work on myself for years. Screaming, punching, kicking were the ways that I could exit, however temporarily the deadness engendered at the core of my being by early childhood mistreatment. I could not complete an episode of work without it. I had to be able to fight with those who so harmed me, and I had to express my own feelings of hate and sadism. This was the only way to return to some relationship with reality and to be in the present even in the limited way that may be possible for me.

## IA. CONTAINMENT AND INTIMACY

A containing environment, which is the first constituent of a holding environment, is created when a therapist creates a physical, ethically guided space, and enters it prepared to embody the characteristics required for therapeutic action. The therapist uses the tool of empathy to register what the patient is experiencing internally, including that which is out of the patient's awareness. Starting from this position, the therapist attempts to effect a moment of meeting with the patient. This means receiving the patient as she or he actually is as a person and taking her or him in. This is a much harder task than it appears. It is not tolerance, or compassion. It is intimacy, a knowing the other as the other actually is. This is the first constituent of the holding environment, and already the task is very demanding for many of us. From this standpoint it is inconceivable to see the other person (patient) as someone who needs correcting, or fixing, or adjusting. To know the other person in this way is to know how they came to be who they are, and how much that history is who they are.

This turns out to be quite a difficult skill to develop and to deploy in a sustained way. I will take the risk to say that much of the criticism of psychotherapy, its slowness, its aimlessness, and the like comes from the fact that therapists are not engaged in this process of embodied containment with our patients. Some of us are too afraid—of the feelings in us and/or in the other; some of us are too narcissistically invested in having an impact; some of us allow the press for our own need gratification to take us out of the posture needed for containment. Whatever the reason, the feeling of aimless, or pointless wandering comes from that lack of presence, not from a fundamental deficiency in the work. The pressure then to produce a method that does more, and faster, is a response to a limitation in the way the therapist behaves and feels, and is not a problem exclusively in the method being used.

Containment is that set of functions which structures the therapeutic environment to make it possible for the patient to reveal and experience that which must be revealed and experienced, thus making intimacy possible. This revelation takes many forms. Here is one compelling description of that revelation from Michael Eigen's *The Annihilated Self*, published in 2006:

Emboldened by their contact and driven by need, this person comes in one day without makeup and shows herself as she is. Chilling, bloodcurdling, necessary. She shows her ravaged self to the one person who can take it. No, incorrect. Marlene [the therapist] may not be able to take it. She shows herself whether or not Marlene can take it. That is closer. To risk in therapy what no one can take. (p. 25)

Eigen goes on to say something that I think relates to the specific and unique function that psychotherapy performs for human beings, that is specific to it, and not only better versions of what relationships should be. He says:

The human race has not evolved the capacity to take what it does to itself, the pain people inflict on each other. In therapy one risks what is too much for another, too much for oneself. One risks what no one can take or may ever be able to take. That enters the room and is shared, whether or not anyone can take it. (p. 25-26)

Containment provides the environment in which that which must be felt and revealed will occur. The therapist prepares the space and most importantly, prepares her or himself for an encounter with what is most real and most painful, and most disturbing, and most frightening for the patient. In bioenergetic analysis creating the containing environment includes creating a physical space in which emotional expression can take place at the most intense, most overt and most evocative level possible for that person. In the context of Mike Eigen's article the

affect is in response to damage, harm and destructiveness. But the same preparation applies to love, pleasure, even ecstasy.

The therapeutic environment is unique in its focus on the patient and the patient's process. It is the patient's experience that takes precedence. This is not to the exclusion of the therapist or her or his experience. It is a matter of prioritization and of the nature of the space. No judgment is offered as the therapist endeavors to receive and experience both what the patient can and cannot tolerate experiencing.

This is the containment that we mean as bioenergetic therapists. There is no suppressive element in it. On the contrary, the space is made safe for as big or as small an expression as the patient and therapist can tolerate. It is part of the therapist's skill to open the space and invite expression that is within the range of tolerance for the patient, so that the experience can be integrated and metabolized. Since what is dealt with is so often chronic relational trauma and the long-lasting effects it leaves behind, the movement of revelation and expression followed by integration is both continuous and slow moving. This is the true nature of catharsis—a powerful emotional experience that results in a new integration of awareness and experience, and so requires a space for contained deeply felt and deeply expressed emotion.

## II. HOLDING

In her book *Holding and Psychoanalysis: A Relational Perspective* (2014) Joyce Slochower describes the holding function in psychoanalytic psychotherapy. In a very elaborated exposition she describes holding as one dimension of the psychotherapy process common across many modalities. She uses holding to denote a condition in which the therapist minimizes the impingement of her subjectivity, her 'otherness' from the patient. Doing so creates the possibility for establishment of a temporary "*illusion of analytic attunement* [italics in original]"

(p. 21). This state permits the patient to feel safe and secure in the therapeutic relationship without being confronted with the therapist's separate and unique self and the perspectives on reality that introduces into the therapeutic field.

Slochower contrasts this condition of soothing attunement that offers reparative possibilities for traumatic experiences of annihilation, abandonment, disregard, and denigration, with interpretative functions. Interpretations are one form of encounter between patient and therapist that require the patient to come face to face with the therapist's subjectivity, his difference and separateness as a unique person. In Slochower's view, holding represents those functions performed by the therapist when the patient cannot respond to the reality of the therapist's otherness without too great a disruption in the holding environment, which would threaten to derail the therapy. Depending on the patient's underlying personality organization the holding phase of the treatment might be short, in response to temporary regression in the patient needing a more soothing adaptation by the therapist. Or it can last for years as the patient strives to build enough ego and self-structure to tolerate the reality of the therapist's personhood, thereby building the capacity to bring other dimensions of reality into the therapeutic encounter.

## IIA. A BIOENERGETIC VIEW OF HOLDING

I take a different view from Joyce Slochower. I use holding to represent all the operations that offer therapeutic contact between the therapist and the patient. These are functions the therapist offers the patient.

Starting with early psychoanalytic concepts of the therapeutic space, holding, in this sense of the term, is a critical element of what makes the space therapeutic. Some of the holding characteristics have been taken now as fundamental to this therapeutic possibility, and are nearly axiomatic in the expectation of creation of such a space. These include holding the patient in non-judgmental positive regard; suspending and holding at bay conventional expectations of social

interactions; acceptance of the patient's self as valid and valued; validation of the person's experience as intrinsically valid and meaningful, are among the most significant. All of these represent holding energies, they are extensions of the therapist's energetic being and presence. The therapist holds the patient (the other) in her or his consciousness, as Bion (1959) suggests, without expectation or desire, in order to apprehend the person. When that specialized relationship between therapist and patient happens other elements of holding can occur. In bioenergetic psychotherapy, those other elements can also be directly physicalized, which adds another dimension to the psychotherapeutic process.

In bioenergetic psychotherapy the holding can refer to direct physical contact. Body-to-body contact can represent holding for the purpose of comfort, or holding for the purpose of restraint, or holding to reassure that the patient is not alone, or to support expression. Holding means, in almost all cases that a physical act, at least in its energetic form is taking place. When the therapist holds the patient in her or his consciousness, remembers the patient, her or his identity and suffering, there is a physical and energetic aspect to this event that we can identify and study. Holding, in this view will involve changes in both patient and therapist along every dimension of psychic and somatic process.

A concrete example of this is what takes place in the bodies of people organized as borderline or schizophrenic personality structures. Many such people have a location in the back, behind the heart, alongside the thoracic vertebrae that is experienced as a black hole. I know this phenomenon both personally and with patients of mine. The experience is that energy runs out of the body through that hole which cannot be stoppered. When I put a hand over that hole, some patients report what I have experienced, that it is as if the hole operates in a realm of absolute zero, no warmth at all, and the hand delivers warmth for the first time ever, even though the touch has been made before. James Grotstein (1990) has written very movingly about this same phenomena from an intrapsychic perspective.



To illustrate this approach using the bioenergetic conceptual framework I will offer three clinical vignettes, the first taking off from this example of the black hole as an effect of early chronic relational trauma (Tuccillo 2012).

VIGNETTE 1: Holding in presence of terror in a cold, dark place.

Eleanor has been a patient of mine for many years. Over those years she has vouchsafed with me the version of her who was terrorized as a child. She was terrorized in a family that looked to those outside, and, amazingly, even to Eleanor on the inside like a happy wholesome family. But the abusive use of children to gratify profound deformations in the parents' narcissistic functions is evident; as is the ignored but regularly expressed hatred and vicious competitiveness with the children. Eleanor, who is very successful in her worldly life, has increasingly allowed me to bear witness to the abused child and hold her suffering in the foreground, even as she herself writhes in torment, accused of the wickedness of false accusations toward her parents.

An experienced patient, Eleanor guides herself into the inner reality of her childhood. Immediately I have to *hold* her conflicted and ambivalent feelings. She can validate the reality of her own experience now, but also wants to disown it simultaneously. She wants me to come and sit by her, but for the first time also expresses her ambivalence about that. An expression like this would be unthinkable in her family of origin. She had to be available at all times and in all ways for her parents in *their* need that she attend first and foremost to their psychic and emotional needs. To feel ambivalent is to be too autonomous. If she expressed the ambivalence, or any other autonomous self-representation they would punitively abandon her.

She decides to go ahead and ask me to sit by her as she lies face down on the bed and asks me to put my hand on her back just below her neck. A long

conversation follows between us in which she asks me questions that I know from past work are based on her experience of her mother's (largely unconscious) hatred of her. Am I disgusted touching her? Is it painful to me? Do the sounds she makes cause me to have contempt for her? Am I repelled by her inadequacy and ignorance? No, I say to each of these questions. I have created a holding environment where my own struggles to deal with the feelings and states Eleanor lives through do not impinge on our relationship.

She says: "I am in a cold dark place. I can be here and there at the same time." This is actually the first time she can acknowledge this fact. Yes, I say, I know that what she is saying is so. As she cries out in pain and terror I am holding her in that cold place, even though no one was there to hold her when she was first thrown into it. I am holding her by my presence and by my touch, holding her ambivalent feelings, and holding her terror of being left there. My touch is a crucial part of the *holding*. When it is time to stop we need to move to end it slowly so that she can substitute holding herself before she can return to the everyday world.

Vignette 2: An unexpected strength late in life.

Jack is an older man, in his middle sixties who has engaged in a deep and life-altering psychotherapy in the five years or so he has been seeing me. Two persistent symptoms that have bedeviled him are profound anxiety and fear of criticism when he teaches or presents material (he is a very accomplished professional scientist and researcher), and an abiding irritability directed at his second wife who is--both by his report and by my direct contact since I did some couple sessions with them before beginning to work exclusively with him—a mature, caring person who treats him respectfully and well. In a session those two themes came together and the resulting associations illuminated an aspect of their origin in his relationship with his mother. The way the work went illustrates another aspect of holding in the holding environment.

Jack came in that day talking about obsessing about perfecting a poem he had written. This is not like him; he is not usually perfectionistic about his creative work, as he is about his professional presentations where his need to secure approval and his dread of criticism pervade the experience. It sounds to me like elements of his relationship with his mother are activated by his striving for self-expression, and I say so. He has to do things perfectly so that she (mother) will feel good about herself. He hopes she will then offer him praise or appreciation that he could turn into some positive self-regard. So, I say, he is very dependent on her for any positive self-regard he might be able to generate.

This reminds him of a recent visit to his mother in a nursing home. She is an irascible woman, often critical of him, and he is devoted, nevertheless, to her care, and she is very dependent on him. On this visit she is in the dining room when he arrives, eating. His wife who happened to be with him on this visit, advises him to wait until she finishes eating before approaching her, knowing, I suspect what will likely happen if he does not. Jack tells me that he “stupidly” ignored his wife’s advice and went over to her anyway. At this his mother becomes “panicked in a way” he had never seen before. She stops eating, and it takes quite awhile for him to settle her down.

Our discussion of this event leads to his considering that he went over when he did with the unconscious intent of disrupting her. He considers this likely, but he can’t feel it. He can’t feel the rage he believes is there underneath a layer of sadness evoked by his mother’s reaction to him. Jack is experienced at active, emotionally expressive work, and when he enters expressions of strong negativity it is clear how strong he is. Despite his age, and an appearance that looks on the surface somewhat collapsed, his chest sunken, his shoulders drooped forward, when he becomes charged another underlying somatopsychic reality emerges and can be seen.

I ask him if he wants to try to find the feelings he believes are there but cannot feel through movement, and he says yes. Often when Jack first starts to breathe deeply he experiences profound spasmodic gagging-like movements accompanied by loud, blasting sounds that carry feelings of rage and pain. That is what happens at first as he stands, bends his knees and increases breath. Knowing the effect on him of hitting with his fists I offer that approach. At first his two-fisted blows to the cushion on top of the bed as he swings both arms down are forceful but not yet infused with much emotion.

This is uncharacteristic of Jack. He usually finds his way to what he needs and wants to express in his negativity quite quickly and needs only my supportive presence to facilitate the expression. But this time I see that he needs more. So using my voice I encourage him to stay with the feeling and to amplify it, to use his own voice. When that is hard for him to do—to amplify his voice and intensify the rage and eventually, hatred, in it--I raise my voice, I make sound also. I see how my guttural angry sounding vocalizations support his extending his expression further. **I am holding him, with my presence and my voice and my intention, in the active expression of his indignation, his outrage, his rage and hatred at his mother's use of him.** Her use of him without subsequent appreciation is exploitation.

The realization that it is exploitation is stimulated by this event. That includes a dawning understanding for Jack that this was the chronic state of affairs between his mother and him. The expression of his rage is not an emptying out of a reservoir of feeling, not only a discharge of pent of emotion, it is also a moment in their relationship when his hurt, his disbelief, his rage at her for her treatment of him as a child can be organized into expression as fully and deeply as he and I can tolerate. Luckily for me he is not yet approaching my limit of tolerance for the experience and expression of these feelings. So I can continue to hold him as we work our way through the layers and formations of his relationship with his mother, started then, and that persist in his life today.

### Vignette 3: A failure in holding accountable.

I worked with Paul for a brief time many years ago. He was a man who rested on the edge of manipulative, self-aggrandizing behavior while failing to find success in life, at least during the time when he saw me. He was almost completely refractory to any of my interventions, many of which were challenges to characterological patterns. His defenses included rationalizations he employed to account for, or justify failures to do what was right, by acts of commission or omission.

There was a significant event in his early childhood that he did tell me about. He lived in a big city, in a neighborhood of modest one-family homes, many with small front yards that were often fenced-in. When he was a toddler he was unsupervised one day, wandered through the open gate in the fence at his house, and was hit by a car passing on the street. He was taken to the hospital, although not severely injured. He reported this story with anger that it happened, but not as evidence of a pattern of neglect or lack of care by his family. I thought it might represent that, but my efforts to call that possibility to his attention for consideration failed to arouse any interest in him.

One day he told me that he was planning to visit a prostitute. In keeping with what I have described above as the non-judgmental quality inherent in the containment provided by the psychotherapy environment, I took no position pro or con on this proposed action. But in taking this position without further consideration and nuance, I made a serious error. Paul was planning this action at a time when public awareness of the sexually-transmitted vector of AIDS was coming into the foreground of public view, and the significant risks of sexual activity with partners who had had themselves multiple partners was becoming known.

Some weeks after the announcement of his intention Paul came in, told me he had indeed been with a prostitute, and then told me that he was ending the psychotherapy with me. I should have warned him, he said, to use a condom, given the current state of knowledge about the risks attendant on his behavior. Taken aback, and certainly not sure he was wrong, I tried to investigate with him what he thought my failure might mean. But as before he was unavailable for further investigation. There was to be no greater connection to themes or patterns of his life. I had done wrong by him and he was going to go.

Afterwards, I began to delve into my failure, his experience of it, my experience of it, and what it might represent in a larger way than he related to it. What I came to understand was that I had acted like his family members in failing to hold him back from acting dangerously. Like his mother who left the gate open to the street, I had failed to hold him in my consciousness, hold his welfare as a priority, and act to create a restraint that would prevent harm to him. These are also elements of holding that take place in the holding environment when the containing functions of the environment have been put into place. **The enactment of this event with Paul created an opportunity for him to live out the experience of neglect to hold him in this way with me, and use that experience to open a way to his feelings about me, his family, and himself.** But he ended the enactment as the events had unfolded in his family, and my failure and his anger led to no new resolution.

Paul held me accountable for my failure to be alert to the danger to him, as well he could. But he did not hold himself accountable. Holding accountable—oneself or another—is a body state. It is a posture that accompanies the resolve necessary to hold one's ground and confront oneself or another with the consequences of behavior. This will become a significant element of the holding environment in understanding the importance of receptivity in the therapeutic relationship.

## **IIB. THE STRAIN OF HOLDING**

Joyce Slochower speaks movingly of the strain of holding in the psychotherapeutic relationship. Whether meant in the narrower sense she means it or the broader way I describe it that is undeniably true. It is true even when the therapist is free to be more herself or himself because the patient is capable of responding healthily and constructively to the therapist's unique personhood. The strain of maintaining the patient's centrality, of maintaining constant awareness, even vigilance on the part of therapist of intention and feeling is tremendously demanding.

It is true because a great deal depends on the therapist's ability and commitment to do this. The patient puts his or her psychic and emotional, and sometimes physical, life in our hands. In other relationships a bond of mutuality and maturity will develop between the partners and the load of care, of attention, of decision-making will come to be shared. In the therapeutic relationship this is not required. In fact, the psychotherapy relationship has been created to heal the damage to that maturative capability in the patient, and healing possibilities are unknown until the work of healing is engaged.

The strain inevitably results in failures. Failures of attunement, lack in understanding or experience, and even acting-out of countertransference feelings and attitudes that injure, or even harm the patient. It is to this dimension of what makes the psychotherapy relationship a healing process that we turn our attention now.

## **III. RECEPTIVITY**

## INTRODUCTION

In the continuing clinical research to understand the healing powers of the psychotherapeutic relationship the emerging perspective of relational psychoanalysis has offered a dramatic proposition. Building on a foundation that comes from feminist ideas about relationships and about psychotherapy, relational theorists consider all relationships to be intersubjective. This means that the partners uniquely construct each relationship. All members of the relationship have equal value and significance; dependency is a feature of the relationship flowing from each member and to each member. In this relationship matrix people know each other through direct, conscious communication. They also know each other through the interpenetration of unconscious self, sharing themselves with each other and receiving each other through various psychic and emotional instruments: empathy, projection, identification, sympathy, are examples. To this bioenergetic therapists would add the transmission of energetic states of being and feeling which are received in various somatopsychic channels—body states, constellations of sensation and emotion that are studied for their complexity.

Receptivity to the other person at this level of openness and vulnerability allows for a knowing of the person that can be brought into the open. This knowing at so basic a level fulfills a developmental need that is in itself healing. It also permits the psychotherapist to continue to create holding moments that are responsive to the reparative, restitutive, boundary-making needs of the patient.

### IIIA. SOMATOPSYCHIC CHALLENGES OF RECEPTIVITY

This way of understanding psychotherapy process does raise significant questions. Joyce Slochower points to those challenges in an interview in a recent issue of the magazine, *New Therapist* (May/June 2016). She talks about the perceptiveness of some of her patients and the fact that they may pick up



aspects of her reactions despite her attempts to keep them out of the interpersonal field (a process she calls bracketing). She goes on to say that for that bracketing process to be successful both therapist and patient must engage in it. The therapist tries to shield the patient from aspects of her that would disrupt the sense of resonance on which she or he relies. And the patient collaborates by removing awareness of those characteristics revealed by the therapist.

This resembles previously understood methods of protecting the primacy of the patient's welfare in a therapeutic space by restricting the impingement of the psychotherapist's needs, attitudes, or destructive impulses. The principles of neutrality, a non-judgmental attitude, abstinence from meeting the therapist's needs, are all elements of creating and preserving a benign space and a benign therapeutic presence. But from a bioenergetic standpoint once we introduce the idea of the interpenetration of energetic unconscious processes the already very difficult task of maintaining the benignness of the space becomes much more complicated. If the core of the therapist's identity is benign, if not benevolent, perhaps things are easier. But what if they are not?

### IIIB. PSYCHOPATHY AND THE FUNCTION OF RECEPTIVITY

This is a sharp term to introduce here, and it may seem to some readers as antithetical to an attitude of receptivity. It is not antithetical to the function called receptivity, which is the ability to see and feel the other. Psychopathy is a narcissistic deformation. It is a compensation for severe damage to a person's self-esteem system. Depending on the level and extent of damage to the system the person so damaged cannot sustain positive self-regard or in the worst case cannot develop even the forerunners of self and other regard: admiration, appreciation, idealization. Where the therapist has no durable and flexible system of positive self-regard, one that can observe negative reflection on the self, the drive to restore approbation can deform the therapist's ability to sustain the

environment I have described above. This can deform, if not vitiate, the containing environment in which holding operations can be conducted in the best interest of the patient.

In the modern understanding of relationships as applied to psychotherapy process failures by the therapist are inevitable and necessary. These failures of attunement and of resonance, or even of loss of the centrality of the patient in the dyad are considered opportunities for the patient to find the long-buried history of similar, damaging failures in earlier life and feel them through. The failures also provide an opportunity for a different resolution to the interpersonal problem with a relationship partner (the psychotherapist) who prioritizes the patient's welfare and the maintenance and support of positive regard for all parties equally, even at the risk of confronting unattractive and unfavorable aspects of her or himself.

These are difficult conditions to maintain, however. Michael Eigen in his online book on psychopathy (2006) describes the prevalence of psychopathic compensations in human behavior. And in an article entitled the "Immoral Conscience" (1991) he talks about the way that omniscience, the drive to represent oneself as knowing everything, always, is a bane of healthy relating. Bernhard Brandschaft (2010) calls attention to this problem specifically for therapists. He warns therapists about the tendency to be so invested in favored theories and ideologies that the capacity to apprehend the patient as a unique person is compromised.

### IIIC. RECEPTIVITY GONE AWRY: TRANSGRESSIONS

How serious is the question of therapists' failures to maintain the most central element of the holding environment, maintaining the centrality of their patients' welfare; and the preservation of the recognition and receptivity for the unique subjectivity embodied by each patient? Articles by Muriel Dimen (2014) and Charles Levin (2014) point to answers. In her article, Dimen, talks about a

“lapsus linguae” a slip of the tongue. Dimen reveals an episode in which her beloved therapist, to whom she feels much gratitude, slipped his tongue in her mouth in the only moment he physically embraced her in a long, and for her very helpful psychotherapy. The therapist never brought up the ‘slip’ and neither did she. Even writing about this long after his death she chose not to name him. Somehow she bypassed the transgression, even as she writes that his failure was greatly compounded by the additional failure of bringing up the lapse in boundary, which was the introduction of the therapist’s need and then its gratification at her expense. In a presentation she made based on this work she called on therapists to find a forum to talk with each other about such lapses in maintaining the holding environment (as I term it in this paper). Thinking about her exhortation I realized the great difficulty in doing so.

Levin expands the discussion of transgressions of the boundaries necessary for maintaining a proper holding environment to institutional training in psychotherapy. His article is in a volume devoted to themes of abandonment and betrayal in the analytic relationship. To my eye it is the most graphic and unapologetic of the articles that detail violations of dependency relationships. Many of the articles are on other subjects, the untimely death of one’s analyst for example. But even among those relating inappropriate therapist behavior leading to betrayal of the therapeutic covenant and rupture of the relationship, his voice is singularly clarion in identifying both individual therapist rationalization and avoidance of blame, together with institutional collusion in covering up the transgressions and their significance. I am reminded of something that happened to me as a therapist, seeing someone—also a therapist— the child of a very well known psychotherapist, who depicted the parent in horrifying terms as an abusive self-centered person. It seemed credible to me. When I talked about it with my therapist his reaction was sufficiently watery that it felt like an apologia for the parent-therapist; enough so to disappoint me. I needed a full-throated denunciation of the parent. Why I needed that may provide a personal example of the question that bedevils me (no pun intended here, because the devil is a

relevant part of this discussion) about the influence of the therapist in the energetic, interpersonal, psychic and emotional soup that constitutes the therapeutic relationship.

## **WHERE WE ARE, WHERE WE GO: THE CHALLENGE OF SUSTAINING A HOLDING ENVIRONMENT**

### THE TRANSGENERATIONAL TRANSMISSION OF ABUSE

My reality is an extreme. Extreme conditions have been used throughout human history to deepen understanding of more normative phenomena. The horrific brain injuries caused in wars past and present has led to more understanding of central nervous system functioning. Terrible burn injuries, and the damage caused by deep-sea diving has led to the development of technologies and techniques to react to and heal the damage. Similarly the exposure of clinicians to the life-long harm to soul, psyche and emotional life caused by chronic relational trauma informs everything we do with patients including those patients whose suffering is less comprehensive, in whom damage to self is less severe, and whose capacity for recovery is greater, than that I know for myself.

I have described much of the life experience and its effects that I am going to refer to here in more detail elsewhere (Baum, 1997, 2007, 2014). To make my point here I will say that I was destroyed psychically and emotionally by my mother and by the environment of people around her who were malevolent mad people who penetrated me body and mind. These people were driven by impulses, urges, and feelings that were unneutralized and carried in adult bodies. My father, who ultimately saved me from all that (long after the damage was done), demanded unconsciously that I comply with his self-serving narrative of what happened by believing that he had saved me, that I had recovered, and that he had created me into an emotionally healthy child.

## FACING WHAT THERE IS TO FACE

To so bend the truth of my own experience, under threat of loss of his approbation, and the threat that he would otherwise forget who I was and leave me, or return me to my mother, meant leaving all connection to inner truth and reality. This demand, plus the destruction already wrought on my inner being; plus a merged identity with my father that included his severe narcissistic deformations; plus the attacks leveled at me by both parents seeking an outlet for their vicious hatred for hypocrites and the sanctimonious self-righteous people who had harmed them, destroyed any capacity in me to develop the narcissistic functions and structures necessary for self-esteem. As Otto Kernberg (1975) delineated in his seminal studies of borderline and schizophrenic personality organizations, the problem for those of us living in that universe is not low self-esteem it is the absence of self-esteem.

Self-esteem is quite literally admiring and feeling good about oneself. Healthy self-esteem is built on the ability to encounter, integrate and metabolize negative aspects of oneself, act responsibly and appropriately in response to those discoveries and return to a positive relationship with oneself. When basic structures that undergird that functioning are destroyed then the craving for positive regard comes to dominate inner life, and the desperate search for anything that will quell the craving becomes the guiding star of behavior. There can be no moral center without the self-correcting mechanism of healthy self-esteem. Also, the craving for relief from self-loathing that accompanies the destruction of self-esteem systems warps all other considerations in decisions about behavior and relationship.

There are many descriptions of people organized this way in human history, in literature and drama. Coincidentally one very trenchant description came to me in an article in the New Yorker Magazine, by Jane Mayer (May 2016) profiling Tony Schwartz the man who acted as a ghostwriter for Donald Trump in the production

of the book *The Art of the Deal*. Schwartz kept detailed notes for himself of his contacts with his subject. Asked about his understanding of the man he says a number of significant things that are relevant to our understanding of the functioning of someone for whom the drive for positive regard is a central organizing principle of his personality.

Schwartz says about Trump: "Lying is second nature to him. More than anyone I have ever met Trump has the ability to convince himself that whatever he is saying at any given moment is true, or sort of true, or at least *ought* [italics in the original] to be true." (p. 23). This mechanism is part of the distorting effects of omniscience. Schwartz says also that Trump is driven entirely by a need for public attention to the point where it is all for "...recognition from outside, bigger, more, a whole series of things that go nowhere in particular." (p. 23) Ultimately, Schwartz sees Trump as driven by an "...insatiable hunger for 'money, praise, and celebrity'." (p.24) Tony Schwartz concludes about Donald Trump that: "He's a living black hole." (p. 24). The damage that gives rise to this somatopsychic effect includes annihilation of self and identity, and I now see more clearly, also of narcissistic functions.

I recognize myself perfectly in Tony Schwartz's depiction of Donald Trump. Family, friends and acquaintances would find this unbelievable unless I have shared with them my knowledge of my interiority. I know it is true. A concrete example is in a comment made to me many years ago by my late wife, who loved me, and admired me and never wished me any harm. She told me that I could start a sentence going in one direction and end it going in the completely opposite direction. She was calling my attention to the fact that reality, facts, opinions, attitudes, everything is fungible in the service of securing the center and the possibility of obtaining narcissistic supplies—admiration, respect, adoration, idealization, idolization.

THE CHALLENGE TO THERAPISTS

We say that power is corrupting. This is partly because power is related to feeling good about oneself. Power is force, energy, and the capacity to do things or get things done. It is related to instrumentality (as described very well by Ron Robbins (1978) in his work on the limb character). It is related to being responsible for oneself. David Shapiro (1965) describes the connection of the disavowal of responsibility to the formation of psychopathic character defenses. It is very difficult to take responsibility for one's actions if it will lead to a devastating collapse of the shell of ego built on extracted narcissistic supplies that cannot be metabolized into somatopsychic structures that allow tissue to swell with pride, and glow with inspiration. In *Narcissism and Power*, Hans-Jurgen Wirth (2009) shows how this deformation of narcissistic functioning shows up in public life.

The corrupting effect comes from the use of power to supply self-interest at the expense of others. Greed certainly is a big element in this, envy also. So is the desperation to garner positive regard. Positive regard that goes as far as needing the centrality of the old-testament God, being at the center of every moment, the basic referent of a person's life.

Granted that most psychotherapists are not afflicted with this in the way I am. Many are likely more benign to begin with. They are likely to have metabolized and organized self and other representations that include the inevitable fallibility and moral confusion that affects all human beings. They may well, as clinicians, have learned to receive, accept and work with critical reactions of their patients about them, including those that have a correct percept of the therapist's narcissistic deformations, or limitations, or slips. I had to create a self that could function as if I lived in the universe inhabited by those people. But as Dimen and Levin call to our attention, the problem of therapist transgression of boundaries to satisfy self-interest is common. Some theorists notably Harold Searles (1965) have made it a central principle of their work to sharpen their awareness of the destructive impulses, attitudes and feelings the therapist has toward the patient.

As I wrote in an article about the two-person identity (2014) I cobbled together whatever shards of soul survived the attacks on me, the projected idealism of my parents and their ego-ideal selves, and the souls lent to me by others—my late wife most of all, my children, my therapists, my friends, my patients, and I developed a consciously intended, purposeful self. As much as I able that self embodies the principles and values of goodness. The connection of pleasure and goodness is articulated now in the theory of Bioenergetic Analysis (Baum, et al. 2010). But the underlying self, as I know myself, built around a core of malevolence, revenge, and madness, cannot partake of that pleasure in goodness. Contempt and disdain and their corrosive effects are at the core of my body and identity and threaten all attachments.

I am acutely aware of the ways that self-interest seeps into relationship. Acutely so because of my knowledge of myself and because of both my father's and mother's mission in life to root it out in everyone, exposing hypocrisy and self-delusion. My father did this while sleeping with many of his women patients, espousing a theory proposed by Martin Shepherd in his book *The Love Treatment* (1971), and then feeling scrupulous because he "didn't sleep with the fat ones". He told me this after I was already a fully qualified clinical psychologist. In this case my swooning need to be enfolded into his being, the only safe place I had ever known (as dangerous to my soul and being as it actually turned out to be), would augment my general incapacity to register reality.

Registering reality, in its most complex, nuanced and subtle ways is what is required if therapists are to conscientiously investigate transgressive behaviors, our own or those of others. Here too a bioenergetic perspective helps to understand the dynamics of the investigative process, and the challenges it poses. I will use myself as the case study again. I know that many of my father's patients benefited from his ministrations, although not those he sexually abused. When I contemplate his sexual abuse of patients my consciousness is split. I can



say categorically that I *know* that what he did was wrong. But the knowing is not uniform. In one of the splits in my being and in my body and in my psyche with which I am very familiar I know cognitively and ethically that what he did yields to no rationalization. But my stomach and my guts do not follow this conviction. I feel the conviction wash out of my insides, even as I know on the other levels that I am right that he was wrong. I have worked on this phenomenon in me for a very long time. I understand the energetic process underlying this phenomenon as part of the necessary transformation of self required of me to secure my adoring undying attachment to my father. I also know it is a manifestation of what was done to me articulated clearly when Mike Eigen said to me: “Your psychic heart and guts were torn out.”

From the bioenergetic standpoint something has happened to my guts. We do not have the means to study cellular process at the level needed to understand this. But the ethical and moral function of gut reactions has been abrogated. It is a particular torment to know so certainly that what my father did was wrong—to his patients and to me, and to be bereft of the gut feelings and the intestinal fortitude to stand and denounce him and his behavior without being shaken by my dissolving insides.

This experience gives me insight into the difficulty we face when we strive to identify transgressive behavior when doing so threatens our relationship with ourselves, and our positive regard. Or when it threatens our relationships with the important others in our lives who we want and need to admire, to identify with, and by whom we need to be positively regarded.

Some people, therapists, I have told about his behavior have not, at first anyway, been able to generate a sufficiently outraged reaction to assist me in maintaining my own in the face of all the historical pressure to relinquish it. It cannot be only a rule-derived reaction. Therapists have to open ourselves to the impact transgressions and violations have on our patients. This is delicate ground. The

daily newspaper tells us how prevalent the rationalization of predation and exploitation is in the world we live in. On the micro-social level this behavior starts in families and the communities that surround them.

## WHAT TO DO

If receptivity means being available to receive the toxic destructive elements of our patients the concept seems straightforward enough. If we hypothesize that there is a healing that takes place in an intersubjective relationship environment and that environment includes the mixing of unconscious material, of emotional energies of both the therapist and the patient, then my experience of myself tells me we are in delicate, and perhaps dangerous terrain. It behooves us therapists to develop methods to investigate our own psychopathy. Even if blessed with a fundamentally benign core self, our irreducible humanness assures the intrusion of destructive, self-interested feelings, and at least occasionally actions, into the holding environment.

The solution does not lie in a kind of neurotic, and ultimately self-righteous scrupulosity, it lies in assisted self-reflection. In developing this as a principle and methods for it, we can lead not only in our field but also in the world around us. Sharpening, refining, delving into the ways that negativity, greed, envy, narcissistic compensations impair the ways therapists deform the holding environment becomes a method for preserving it. Talking about it, among us and in the world is a mission to convey the hard-won knowledge that comes from the difficult work of psychotherapy for use in dependent relationships of all kinds.

**The technical knowledge in bioenergetic analysis is the development of the set of skills necessary to know how to initiate, adjust and maintain the holding environment. The capacity to add the dimension of body-to-body contact between patient and therapist creates new dimensions of the holding environment. The purpose of that environment, in modern**

bioenergetic analysis, and in other expressive therapies is to allow for as near to absolute freedom of expression without risk of harm. The aim of modern bioenergetic analysis is to create a holding environment that has the broadest dimension of durability that the therapist can manage. Included in that is the challenge to the therapist for the most direct, deepest encounter with her or himself that the therapist can sustain.

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