

# Nonverbal Stories: The Body in Psychotherapy

*Richard G. Erskine*

## **Abstract:**

Emotional experience is stored within the amygdala and the limbic system of the brain as affect, visceral, and physiological sensation without symbolization and language. These significant memories are expressed in affect and through our bodily movements and gestures. Such body memories are unconscious non-symbolized patterns of self-in-representation. Several methods of a body centered psychotherapy are described and clinical case examples illustrate the use of expressive methods within a relational psychotherapy.

**Key words:** body centered psychotherapy, body therapy, relational psychotherapy, inhibited gesture, retroflexion, integrative psychotherapy, emotional experience, touch in psychotherapy, music therapy

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Some of my earliest memories are the sensations in my body, my physical movements, and being cuddled in another person's body. I must have been about three years old when my mother woke me each morning by rubbing my back. Her touch provided a warm secure feeling -- an emotional memory that I periodically recall today when I am in need of nurturance. There is a particular spot on my back that I relate to being unconditionally loved, a spot that my mother always touched with firm tenderness.

This physiological memory of nurturing is in such contrast to another early childhood experience of my parents having a loud argument in the kitchen. I tried to escape the emotional turmoil by going to the next room and pounding on the keys of the piano. Yet I also kept watching to see if my father would hit my mother again. My shoulders and neck were tense. I must have been scared. I cannot recall a sense of fear but I know that making noise on the piano was a distraction from the emotional havoc caused by their screaming.

The tension in my neck and shoulders remained within my body for years. The tension was intense whenever I faced conflict until I attended a music therapy workshop conducted by two colleagues. When I arrived the room was full of people so I sat on the floor next to the piano. There was some discussion among

the presenters and the audience that made me feel uncomfortable. I spontaneously reached up and began to tinker the base notes on the piano. Before I could stop myself one of the music therapists encouraged me to continue, to close my eyes, and let myself hear and feel the sounds I was making. I pounded the piano harder and then even harder. I began to shake with fear. I was nauseous. A deep cry burst out of me as I screamed for my parents to stop fighting. This cry expressed the natural protest that I had inhibited as a fear-based reaction to my parents fighting. For more than forty years my tight neck and shoulder muscles had inhibited my need to make an impact; my need to protest had become *retroflexed*, immobilized, and transformed by distraction (Perls, Hefferline, & Goodman, 1951).

*The Body Keeps the Score* is the title of Bessel van der Kolk's 1994 article about trauma and memory. My body kept an unconscious "score" of emotional and physiological memories of the trauma of witnessing my parents fighting. Until that day of music therapy I had no conscious memory of those early events in my life. So it is with many of our clients. They say they have no memories of being younger than ten or twelve years of age yet they describe having anxiety attacks, bouts of depression or loneliness, digestive problems, back aches, or like me, the tensions in their shoulders and neck. Each of these emotional and physical symptoms may be the memories -- often the only memories -- of despairing loss, neglect, or traumatic events. These significant memories are expressed in our affect and through our bodily movements and gestures. Such body memories are without form or thought, what we often refer to as unconscious: a non-verbal, non-symbolized, pattern of self-in-representation.

My body yearned for an opportunity to release the physical tension, to scream, to make an impact, to be protected and comforted. In not having parental affect regulation and psychological protection I had retroflexed my fear and inhibited my protest; I held in my scream and distracted myself. The retroflexion of my need to protest and the physical tension in my neck served the psychological function of affect *self-stabilization* in a situation where I needed my parents to provide the stabilization of my overwhelming fear.

My therapy experience was an expression of visceral, physiological, and emotional memories -- memories that were pre-symbolic, implicit, and relational - - coming to awareness as I sat below the piano and began to tinker the keys. This was an emotionally laden story waiting to be told. In my ongoing therapy I had talked about inhibiting my protest, being afraid of conflicts, and the tension in my neck. But, my therapy had been completely verbal and my examples were of current life. The stimulus and safety of the music therapy demonstration made it possible for me to have a supported and therapeutic reenactment of my early trauma.

Our bodies hold our pre-symbolic, implicit, and procedural memories within the nervous system, muscles, and connective tissues. These emotional and physiological memories may be expressed as gestures, inhibitions, compulsions, physical tensions, and unique mannerisms. Eric Berne referred to such tensions and gestures as the “script signal”. He said, “For each patient there is a characteristic posture, gesture, mannerism, tic, or symptom which signifies that he is living ‘in his script’”. (Berne, 1972, p315).

Gestalt Therapy defines such habitual mannerisms and interrupted gestures as a “retroflexion”, a holding in what is needed to be expressed in order to avoid awareness of psychological discomfort (Perls, Hefferline & Goodman, 1951). People tense the muscles of their body as a distraction in order to self-stabilize after being flooded with overwhelming affect. Often the retroflexion becomes habitual and interferes with internal contact, the awareness of sensations, affect, and needs.

### **Unconscious or in the body?**

Most of what we colloquially refer to as “unconscious” may best be described as pre-symbolic, sub-symbolic, implicit, or procedural expressions of early childhood experiences that constitute significant forms of memory (Bucci, 2001; Kihlstrom, 1984; Lyons-Ruth, 2000; Schacter & Buckner, 1998). These forms of memory are not conscious in that they are not transposed to thought, concept, language, or narrative. Such sub-symbolic or implicit memories are phenomenologically communicated through physiological tensions, body movements, undifferentiated affects, longings and repulsions, tone of voice, and relational patterns (Erskine, 2008; 2009).

Freud postulated that “the unconscious” was the result of “repression” where uncomfortable affect-laden or traumatic experiences were defensively prevented from coming to awareness (Freud, 1912/1958, 1915/1957). In working with many clients in psychotherapy it has become clear to me that particular memories, fantasies, feelings, and physical reactions may be repressed because they may bring to awareness relational experiences in which physical and relational needs were repeatedly unmet and related affect cannot be integrated because there was (is) a failure in the significant other person’s attuned responsiveness (Erskine, 1993/1997; Erskine, Moursund, & Trautmann, 1999; Lourie, 1996; Stolorow & Atwood, 1989; Wallin, 2007).

I have had clients who were extremely afraid of remembering their own childhood experiences. They knew that their memories were emotionally painful, even overwhelming, and they did not want me to do anything that disturbed their self-protective equilibrium. They actively repressed awareness of what they “sensed” had occurred in their past. These clients often found clever and sometimes

destructive ways to distract themselves from remembering. I found that it was essential that I build a solid therapeutic relationship with these clients before doing any historical inquiry or body focused therapy -- a therapeutic relationship based on patience, respect for their fear of remembering, and a sensitive responsiveness to their affect and relational-needs.

Experience that is unconscious is not only the result of psychological repression and distraction. Research has shown that trauma and cumulative neglect produce intense overstimulation of the amygdala and the limbic system of the brain such that the physiological centers of the brain are activated in the direction of flight, freeze, or fight. There is little activation of the frontal cortex or integration with the corpus callosum so that time sequencing, language, concepts, narrative, and the capacity to calculate cause and effect are not formed (Cozolino, 2006; Damasio, 1999; Howell, 2005, Salvador, 2013). The brain is then unable to symbolize experience (Bucci, 2001), but the experience is stored in the neurological interplay of affect and body.

This neuropsychology research provides a basis for the psychotherapist to work directly with the clients' visceral sensations, muscular reactions, movements and interrupted gestures, imagery, and affect. Along with body centered methods I often used phenomenological inquiry and therapeutic inference to help the client construct a symbolized mosaic composed of visceral sensations and emotions, body reactions and physical tensions, images and family stories. This co-constructed mosaic allows the person to form an integrated physiological, affective, and linguistic story of their life's experiences.

Some developmental experiences may be unconscious because the child's emotions, behaviors, or relational needs were never acknowledged within the family. When there is no conversation that gives meaning to the child's experience, the experience may remain as physiological and affective sensations but without social language (Cozolino, 2006). A lack of memory may also appear unconscious because significant relational contact did not occur. When important relational experiences never occurred, it is impossible to be conscious of them. If kindness, respect, or gentleness were lacking, the client will have no memory; there will be a vacuum of experience but the body may carry a sense of emptiness, loneliness, and longings. This is often the situation with childhood neglect. Lourie (1996) described the absence of memory in clients with cumulative trauma that reflects the absence of vital care and an ignoring of relational needs. Psychotherapy that integrates a focus on body sensations and affect with a sensitive phenomenological and historical inquiry provides the opportunity to address that which has never been acknowledged and to create a verbal narrative that reflects the body's story.

## **A consideration of methods**

In the previous story about my music therapy experience, the safety and nonverbal aspect of the music therapy made it possible for me to re-experience a trauma that had previously not been available to my consciousness. As cited by Bruscia (1987), Merle-Fishman and Katsh have developed the technique of Metaphoric Improvisation Therapy; a form of music therapy which works with pre-symbolic and procedural memories (pp. 319-334). Art therapy provides additional methods of working with preverbal memories. Movement and dance therapy may also be evocative of early memories. As a psychotherapist I use a number of body oriented methods such as these to facilitate my clients' psychotherapy. However, I am not a body-therapist who relies on either evocative or provocative techniques alone, I am a psychotherapist who focuses on the body and the unconscious stories requiring resolution.

I often engage in doing body oriented therapy that involves clients becoming aware of their breathing. I facilitate their experimenting with various forms of breathing to find their own natural rhythm. Sometimes this alone is enough to stimulate an awareness of memories or where they are holding muscular tension in their body. Or, the therapeutic work may focus on grounding, that is, helping the client to feel a solid and dependable base under his or her feet or buttocks. I watch for the inhibited or interrupted gesture. These are often the "script signal" that reflect a much larger emotion filled story embedded in the body. I carefully watch for interruptions in internal contact, that is, a loss of physiological awareness: smell, taste, sound, sight, skin sensations, and digestion. I periodically inquire about or devise awareness enhancing exercises that stimulate a consciousness of various body sensations that may either be blocked or that may serve as a way into sub-symbolic and procedural memories which are physiologically retroflected and therefore not-conscious.

With other clients I may either encourage them to exaggerate the inhibited gesture, to tighten their jaw or fist even harder. I may ask them to complete the interrupted gesture and explore what sensations, affects, fantasies, or associations come to mind. This may revamp into work with larger muscles where the clients explore moving in space. Movement, movement awareness, and awareness of body tensions is often evocative of unspoken childhood experiences. I may have the clients focus on where they feel sensations in their body, where there is little or no sensation, and the cognitive and sensory imagery that this type of inquiry brings (such as the memory of smell, taste, touch, sound, and visceral sensations).

It is essential that I remain aware of my own body process when doing any physiological work with clients. In my attempt to have a physiological resonance I often vicariously experience their body tensions. Through attending to my own breathing and body sensations I seek an awareness of the difference between

my sensations and the clients' sensations, even though I am simultaneously identifying with their bodily experience.

For some clients body awareness work can be done through fantasy. I ask them to imagine using their body in a different way such as running away, hitting back, standing up for themselves, or embracing and cuddling. Some of the time the body focused therapy involves working with imagination such as having them visualize reaching upwards and then imagining someone picking them up. In some groups what begins as one person's body awareness and movement work may morph in a psychodrama involving the whole group. Psychodrama is a powerful method of facilitating clients' resolution of traumatic or neglectful experiences.

Communicative sounds such as "oh, "uh", "thisst", or a sigh all have a physical and affective component. I often respond to these communicative moments by asking questions similar to "What is happening in your body right at this moment?" or "What do you experience internally when you say, "uh"? If the client seems open to such an inquiry, I may say something that reflects my observations of his or her body tensions: "Pay attention to your left shoulder," or "Feel what just happened to your throat," or "You made a sigh just now. Your body may be expressing something important."

Each of these body centered techniques and methods can be highly beneficial as an adjunct to a relationally focused, in-depth psychotherapy. When using body oriented approaches I am focused on the necessity of titrating the technique or method to the affect tolerance of the client. I am watchful that the awareness exercise, art expression, body movement, hitting or kicking a cushion, or psychodrama experience is at a level where the client can affectively process the experience without becoming emotionally overwhelmed, triggering a reinforcement of the strategies of archaic self-stabilization. Titrating of the clients' level of affect requires constant phenomenological inquiry and observation of the clients' body movements before, during, and after using body centered methods.

I strive to attend to the subtle physiological shifts that occur when clients are talking, such as the changes in volume, inflection, rhythm, and tone. These utterances may reflect the sub-symbolic, implicit, and procedural memories embedded in the client's affect and body. I am also watching for the little physical gestures such as pupil dilation or contraction, the tensing of the neck or jaw, changes in breathing, tightening the pelvis or legs, and looking away that may indicate that the client is becoming overwhelmed with unexpressed affect.

My therapeutic goal is to stimulate and enhance the client's sense of visceral arousal and awareness so that he or she has a new physiological-affective-relational experience. I want to activate the client's inhibited gestures and relax the retroflexions while being attentive to the possibility of overstimulation and re-

traumatization. If the physical gestures that reflect possible affect overstimulation and potential re-traumatization do appear it is my responsibility to shift the focus of our body work or the content of our conversation, to ease up or stop any touch, to change the physical activity, and to cognitively process the emotional experience with the client. Returning to phenomenological inquiry and an interpersonal dialogue is often the best way to provide the client with the needed physiological stabilization and affect regulation so that the he or she can integrate the therapeutic experience physiologically, affectively, and cognitively (Erskine, Moursund & Trautmann, 1999).

### **Body oriented therapy without touch**

Before I talk about body therapy that includes touch I would like to describe a therapy situation that was primarily body focused and did not involve touch during the early phase of the psychotherapy. Jim came to group therapy because he could not maintain friendships or find a life partner. In the first few sessions it was obvious he tended to invade people's space. When he entered the office he piled his coat on top of other peoples' coats rather than using his own hanger. He left his shoes where others tripped on them. He often plopped down on the sofa almost on top of others. He put his feet on someone's lap. People in the group began to find him a nuisance. When the group members first confronted him about his behavior and how they felt invaded, he seemed to have no awareness of what they meant. After a few sessions of such discussions he gained some awareness of his own behavior but he seemed to have little self-management.

I observed that he was lacking in exteroceptive sensitivity and limited in knowing the boundaries of interaction between his own and other peoples' bodies. In the following session I had him close his eyes and feel the chair, to touch his legs, to then feel his feet solidly on the floor, to then spread his arms and feel the dimensions of his external space. He slid off the sofa onto his knees. I suggested that keep his eyes closed and to feel his knees and hands grounded into the carpet.

He began to crawl like a toddler. I encouraged him to pay attention to each sensation in his body. As he crawled along the floor he seem tight and restricted in his legs and shoulders. He was tense. I assumed that he was afraid. After several minutes of crawling he began to cry, at first softly, and then with deep sobs. He remained on his knees, eyes closed, with his arms stretched in the air crying to be picked up. In a later session he reported that he had a reoccurring dream in which he is crying for someone to take his hand, to help him walk, and to hold him on their lap.

In several subsequent sessions he surmised about the parental neglect that he may have received between the ages of one and two years. Through our group therapy sessions he created a mental mosaic composed of some explicit memories, physical sensations, observations of his mother's dismissive behavior toward his brother's children when they were toddlers, and family stories of mother's abuse of alcohol when he was pre-two years. He was forming a narrative of his sense of his own body in space and in relationship: lost, lonely, and longing for body contact with someone. He also became aware that he had a deep fear of rejection if he did reach out to touch someone. We spent several months in group therapy with Jim taking a portion of time each week to become aware of his body-based emotions, to explore space and the touch of others, to resolve his anticipation of rejection, and to receive encouragement from the group members for experimenting with new ways of being in relationship.

### **Therapy through healing touch**

I touch some of my clients, yet I have had many clients that I have never touched. The decision to touch or not to touch depends on the therapeutic needs of the client, the quality of our psychotherapeutic relationship, and the level of body awareness and accompanying affect that the client can integrate. The decision to touch must be a mutual agreement, based on the welfare of the client as determined by the client and psychotherapist in consultation, and should not be based solely on the therapists theoretical or technique preferences. Each client, at various times in the ongoing process of psychotherapy, may therapeutically benefit from touch -- touch from the psychotherapist that may range from a gentle holding of the hand to deep massage of the back or shoulders to help the client vigorously move the large muscles to release previously retroflected emotions such as sorrow, disgust, terror, or anger.

Some clients benefit from a warm soft touch that to them feels supportive and protective. With one seventy year old woman I initiated holding her hand during a session as she talked about her despair and panic in having cancer. As I held her hand she had a pleasant memory of feeling secure when she was touched as a child. She experienced our hand holding as saying, "You can manage this crisis. I am with you". That triggered a memory of her father sitting at her bedside holding her hand when she had a high fever at age nine. For more than sixty years she had forgotten the warmth and security that this memory provided and she contrasted it with living alone as an older woman. This hand holding session opened the door for us to do an in-depth psychotherapy that focused on her body sensations, emerging associations and memories, the intersubjectivity of our therapeutic relationship, and the construction of a personal narrative that repaired the relational disruptions that had occurred before and during the time her mother was hospitalized with depression. The hand holding and good-bye



hug were the only touching that we did but my initiating the handholding remained meaningful to her.

I used therapeutic touch in a very different way with another person. Jennifer was an experienced psychotherapist. She had attended a series of training workshops where she was actively engaged in learning and supervision. On a couple of occasions she talked in the training group about her feelings of despair, the lack of energy she often felt at home, her growing resentment in providing therapy to others, and her desire to “withdraw and just give up.” She was disappointed in her personal therapy. She said, “I just talk and talk. My therapist is very supportive but I seem to go around and around on the same old subjects. I either need a different kind of therapy or I should just quit.” Her posture reminded me of previous clients who's bodies were encumbered with a sense of hopelessness.

On the strength of our already established supervisory relationship (and with the support and permission of her therapist) she came to a five-day therapy marathon where I was doing personal therapy with a group of psychotherapists. I did not yet have a therapy plan but I sensed that once thcohesion and internal security had developed in the group something significant would emerge within our therapy relationship. I did consider the likelihood that she was already slipping into an enactment of some significant childhood memory and the possibility that she may benefit from some form of body therapy but I needed more observations of her breathing patterns, physiological movements, body tensions, and how she related to both me and others in the group before I formed a sense of direction. My intention in the first couple of days was to create a secure and cooperative group environment where it was safe for clients to have a supportive therapeutic regression to resolve fixated fear, trauma, or neglect. Importantly, I want clients to feel protected so that they can relax their physiological retroreflections, to finally put into movement what was previously inhibited, and to have a chance to make the therapeutically necessary physiological and affective expressions -- expressions where the neurological system is transformed and healed.

On the afternoon of the third day I was working with another woman who was crying and talking about the neglect and physical abuse she suffered at the hands of her mother when she was young. I noticed that Jennifer was curling up, rocking herself, and whimpering like a very young child. As the work with the other woman ended I went over to Jennifer and quietly sat with her. After several minutes she opened her eyes and acknowledged that I was with her. She said, “I am terrified. My body is so stiff. This is what happens to me when I am home. I just want to disappear.” I talked to her about the possibility of our doing some touch therapy. I described both the advantages and possible adverse effects of such emotionally inducing work. We talked about how she could stop my touch at any time by either pulling on my shirt or saying the words “Richard Stop.” I knew

intuitively that it would be essential for her to have a sense of choice and control. She agreed to the contract that gave me permission to do some therapeutic touch on her tight muscles.

With the protective presence of the group, I invited her to go back to the physical and emotional experience of curling up and rocking. As she tightened into a fetal position, with eyes closed, she wiggled away from me and tried to hide under one of the many mattresses. I put my hand on her back, over her heart. She was extremely tense as though her back was an iron barrel. I began to massage the tight muscle of her upper back, at first lightly, and then with more strength. During the massage she squirmed and wanted to escape being touched. I had her look at me and reminded her that I would stop immediately if she said, "Richard Stop". She pushed on the cushions; I sensed that it wasn't me that she was pushing away. I encouraged her to make sounds, any sounds that reflected what she felt inside. As I did a deeper massage in the thoracic area of her back she clawed at the mattress, cried like a young child, and struggled to move away. For the next few minutes she repeatedly howled "go away," "don't touch me," "don't feed me," "I don't want you," while alternately squeezing and scratching a cushion.

I could hear her sounds of helplessness and see that her full expressions of natural protest were still inhibited. If she was going to have a therapeutic closure that could alter the neurobiology of the original neglect and/or trauma, she needed to move her body in a grander way and to feel the sense of anger that she was still retroreflecting. I had her roll onto her back. I sat behind her head and began to massage her tight trapezius muscles. In this supine position she was able to move her legs and slowly began to push with them. I asked the group members to surround her with mattresses and pillows. As I continued with a deeper massage she began to kick. I encouraged her to kick harder and faster and to say out loud anything that came to her. She kicked wildly, with such a great force that it took six people to hold the mattress. During the intense kicking she screamed in a strong and determined voice: "I don't want your touch, Mother." "You have always hated me." "You squashed me, but now I know the truth." "It was never my fault." "You are the hateful one ... not me." "I was a good child and you never saw who I was." "All my life I have blamed myself and kept myself hidden -- no longer, mother. I am now free." "I don't want to carry your depression." "I am not going to hide who I am."

Throughout this therapy my body resonated with Jennifer's physiological and affective expressions. I experienced a series of alternating sensations: compassion, worry, anger, relief, as well as the ongoing processes of my own internal somatic and affect regulation. My shoulders, back, and legs tightened as I vicariously sensed the retroreflections in Jennifer's body. I resonated with the inhibited, frightened, and disgusted little girl. Each of my internal sensations served to keep me attuned to Jennifer's changing affect and body reactions and provided me with a sense of direction in our psychotherapy.

Although Jennifer's words sound as though she made a cognitive redecision, the significance of the therapy was not in the words she screamed or what she was thinking or saying. The principal and predominant change was physiological and affective -- a neurological reorganization facilitated by the working directly with the retroreflections in her body. She changed some brain-body-affect neurological circuits by allowing herself to feel the deep touch on her back, the related emotions that had been disavowed, and the sub-symbolic and procedural memories that were housed in her tight muscles. She kicked, screamed, and released her retroflected anger at her mother's disdainful and neglectful behavior. Then she relaxed into the caring touch of several group members who gathered around to hold her and express their support.

## **Conclusion**

There are many other case examples of body centered psychotherapy that I could use to illustrate the great variety of therapeutic methods available when working with protracted affect, retroflected movement, and sub-symbolic memory. Most of the methods involve a combination of focused awareness on breathing and body sensations, experimentation with movement and body tension, fantasy, grounding, and self-expression. These methods may include touch that is warm and protective, or deep and evocative of body memories. Of particular concern is the ethical practice of the client having the choice over the nature of the interventions and the control to stop any form of body oriented psychotherapy.

All experience, particularly if it occurs early in life or if it is affectively overwhelming, is stored within the amygdala and the limbic system of the brain as affect, visceral, and physiological sensation without symbolization and language. Instead of memory being conscious through thought and internal symbolizations, our experiences are expressed in the interplay of affect and body as visceral and somatic sensations. To again quote the title of Van der Kolk's article, "*the body keeps the score.*" It is our task, as psychotherapist, to work sensitively and respectfully with our clients' bodily gestures, movements, internal images, and emotional expressions, to stimulate and enhance the client's sense of visceral arousal and awareness so that he or she has a new physiological-affective-relational experience. Such sensitivity and respectfulness requires us to be attentive to the possibility of overstimulation and re-traumatization and to take ameliorative action. The narrative of the body is a special language with form, structure, and meaning. Through a body centered relational psychotherapy we are able to decode the stories entrenched in our client's affect and embodied in their physiology.

## Author:

*Richard G. Erskine, Ph.D., is the Training Director, Institute for Integrative Psychotherapy. He is a licensed clinical psychologist, a licensed psychoanalyst, and has integrated body centered methods in his practice of psychotherapy for forty years.*

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