Chapter 7

What Implications do Forms of Vitality Have for Clinical Theory and Practice?

A brief historical note may help to set the stage. Why are vitality forms not more directly addressed in clinical theory and practice? After all, these forms are experienced all the time by therapists and patients, in themselves or in the other, consciously or non-consciously. The evolution of the branch of talking psychotherapies originating in psychoanalysis sheds light on this question. Why did psychoanalysis develop as a “one-person psychology,” i.e. as having a disproportionately large interest in the intra-psychic, at the expense of the inter-psychic? Why was the therapeutic relationship conceived of as primarily a manifestation of the illness (the “neurosis”) of the patient? Why was a sharp cleavage established between talking and acting, and between verbal and nonverbal, and why was the word, the symbolic, given such a remarkably elevated and protected status? And in the same vein, why were most movement-related therapies split off from the talking therapies for so long, and initially assigned mainly to handicapped or autistic patients as second-class treatments? These questions are all interrelated.

When Freud was creating psychoanalysis, he ran into a potentially disastrous problem. Several of his disciples were having romantic and sexual relationships with their psychoanalytic patients. Such behavior threatened the therapeutic frame as Freud conceived of it. Also, and of great importance, he was
concerned that such “acting in” and “acting out” (of the session) would be ruinous for the reputation of psychoanalysis within the medical community in Vienna. At the time, the reputation was not on a solid base. Within this context he wrote the “technical papers” (Freud, 1915, 1918). The major points were that the psychoanalyst should maintain “abstinence” with regard to the patient, and the therapist should act “like a surgeon” in maintaining emotional neutrality and be in the position of a “third-party” observer and actor who “uncovers” the workings of another’s mind, in an uncontaminated field. (Freud also had the genius to identify transference and countertransference at the heart of the problem, with Ferencyz’s help.) These two phenomena then became bedrocks of the psychoanalytic endeavor.

Movement in general, and “acting” in particular, were left at the wayside (at least clinically), and all forms of verbalization were privileged.

Since the formative period of “classical” psychoanalysis, psychotherapy (including most psychoanalytic approaches) has evolved greatly over the past several decades (e.g. Cooper, 2005; Person, Cooper, & Gabbard, 2005). Major issues have shifted. Some of the current issues today include the following:

- How can we conceive of the clinical role of a more widely conceived therapeutic relationship, a more relational approach? Where are its limits, and where is intersubjectivity to be placed in this enlarged role?
- Moreover, in a related vein, what is the nature of implicit compared with explicit knowledge and memory? Is explicit knowledge in the form of verbal interpretations needed for change, or are changes brought about largely through relationship experience?
- What is the optimal balance between working on the past and in the “here and now”?

- What is the nature of body concepts and their role in providing an infrastructure for language and verbal concepts? In addition, what do we mean clinically by an “embodied mind”?
- What level of observation and therapeutic action is currently most needed? Is it micro-observation of behavior at the “local level,” or more abstracted notions such as narratives, or a more phenomenological perspective, or a more relational and intersubjective focus?

Given this slow revolution–rapid evolution in the field, can we see more clearly the roles played by the dynamic experience of vitality forms? A closer look at vitality in the clinical context will help to reframe some of the basic shifts that are now under way.

Some of the roles played by vitality forms in psychotherapy

Vitality forms and spontaneous talking

The deaf and the blind find it very difficult to acquire the amenities of conversation ... They cannot distinguish the tone of the voice or, without assistance, go up and down the gamut of tones that give significance to words; nor can they watch the expression of the speaker’s face, and a look is often the very soul of what one says.

Helen Keller (1902, p. 23)

I shall start with spontaneous speech, as that is by far the main activity of talking therapies. It is the defining aspect of these therapies both practically and theoretically. It deserves the first look. Let us then consider the dynamic features of the action and process of unscripted spontaneous talking as it occurs in most therapies. For the following discussion, it must be held in mind that speech production requires physical (as well as mental) movement. The voice is an instrument involving voluntary movements of the vocal chords, tongue, mouth, lips, breathing, etc.
Spontaneous spoken language sounds human, compared with a robot, because it is richly dynamic. The prosody of speech consisting of melody, stress, volume modulation, vocal tension, etc. creates forms of vitality. These let the listener know that the speaker is a living person and what is “really” meant by what they say in words at that moment. The difference between the words as spoken here and now, and as they exist generalized in dictionaries and the “official” language, is a fertile field for understanding human social behavior (e.g. see Crystal’s classical text on “The English tone of voice” (Crystal, 1975) and Lacan’s distinction between la parole and la langue (Lacan, 1953)).

Secondly, there is the motive to talk. The listener feels the ongoing action of the intention through the vitality forms of its expression. Thirdly, in spontaneous speech there is a kind of imprecise, messy, hit-and-miss work to find the “right” words to communicate what one wishes. This messy work is visible or hearable by the listener and made manifest in the forms of vitality used.

Here is an example. Suppose a patient says, “I’ve told this story so often that it has become the reality of what happened ... I even sort of believe it ... but it isn’t what really happened ... What really happened was ... .” The therapist will naturally be interested in what “really” happened, and will explore why the distorted first version was needed. However, if the therapist waits and first focuses on the vitality forms and experience of the telling, not its verbal import, he or she can take a different path that might go further, faster, or elsewhere. The therapist could say (if it were true), “You said that with such a rush, like it was being held in prison and finally burst out” (i.e. its form of vitality). This might lead to the patient telling of the forces that created the revision in the first place.

Alternatively, if the patient spoke differently with different forms of vitality, the therapist might say, “You said that so hesitantly, like walking in the dark across an unknown room, like you were afraid of bumping into something.” This might evoke the patient’s fears of being punished or hurt or humiliated by revealing the real story. In other words, the experience of the defenses in the form of vitality forms can be evoked well before exploring the explicit conflict leading to the defenses. This focus on the dynamics of telling will, in fact, facilitate the exploration of the conflictual content.

In short, the focus is on the vitality forms of how the patient expressed himself, not the strict sense of the words. If that is fruitful, the patient will himself directly get to why the “real version” was disguised. In addition, the patient will get a first-hand experience of how his defenses operate and what the therapeutic relationship can tolerate and contain.

In unscripted speech, there is something in mind that wants expressing. Let us call this “something in mind” an image, in the broadest sense of the term. The image can be an idea, a movement, a gesture, an emotion, a vitality form, or a background feeling. Usually none of these are initially in a verbal form. Now comes the messy work of fashioning spontaneous speech. There is an intention to link the image (the “something in mind”) to words. For almost each phrase, the intention enters into a dynam-ic dialogue with the speaker’s repertoire of pieces of language to find the best fits. This is an “intentional unfolding process,” where intention and language are yoked. Emergent properties form. New linkages are created, tentatively accepted, revised, rejected, reintroduced in a different form, and mixed with all the other creative products of the intention-unfolding process. This process, which usually takes several seconds, is unpredictable, messy, widely distributed in the body and mind, and usually involves conscious and unconscious bodily happenings.

This nonlinear process is perhaps what makes us most human. It would include how the word search is performed, with what
deliberation or rising excitement, and with what burst of enthusiasm or calm when it “catches” a word. It is a process that can rush forward, hesitate, stop, restart gently, etc. It can express itself in various forms of the repertoire of vitality.

Even after the word is chosen and out there in public space, it can be partially taken back, and revised or deleted as the talker stumbles forward with more or less grace and coherence. (It does not matter whether there is a “right” fit. Often none exists. It only has to be good enough for effective communication.) It is these dynamic qualities that give the impression of an “inhabited body” — that is alive, now. Without these dynamic vitality features of the intention-unfolding process we would not experience a vital human being behind the words that are being said.

This body/mind dialogue of implicit experiencing along with reflective—verbal processing makes it possible for a psychoanalyst and his or her patient on the couch, not even seeing each other face to face, to know much of the implicit and to share an intersubjective space (BCPSG, 2010).

A distinction is required here. There seems to be a difference (felt at least) between a more or less conscious and clearly non-conscious intentionality. The idea of an “intentional unfolding process” is appropriate if one imagines that an initial intention was somehow conscious, or very close to consciousness. The sheet of paper on which the initial intention is “written,” even if faintly or in code, only has to be unfolded to read the original. Indeed, many intentions feel this way. However, for many others it is not so clear that there was ever a well-formed original intention. In these cases, the term “initial intention” should be replaced with the term “initial tendency.” There is no initial intention to be revealed by unfolding, but rather there is a tendency for action that must be specified. The original meaning of intention gets partially lost, i.e. the “aiming” of the intention toward the “intentional object.” Tendencies do not have a clear target. They imply soft-assembled specific actions that were unpredictable and never “written,” a priori, but which find a goal and are fitted en route from moment to moment.

For this process, a better term might be the “intentional emerging process.” The role of the body, perception, and the ongoing dialogue between all of the factors gives vitality forms more room to interact à la Merleau-Ponty (1962).

The sharp distinction as just proposed may be unnecessary, even unhelpful. Phenomenologically there seems to be a spectrum between intentions and tendencies and accordingly between “unfolding” and “emerging” processes. It remains to be seen how this felt spectrum is handled neuroscientifically.

The notions of the primacy of movement, an embodied mind, vitality forms and the idea of goal-directed movement being “soft assembled” on the spot to meet the immediate context may help to ease this conundrum. The nuances of soft assemblage require that vitality forms do the job of fine-tuning to the found context. Suppose that most or even many goals are not only hazy and inexact to begin with — more like tendencies. They may also remain non-conscious until they scream at you and are specified through reflection or action.

Not to be forgotten, the process of talking involves another person, a partner in dialogue. The two find their way in a rapidly changing field. The person listening has their own shifting vitality experiences, which are a crucial part of the field. In other words, there was never an exactly specified goal. There were tendencies in search of a finality. Moreover, on the way, they found a series of evolving goals and intentions that were constantly updated and changing.

Our clinical view is generally limited because we tend to consider events when they are completed and seen retrospectively (after the session, when they can be talked about). From this
vantage point it seems reasonable to imagine that a specific ini-
tial state somehow found the means to arrive at a predestined end state. However, when an event is viewed while it is still ongo-
ing and unfinished, neither the initiating state nor the end state is so clear. We move from an inquiry about intentions, means, and goal states to an inquiry about processes of creation, emerg-
ing, and becoming. The work of the Boston Change Process Study Group (BCPSG) has attempted to focus on this (BCPSG, 2005a, b, 2008).

Further pursuit of this line is beyond the scope of this book. Suffice it to say that vitality forms in spontaneous speech reveal much of what is underneath unscripted language.

There are other perspectives on the issue of spontaneous speech and what mental entities lie “behind” or “alongside” it. David McNeill (2005) introduces the concept of the image/ gesture to refer to all the bodily shapings of spoken thought. He sees spoken language as consisting of two components of equal generativity and importance. First, there is language, which is usually conceived of as a more or less static structure. Secondly, there is a dynamic process that he calls the image-gesture process. Superficially, this dynamic process consists of the gesticulations that are synchronous with speech. He points out that spoken speech is inhabited by the body moving in time, including facial expressions and head nods. Similarly, while gestures have their own isolated morphology, in real speech they become shaped by imagery and intention. They are tantamount to vitality forms, or at least contain them.

The dynamic interplay of intention and word has similarities to choreographing dance or composing music, where the inter-
play is between the inchoate intentions of the creator and move-
ments or notes (Kurth, 1931).

Experienced therapists are peripherally aware of many of the above dynamic features of their patient’s speech that influence their overall clinical impressions. However, because of the emphasis on word meaning in talking therapies, the dynamic vitality-related features of speech are less often the central focus of attention.

The above considerations lead us to pay a special kind of attention to the vitality forms in spontaneous speech in the clinical setting. They can reveal what is hidden in the words or behind them, such as the degree of authenticity, hesitation, conflict, difficulty and fear in telling, the amount of excitation or engagement, the distance of the narrative stance from the “here and now,” boredom, deadness, disavowal, the amount of defensive blockage in the passage from mind to speech, and much more. This kind of sensitivity requires sensibilization to vitality forms to disembody them from the rest of the verbal flow and the emotions elicited.

In this context, “meaning” takes on a different sense. Language and symbolization are no longer the only, or even necessarily major, creators of meaning. The dictionary definition of “mean-
ning” is illustrative on this point. “Meaning” is defined as “what is in mind,” “what is intended,” and “what is shown forth.” The linguistic sense of meaning is either not mentioned or is given a second place in dictionary definitions (Oxford English Dictionary, p. 1053; Webster’s New Twentieth Century Dictionary, p. 1115).

In short, the “intention unfolding/emerging process” shaped by vitality forms is a rich source of clinical material that is fre-
quently not fully used.

**Dynamic forms of vitality as paths to memory**

The traces of vitality forms that were experienced in the past are carried in memory. They are connected with the other aspects of remembered experience. When the vitality forms of the experience can be evoked, a whole experience can tumble out.
The fading of a church bell can evoke a time when someone slowly left the room or disappeared from the relationship, etc.

How can a therapeutic inquiry be directed to use the vitality forms? An obvious key is to stay with direct experience at the local level, not abstractions about experience, and moreover to stay with dynamic events such as movements (mental and physical) that unfold in time, not mental states conceived of as static entities. Nor should one stay with body parts or positions to find the experiences they “contain,” as some body therapies do, but rather evoke experiences of the movement of forces in time, space, and intentionality to recall different vitality forms. The overall idea is for therapists to pour themselves (empathically) as far as is possible and clinically useful into the lived-movement-evoked experience of the patient and begin the dialogue there. The goal is to evoke a vitality form that will pull into consciousness some aspect of the whole lived experience. Here is an example.

An adolescent boy had a sudden and dramatic “break.” He retracted into a mute silence with no show of emotion. It had lasted several days. The provisional informal diagnosis was a “schizophrenic episode.” All that is known is that on the night preceding the “break” he had been in the back seat of a friend’s car with a girl, whom he liked, sitting on his lap. Many questions were posed to clarify what happened and break through his silence: Was she important to him? Did she like him? Did he reject any advances? Was he hurt, sad, angry, or humiliated? Was there a previous history? And so on. None of these opened his silence. It is worth noting that all of these questions ask about something (usually static) that might have happened. They are hypotheses about his possible mental state. However, the only things we do know are that he was in the back seat of a car with a girl on his lap. From this physical reality, this local level, the following question arose, “As she sat on your lap and shifted her weight, what did her moving weight feel like on your legs?” After a short while, the boy looked up and tears slowly started to fill his eyes. The door to therapy was opened a crack.

Here is another example.

A man was very uncertain about how he felt towards his wife. Did he want to stay in the relationship or leave? The marriage had been difficult and more dead than alive for a long time. After an absence of several weeks, his wife flew home. He met her at the airport. The therapist asked how he felt about her. He said he still did not know. Instead, the therapist might have asked, “When you first saw her emerge from the gate and come toward you, did anything jump up or fall down inside you?”

The difference between these two questions is not small. The first is about static mental states and the second is about vitality forms.

Most experienced therapists do this sort of thing without thinking much about it. I am not pretending to invent them. I am trying to identify, conceptualize, and give a name to such experiences, to better understand and use them.

Memories evoked via the path of dynamic experience may be unconscious in the sense of being under repression or dissociated, or may reside in implicit relational knowing. Therapeutically, vitality forms can be used along with other approaches, or alone initially, or after other more explicit approaches fail, or to complement the other approaches, or to jump-start them.

**Vitality dynamics as a path to “(re)-constructed” phenomenal experience**

We usually do not bother to make a distinction between memory and phenomenological experience. Memory is restricted here to remembrances that are selected and assembled to address a specific “present remembering context,” i.e. to adapt to a novel present moment. One “remembers the present,” i.e. one uses the past as a guide to adapt to the immediate present situation (Edelman, 1990).

Phenomenological experience, on the contrary, is happening now (memory is the recall after it is over and put into a coherent form). It is whatever is crossing the conscious “mental stage” right now (including its immediate past echo, which has not yet
faded into the past). It is purely subjective. It does not matter why or how it got onto the mental stage, nor whether it refers to real events, past events, or future events, or even if it never happened before. It has phenomenological “reality.” It is in the nature of direct phenomenological experience that it cannot be verbally recounted as it is happening (attempts to do this would disrupt the happenings), so when the happenings are recounted later it is only a selected memory of what was experienced phenomenologically.

It would be most interesting clinically if we could get at pure undistorted phenomenological experience (a completely free “free association” in its purist form comes close). Phenomenological experience is not retrospectively selected to meet the unicity of the present remembering context, and selection is less based on defensive operations. It is lived experience. If we could get a hold on it, it might offer different paths to different clinical material.

There are techniques that can approximate direct lived experience but never capture it fully or faithfully. Simple introspection as to what happened subjectively has proven problematic. We have devised a more complicated way to piece together retrospectively the phenomenological experience in a multilayered fashion. The technique is called the “microanalytic interview,” which can also be used clinically. (This has been mentioned in Chapter 5. A detailed description of the “microanalytic interview” can be found in the appendix of Stern, 2004, pp. 229–240.)

The technique grew out of a project to explore the “present moment” as a phenomenal experience. I ask subjects to tell me what they experienced several hours earlier that morning at breakfast (it was originally called the “breakfast interview”). Usually they answer, “Not much.” After a while we agree on a brief stretch of time where they know exactly when it started (e.g. “The kettle began to sing”) and when it ended (e.g. “Then I sat down and picked up my cup”). Once these boundary markers are in place we explore their subjective experience of “all” that crossed their conscious mental stage during the 20 or 30 seconds between these two boundaries (things they would not have remembered ordinarily, i.e. never needed to remember).

They are asked, in no particular order, what they felt, thought, and sensed, what positions their bodies were in and when did they change position, what gestures and when, what head positions, did any memories pop up, did they have visual images, and did they project themselves into the immediate future. If they were the director of a movie about their subjective experience during those 20–30 seconds, and I was the cameraman, what angle should I shoot the scene from? Would I use close-ups or long shots for different moments? How would I cut from one shot to another? And so on. In effect, any question could be asked that might throw them into reliving the event. The technique does not prioritize whether questions target movements or mental states.

The response to each question is graphed in the type of a vitality form (the intensity of force, its duration, and contour as subjectively felt). Each response is graphed as a separate time line, one below the next (feelings, thoughts, movements, etc.). Accordingly, the final record resembles a symphonic score with each instrument (response to a question) having its own line.

When the next question is asked it often leads to a change of the previous responses, which then have to be regraphed. All together, a layered composite narrative results. This account is different from a simple reconstruction in that the interviewer uses verbal and nonverbal primers to evoke the experience in multiple ways. A minutely re-worked narrative is created that is different from a memory. It is more comprehensive and continuous but usually less coherent than a memory.
When working at this level of microanalysis, the role of dynamic forms of experience comes to the fore. Personal psychological themes are revealed in unsuspected details that would not have popped up using other techniques.

For instance:

A graduate student described going to the refrigerator to get orange juice for breakfast. He opened the refrigerator door. He then, without thinking, while he was talking, made the same gesture he used to open the refrigerator door. This struck me as strange. Everyone knows how to open a refrigerator door. I asked him if there was something unusual about opening the door. He focused on his gesture and repeated it, explaining that the door was broken and if he pulled it too strongly it would swing wide open and bang into the cabinet. If he pulled it too weakly it would swing back to close and he could not get his juice out. But if he pulled it open with just the right strength it would stay open—just so. He said it was a sort of game with himself to see if he could fashion the right movement, i.e. give it the right vitality dynamic. Not too strong, not too weak, not too fast, not too slow.

He then took the juice out of the fridge and poured it into a glass on the table. He tried to fill the glass almost to the brim, so it was not so full that it would spill when bringing it to his lips, but had as much juice in it as possible. That too was a sort of game. While recounting this, he realized with surprise that the juice and the refrigerator door were both a kind of risk taking, of seeing how far he could push the envelope. He then recalled that the night before he had been trying to finish writing the conclusion of the research that was his doctoral thesis. The writing involved deciding how far he could go in the scope of his conclusions. At what point would it be overreaching or too timid? Along with the experience of the night before with his thesis, we agreed that in general he was a risk taker in life, from big things to refrigerator doors and juice pouring.

The extensiveness of this trait would not have been apparent to him from most memories. It popped easily out of a (re)construction of an ordinary phenomenal experience revealing a current psychological conflict as well as a character-like trait. In addition, the subject himself put it all together. It is in this sense that a microanalytic approach to phenomenal experience can open up a somewhat unique clinical landscape that might have had to be more laboriously constructed over time by other paths.

When used clinically, this interview can be greatly abbreviated to fit the situation and therapeutic relationship.

**Vitality forms and imagined movement, including verbal descriptions**

Experiences that are described verbally, or imagined, or witnessed in others, or enacted by oneself, seem to be inter-connected by the brain. No matter how the experience was generated or received, it ends up in all of these domains to some extent.

An example illustrates this. If someone is standing, ask them (a verbalization) to imagine taking a step forward, but not to take it (an imagined movement). You cannot notice any movement in their stance. However, if you give them a little push forward from behind they will fall forward and take a little step to break the forward movement. On the other hand, if you give them the same directions and the same little push, but backward from the front, their body resists it, and they will not move (Paxton, 2008). Real movements (imperceptible to the eye) in the form of shifts of tonicity are also involved.

When someone imagines a movement with its vitality form, something happens in the cortex that then sends a signal to the appropriate motor areas to activate the musculature of the body that would have been used if the imagined event were enacted. However, although some activation is recorded electrophysiologically in the muscles involved, it is not enough to release a movement.

Perhaps the final common pathway for understanding words, imagining actions, intending to act, or imitative, identificatory, or empathic actions is by way of "imagined movement."
Movement remains primary for animals, but during evolution it may be that imagined movement has become primary in humans. It is the pivot through which all action and thought pass.

Recall that when a word is heard the signal goes not only to the language centers of the brain but also to the part of the brain that would be involved in an enactment of the word. For instance, when the words “skip,” “jump,” or “run” are heard, the signal will also go to those different parts of the motor cortex that control the slightly different motor patterns of skipping, jumping, or running. An imagined movement is created alongside the word meaning.

This perspective on imagined movement helps explain why “narrative therapies” have developed (e.g. Freedman & Combs, 1996). Storytelling is used to provide virtual experience about the self. It brings about change both through its virtual enactment of narrated actions (Gentili, Papaxanthis, & Pozzo, 2005; Fontani et al., 2007) and through its narrative coherence as the personal autobiography of how you got to be who you are (Spence, 1976; Schafer, 1981).

In this light, it is clear that imagined movements are used in both movement/body therapies and talking therapies. This includes techniques such as “visualized movements,” “mental movements,” preparations for movement, virtual movements, and “phantasied movements.” Music and dance therapy, movement therapies, and some sports therapy depend on these connections through imagined movement. Changing a golf swing or tennis stroke can occur by doing it, or by imagining your swing differently, or by seeing another do it.

The imagined movement is not disincarnated — it has the flesh of a virtually embodied vitality form.

There is a growing notion that therapeutic change cannot happen if there is not a “real” or imagined action at the local level. For instance, the BCPSG in studying the change process in a therapeutic session proposed that changes in “implicit relational knowing” occur only when one “does,” i.e. enacts an aspect of the relationship in a new way. It need not be reflected upon and verbalized (Stern et al., 1998; BCPSG, 2002, 2005a,b; 2008). Gestalt therapy has been using such imagining techniques for a long time, as have others.

In short, mental models and neural networks can be reshaped by doing something differently, imagining it differently, seeing another doing it, or by hearing about it in words. The walls separating different modes of experiencing are starting to come down as we realize that all has to pass by way of imagined movement.

The brain’s neural networks function so that successive inscriptions of experience (cognitive, emotional, sensory, or motor) can alter and re-transcribe previous traces. The neural networks are in almost constant change depending on experience. Existing neural synapses can cease to function if not used, or get stronger if frequently used; new ones can form, not only in the developing person, but also throughout life. The brain’s plasticity and dependence on accumulating experience have long since been assumed (Givon, 2005), and have been the subject of much diverse neuroscientific and behavioral research (e.g. Freeman & Schneider, 1982; Ghaem, et al., 1997; McCandliss, Posner, & Givon, 1997; Freeman, 1999; Jones & Greenough, 2002; Collingridge, Isaac, & Wang, 2004; Lamprecht & LeDoux, 2004; Gage, Kempermann, & Song, 2008).

Ansermet & Magistretti (2004) have related brain plasticity changes and psychoanalytic changes as viewed in parallel.

**Vitality forms and the “local level”**

The “local level” is a concept that underlies much of this book. Vitality forms are realized at a “local level.” “At this level, the
scale of analysis becomes more microscopic—gestures, expressions, spoken phrases, or the emergence of a thought usually last between 1 and 10 seconds, enough time to execute a grasp of consciousness of a single whole event, a Gestalt. The units of meaning at this level are made up of movements/actions (verbal or non-verbal) that imply an existing or emerging intention. The actions acquire their inevitable vitality under the influence of the local conditions of specific time and place, and the internal motivational force (BCPSG, 2002, 2005a; Stern, 2004).

There is a general tendency to see local-level happenings as less clinically important than the motives “behind” them, the larger psychodynamic forces. In this view, local-level events are seen as only behavioral, non-verbal, unreflected, unelaborated, non-abstract, and not generalized, compared with a verbal interpretation as the best clinical example of being elaborated, verbal, reflected, and generalized. Countering this view is the evidence showing that implicit relational knowings and other body/mental models (e.g. primary metaphors) are, indeed, concepts and abstractions, although not arrived at through conscious reflection and verbalized.

Traditional psychoanalysis and related approaches see local-level meaning as “superficial” compared with the “deep” meanings provided by more macro-psychodynamic (narrative) meanings. The approach taken here sees the micro-level as just as deep in meaning, and the macro-level as just as superficial because it is built upon the reality of the micro-local level and in that sense is secondary and derived (BCPSG, 2008). We view the local level as containing the events that verbal abstractions are drawn from, and as providing the terrain upon which the abstractions and generalization are then instantiated and given expressive form.

The dialogue flows from movement at the local level to mental operations at the abstracted level, then back down to instantiation in movement at the local level. Concerning “superficial” and “deep” there is no upside down or right side up. Dialogical circles between them continue to turn. Each is necessary for the evolution of the other, and offers different ports of entry into the mind.

**Vitality forms and intersubjectivity**

Where you start from determines in large part where you go and what you find on the way. We shall start from a set of philosophical ideas and scientific findings that include:

- the philosophical notion that the human mind is “innately open to other minds” and to seeing “others as having embodied minds like me” and “with me”
- the developmental history of intersubjective capacities from early infancy (early imitation, interactional synchrony, pointing to align the other’s attention, social referencing, affect attunement, etc.)
- the “mirror neuron” story that starts to explain how we become immersed in the experience of others
- the findings of “intention detection centers” that start to clarify how we mind-read the intentions of others
- the tendency for self-reflection (Fonagy & Target, 1997)
- the notion that an infant does not pass through a longish phase of not differentiating self from other, or a phase of normal symbiosis, but rather that the main early developmental tasks are to become socio-affectively competent and establish attachment ties, rather than to first become autonomous and independent.

Thus the focus has to be on inter-psychic events. The emergence of the intra-psychic domain can only be observed in the larger context of the inter-psychic. This is true in general as well as developmentally. Accordingly, the inter-psychic happenings
between the patient and therapist cannot be seen only in terms of transference and counter-transference, but rather under the larger roof of intersubjective relatedness, which includes what happens in a therapeutic session, but as a special subset of general intersubjectivity.

In therapy, the spontaneous speech (or vocalizations) of the therapist is rich in vitality dynamics. A therapist can hardly open his or her mouth without using a vitality form and doing a sort of affect attunement with what the patient just said or what they might say next. This results in the fine-tuning of their intersubjective field. Suppose that therapists limited their responses to only “Hmmm,” “Uh huh,” or “Aahhahah.” Each is quite different. “Hmmm” usually has a fall in pitch at the end. This kind of terminal pitch fall usually evokes a vitality dynamic that signals a closing out, or a termination – “I got it, go ahead, you can move on.” It can have a slightly negative valence. “Aahhahah” usually has a terminal pitch rise with an implied question mark. Its vitality form signals an interest in what was said and in what may follow. It usually carries an implicit encouragement and curiosity. “Uh huh” is more neutral. It is a placeholder signaling “I’m still here and listening.”

Now add to these three utterances the multiple variations in duration, force, and temporal contour of the utterance, and one ends up with a huge repertoire of nuanced vitality forms that indicate exactly how the therapist felt about what was just said. An intersubjective exchange is taking place with only three sounds. Furthermore, this attunement (under- or overattunement) acts as a sort of non-conscious compass to guide the course of the session and therapy. These vitality forms from the therapist act like the affect attunements (vitality form matching) we have seen mothers perform for their infants. However, here what is being sculpted is the nature of the relatedness between patient and therapist – the therapy itself.

The role of vitality forms in intersubjectivity leads to a renewed interest in some of the basic notions of non-verbal therapies. “Improvisation music therapy” provides an example. Tony Wigram (2004) describes what he calls the “basic therapeutic methods” of improvisation music therapy. These include the following.

1. **Mirroring**, imitating, and copying. The therapist does exactly what the patient just did – its vitality form, rhythm, melody, etc. – on the piano or drums or some other instrument.

2. **Matching**. This is a partial and selective imitation. The dynamic features of what the patient did are maintained, but other features are altered. This is essentially a musically based affect attunement. It is “one of the most valuable improvisational methods that can be applied in therapy” (p. 83). Just as affect attunement (vitality form matching) has been shown to be so valuable in parent-infant therapies (Markova & Legerstee, 2006), so it is in all non-verbal therapies.

3. **Empathic improvisation**. The therapist improvises a response that reflects (without imitation or attunement) the emotional state of the patient, his “way of being” at that moment. It is a musical rendition of the patient’s state. This relies on some meta-modal matching of vitality forms.

4. **Grounding, holding, and containing**. The therapist creates a stable musical “anchor” (e.g. steady pulsed beats on a bass drum). This provides a dynamic framework that the improvisation can work within.

5. **Dialoguing**. Turn taking is a major manner of dialoguing. Smooth turn taking involves sharing a convention about the time flow of that interaction. In adult verbal conversation, dyadic speaker turn-taking pauses (when one ends and the other has not yet started to talk) must be mutually adjusted
to the timing of the other. Otherwise there are either constant interruptions or too long silences (Jaffe & Feldstein, 1970). This very fine timing is not based on verbal content. Even infants during the first half year of life learn to do it with their parents (Stern, 1971, 1977; Stern et al., 1975; Beebe, 1982; Jaffe et al., 2001). In other words, it involves a form of intersubjectivity.

6. Accompanying. The therapist provides an accompaniment that is different from what the patient is playing but lies "dynamically underneath the patient’s music" (Wigram, 2004, p. 106).

In short, the basic methods in improvisation music therapy all require the use of vitality forms to share or interchange experience.

From a related point of view, some music therapists stress the intersubjective aspects of the therapy. For instance, Trolldalen (1997) among others sees musical interplay as offering the potential for intersubjective meetings. As the therapist and patient enter the same dynamic flow created by the music, there will emerge moments of “mutual recognition” when they both realize, at the same time, that they are sharing a common experience. This is brought about through affect attunement, joint attention, and mutual confirmation. Such shared moments then act much as do “moments of meeting” in changing the relationship and moving it to a deeper level of intersubjectivity (BCPSG, 2008).

Immersion in the dynamic flow is the central condition that creates these events. Accordingly, this view of music therapy also rests on vitality forms with some cognitive aspects added, especially the importance of mutual recognition.

Of course, once the dynamic musical work has occurred and aspects of the patient’s “way of being with the other and in the world” have been musically manifested, the therapist can, but need not, verbalize and render what is heard into a meaningful narrative structure, depending on the school of approach. This rejoins the dialogue between explicit and implicit techniques, between talking and acting.

The situation in other movement therapies is roughly parallel to what has been described for improvisation music therapy, in particular the central role of vitality forms in establishing contact with the patient and working with them. Movement therapies that rely on vitality forms include dance therapy, body therapy, Feldenkrais, Alexander technique, and others. This list should also include role-playing techniques. It is beyond the scope of this book to overview all of these. The example of music therapy will suffice.

The central point is that forms of vitality play an essential role in the expansion and adjustment of the intersubjective field between patient and therapist, regardless of whether one is using a talking or non-verbal therapeutic approach.

Vitality forms in identification

Identification and internalization remain incompletely understood. Can exploring the dynamics of vitality forms lead to better understanding? What is it about another that we identify with? Is it what they do, or why they do it, or how they do it? It is all three. Nevertheless, how it is done is often the most mysterious and least explained. We now know a good deal about the “What?,” thanks in part to the mirror neuron story. In addition, we know that the brain has centers that detect likely intentions (Ruby & Decety, 2001). This helps us to understand the “Why?” (Of course, much more is needed, such as a tendency to seek out, perceive, and think about others’ actions in terms of intentions and motives.)
We return to the “How?” It is always remarkable to see/feel yourself walking and moving like your father or mother, or making the same facial expression while tilting your head a certain way, or sighing audibly in a way that they do or did. That sigh is not any sigh. What most makes it particular is its dynamic features—the force and duration of expiring the air, the tension of the vocal chords and the opening of the mouth, the attack, the fade-out, etc. (Recall that mirror neurons apply to unseen vocal chord movements as well as to visible gestures.) Every sigh has a beginning, middle, and end with a stress somewhere along the timeline. To “take in” another’s sigh one has to have been inside their skin. Identification and internalization are in this sense more complete immersions in another’s dynamic experience than empathy needs to be. Without the vitality forms, identification and internalization would be like rules of action, not a felt immersion.

These mental processes occurring out of awareness are seen in young children. We often think of identification and internalization as more inexplicable and quite separate from learning in general. However, we learn to talk by hearing others talk. We learn to sigh by hearing/seeing certain others sigh. The mechanisms are different, but the end product of learning how to function in a certain way is similar.

In an average nuclear family, the infant is surrounded constantly by the same few people. In the first few years of life the opportunity for a generalized learning (beyond the family) of what, why, and how people do what they do does not occur. They have to learn how to be someone else, as they learn to be themselves. They learn a repertoire of vitality forms that they can choose from.

We see many acts performed by others every day. We attribute motives to them. We observe the manner in which they are accomplished. We grasp the context. But why do we care?

How is the what, why, and how of any particular act lit up and selected as worth “talking in,” to internalize, or identify with, or empathize with? If this question cannot be answered, all the rest would lose much of its clinical value.

The act of another to be identified with must belong to that other specifically. It must carry their personal signature. It cannot be any member of a class of acts. The vitality of the forms of the actions of the other must be specific to them. It is what gives it its uniqueness.

Even more serious, without a selection process we would be constantly captured and inundated by the behavior of others in our presence. Our mirror neuron system would be the prisoner of other people’s motor neuron systems. Some gating and braking mechanisms must operate.

The selection of a specific other to identify with is primordial. That person must have a special relationship with us. We cannot get away from this notion. There must be a way that the behavior of the other has more value because of who they are to us, in reality or imagination. We must love, hate, respect, fear, admire, be attached to, or be dependent on them, (i.e. be in an important relationship with them). Their presence, then, has a special value (conscious or unconscious). This value is built up over previous experiences with the other, or the other’s prototype. These accumulated experiences link the other to motivational and emotional centers. They are “charged” by virtue of this linkage. They become “charged others.” Their presence alone will cause some activation of the arousal, motivational, and emotional centers associated with them.

To capture this, Freud (1895) first used the term cathexis (besetzung). He meant the amount of psychic energy attached to an object (idea, etc.). Psychoanalysis has in part kept this concept based on the “economics” of psychic energy as a physical reality. Over time, the psychic energy notion has become less of
a reality and more of a metaphor for value, or the affective value, or the amount of excitation elicited by an object (Laplanche & Pontalis, 1967). I shall continue to use the term “value” as it is accepted across many related fields. Arousal and emotion measure its value to us.

So far, we have an individual who will be identified with or internalized. They have been pre-chosen by past experience. But how do they become internalized? They don’t – not as whole objects and not as “part objects” (e.g. breasts). It is their forms of vitality as these relate to specific actions, feelings, attitudes, reactions, and how they respond to us and make us feel that are internalized and identified with. What we take in has been experienced at an intimate and local level. It is the interactive experience that is internalized, not “objects.”

Suppose that a “charged other” executes a dismissive toss of the head to someone else, or makes an attempt at seduction, which is readily seen and heard in the voice, or that the other is involved with their whole body in an act of holding a baby a certain way. These actions with their vitality forms are the ongoing perceptions of the charged other that the observer–identifier is concerned with.

How do we internalize the local-level actions of a highlighted other? The work of LeDoux (1996) offers some suggestions. Recall that the arousal systems will enhance the activation of ongoing perceptions. Perceptive processes that are not so engaged will not be activated (see Chapter 4). How can we build on this basic idea?

It is reasonable to assume that the simple presence and actions of people who are loved, hated, feared, or attached to will elicit activity in the arousal and motivational centers that regulate these states. Suppose further that a “charged other” is now executing an action (the dismissive toss of the head, etc.).

Such actions are the “ongoing perceptions” of the “charged other” that the observer–identifier is concerned with.

In such a situation, the arousal systems will be doubly triggered – first, by the presence of a “charged other,” i.e. by the activation of the motivational centers, and secondly, by the “ongoing perception” of a specific act with a specific vitality form. The arousal systems will then re-ascend to the cortex to augment the activation of the “ongoing perception” that is already under way (like the dismissive toss of the head). This action, as perceived, is thus selectively more activated. It becomes a lit-up action that focalizes attention and interest. The mirror neuron system is also called into play and directed to the lit-up action of a lit-up person, and creates a virtual enactment of the other’s action, an imagined movement. This imagined movement must follow the exact dynamic form of the original. The virtual enactment can then rearrange the neural circuitry of how such an action should be performed by the identifier in a certain context. The person who has identified ends up with a modified gesture for the action in question, and with the feel of what it is like to perform an action as if they were its original performer. A building block for a larger internalization has been put in place.

What we call empathy englobes all these processes – object choice, sympathy, empathy, and enactment. Rather than see these processes in sequence, they enter an ongoing dialogue and shape one another.

The above teasing apart of empathy may be helpful in evaluating our therapeutic responses or failures, in particular those involving the nature of our “countertransference,” i.e. those occasions when empathic processes are overfacilitated, overinhibited, or disinhibited, and those moments when object choice and empathic action are taken.
We are perhaps taking a step toward understanding better "taking in," i.e. the general process behind identification, empathy, and internalization. In any event, these processes have enormous importance for clinical theory and practice, and further research is needed.

**Vitality forms, authenticity, and aliveness**

Authenticity is cardinal in both patient and therapist. Being authentic is not an all-or-nothing state – there are degrees of authenticity that can shift (just think of politeness). It is hard to imagine how the nuances of authenticity are transmitted without relying heavily on vitality forms. Ekman, Friesen, & O'Sullivan (1988) have shown that authentic facial displays (telling the truth) versus inauthentic facial expressions (lying) can be distinguished based on their vitality dynamics (see Chapter 3). In natural situations, including therapy sessions, what goes into authenticity is far more complex, involving gestures, physical positions, muscular tonicity, voice, and language. The possibilities for expressing level and shift in authenticity are many.

The notion of level of authenticity needs further discussion. An example involving an infant is useful here.

- A mother and her 9-month-old son were sitting side by side on the floor playing with a cardboard jigsaw puzzle.
- The boy picked up a piece of the puzzle and brought it to his mouth.
- His mother said in a normal voice, "No, it's not to eat, it's a leaf" (of the puzzle). She stopped his movement with her hand.
- The boy answered "Ugh." Then he tried again to get the piece to his mouth.
- She repeated, in a firmer voice this time, "No!"
- His response was "Uugghh!"

- She escalated even higher and said, "NO, IT'S NOT TO EAT!!!"
- He escalated even further, "UUGGHH!!"
- She then leaned forward towards him, lowered her eyebrows, and said in a flat voice with no melody and much vocal tension (as in anger), "DON'T YOU YELL AT YOUR MOTHER. I SAID NO!"
- He then overescalated her, yet again, and said, "UUUGGGHHHH !!!!"
- At this point she gave up and conceded the victory to him. She sat back, her face softened and broke into a slightly seductive smile. She said, with a melodic voice, "Does that taste good?"
- He then put the puzzle piece in his mouth.
- She then made him pay for his victory. With a disgusted wrinkling of her nose and a slightly contemptuous voice she said, "It's only cardboard, does that taste good?"

The mother's family of origin was quite "macho." Her mother and father were constantly in negotiations where her mother said "No" and her father said "Yes" to whatever was the source of contention. This went on until he progressively raised his voice and his physical threat level to a point where she would give in to him. After he got what he wanted she made him pay for it with contempt and belittlement: "You're an idiot, you're such a baby," and so on.

She and her older brother repeated the same pattern, and it recurred in her marriage with her son's father.

Therefore the whole scene between the mother and her son was not a simple prohibition against putting things in his mouth, as it first appeared. Rather it was a lesson for him in how to negotiate with a woman. The whole negotiation turned around the point when she stopped escalating, and let him overescalate
her, as if giving up the battle to him. When are the “sincerity conditions” such that adequate authenticity has been reached?

The whole thing is about measuring, judging, and enacting authenticity. That was the important cultural message. The prohibition against mouthing things was just the convenient vehicle. In addition, the negotiation was conducted mostly with changes in vitality forms.

Recall that the infant was only 9 months old and he was already learning non-verbally about the negotiation of the authenticity of desire. He will spend the rest of his life expanding his knowledge of how to do this. In addition, it will come into play in the consulting room. It could never be done without vitality forms as a medium.

Here is a quite different example of our ignorance about identification and empathy and the role of vitality forms in their operation. It concerns transference and countertransference. Heller & Haynal (1997) studied the videotapes of therapy sessions with patients who were high risk for a repeated attempt at suicide. The therapists could not predict who would make another attempt. Consciously they did not know. Heller and Haynal, and a panel of judges, carefully examined the facial expressions of the at-risk patients. UsingEkman and Friesen’s Facial Action Coding System, they could not predict who would again attempt suicide. However, when they studied the facial expressions of the treating therapists, they could make a significant prediction of which patients would attempt suicide!

Something in the patients’ behavior must have evoked forms of vitality in the therapists that let them know (unconsciously) that certain patients had a different level of authenticity of their belief in “going on being.” It was as if a shadow fell on their vitality. Perhaps I am taking a step too far. However, the overreach attests to the clinical possibilities that invite exploration when vitality forms are brought to the fore.

It is crucial to remember that the most transforming and curative element in psychotherapy is the experience of the therapeutic relationship, not the theoretical approach or the technical maneuvers. Most evidence leads to that conclusion (BCPSG, 2009). I have tried to show that the flesh of the therapeutic relationship is formed in part from the interplay of vitality forms. These are essential to psychotherapy whether we recognize it or not.

In speaking about the process of supervising young therapists in training, it is often observed that everything that the trainee does not tell their supervisor is what really went on in the session.

**Overall summary**

This book calls attention to the domain of dynamic forms of vitality. It demonstrates that such a domain exists, and shows that it is separate and distinct from the domains of emotion, sensation, and cognition. It stands on its own.

The second task has been to describe the scope of the domain of dynamic forms of vitality in psychology, the arts, psychotherapy, development, and neuroscience. It is ubiquitous as a part of all experience.

Finally, it intends to influence some of our current notions and suggest further paths of inquiry into this domain and all that it touches.