INSTROKE, EMPATHY

And

THE THERAPEUTIC RELATIONSHIP

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Key Words

Right brain domination, collaborative alliance, Wilhelm Reich, Instroke, Functional Analysis, endo-psychic self, implicit self, self organization, self referential, self relations theory, autopoiesis, psychic metabolism.

Introduction

At the 4th International Biosynthesis Congress in 2006, Dr. Allan Schore made a presentation and participated in a panel discussion with David Boadella. Throughout his discussions, Schore emphasized the results of his research on right brain activity and the value of this information in therapy. Schore's developmental neuro-science focuses on right brain functioning which involves emotions more then the left brain which is dominated by logic. For Schore, affect lies at the core of the self, there are two brains – left and right - and as a result, two selves. The right brain self he calls the implicit self, and the left brain self he calls the explicit self. The affect dominated right brain is the seat of the unconscious and the source of Freud's drives. The self of the right brain is a body-based, non–verbal, emotional, implicit self. It is here that we learn affect regulation. (The logic dominated left brain is concerned with the explicit self). He cited research that shows that 50% of effective therapy is based on empathy no matter what approach the therapist may be using. He pointed out that empathy is also right brain, affect based. He spoke of creating a "collaborative alliance" with the patient as being the most effective therapeutic approach – more effective then any technique or theory. Normally we think that conscious control is the key to effective functioning. But Schore states:

> The unconscious regulates the conscious ego. Unconscious affect regulation (within the implicit self) is more important then conscious emotional regulation in both development and in psychotherapy.

Along with Schore, the research and concepts of Antonio Damasio and Bessel Van Der Kolk, among others, offers body psychotherapy a great deal of explanation and validation of what we have been doing for many years. Despite the value of this information, it is difficult to translate this "hard science" research into a practical application in the therapy setting. During the panel discussion, the moderator Esther Frankel asked Dr. Schore how he adapts his research to the therapy setting. He responded by emphasizing empathy but offered no concrete description of how he applies his research or how to create an empathic relationship. (In his article in Energy & Character about Schore's work, David Boadella elaborates more fully on the establishment of empathy in the therapeutic setting in terms of somatic resonance, transference and other psychological phenomena.) I believe that an understanding and application of the instroke is the most effective way to establish an empathetic relationship and therefore a practical way to integrate the fields of psychotherapy, biology and brain research.

Instroke and Empathy

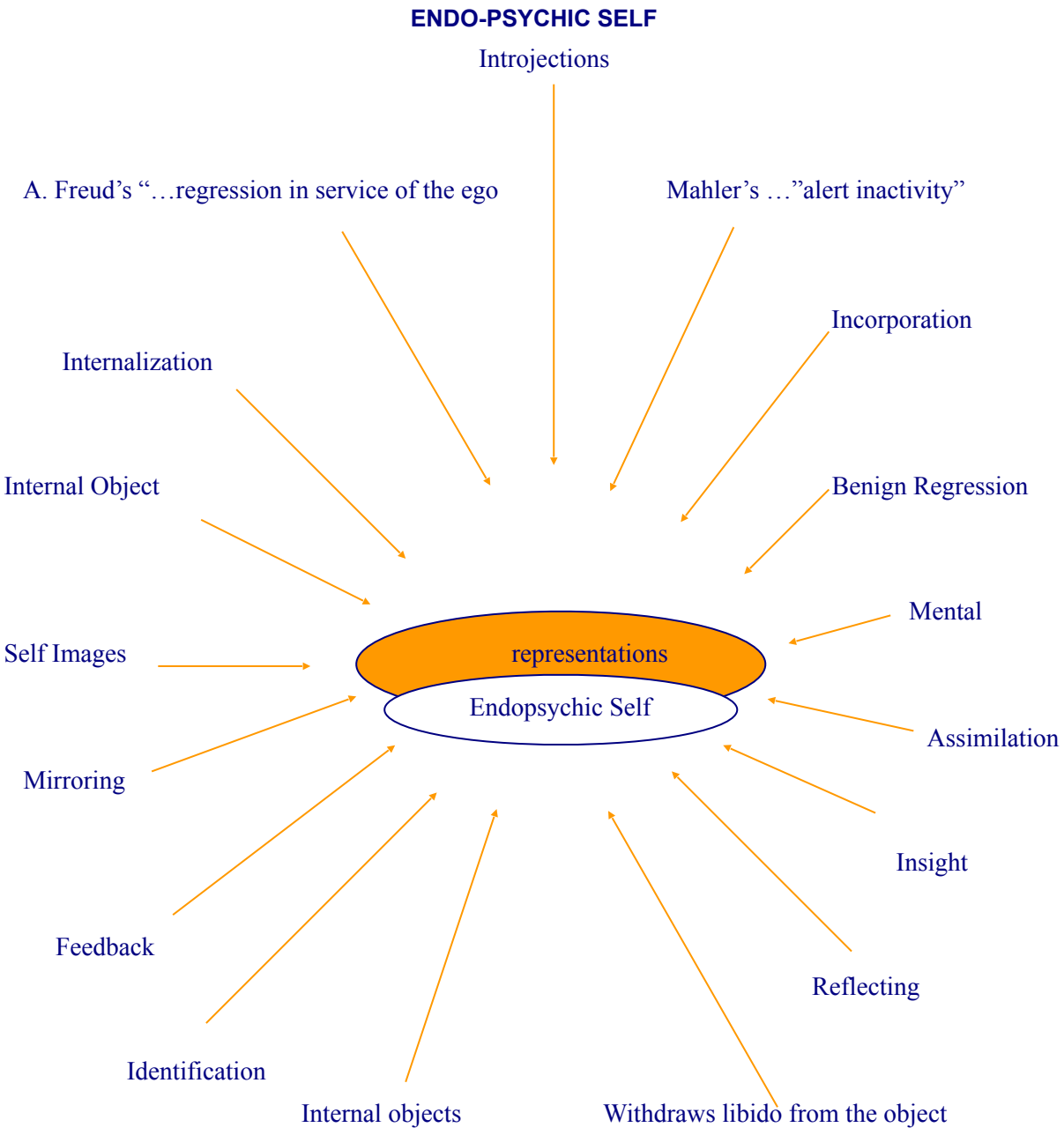
In a supervision many years ago, a psychotherapist who began using instroke methods commented that he was continually impressed by what he could now say to his patients. He reported that before if he had commented on a specific behavior of the patient he would have had to spend the next six sessions working on the problem that was created by making such a comment. Now, he can say almost anything, the patient either agrees or disagrees and they discuss the theme brought up. He felt it was like sitting in the audience watching a theater piece with the patient, while at the same time the patient is also up on the stage. The patient becomes curious about what he is seeing which of course is himself.

In Functional Analysis (FA) we call this aligning oneself with the patient. There have been many terms used reflecting this idea including Schore's collaborative alliance. In his article, Boadella lists (somatic) resonance, vegetative identification, organic transference, and projective identification as examples of an empathy based contact. I would add Reich's genuine transference and Carl Rogers' unconditional positive regard. The concept isn't new. The question is what is (are) the best way(s) to establish a bordered, caring, empathic relationship in therapy. After more then 20 years of clinical research on the function of the instroke, I believe that through touch and talk, mobilizing the instroke is the most effective way to develop an empathic therapeutic relationship.

The instroke represents the open, inward, gathering movement of the pulsation of the life force. It replaces Reich's term of contraction because not all movements towards the center are contractive. (Davis 1999) Among other expressions, Boadella's inner ground and Michael Balint's benign regression and Positive Psychology's "Flow" are examples of formulating an instroke process, the gathering, coherence forming force that can be systematically mobilized in therapy.

Instroke functioning is not only the model for an empathic therapeutic relationship, but it serves as a developmental model too. Developmental theory and psychotherapy are filled with instroke oriented words and expressions: integration, incorporation, assimilation etc. Instroke is not an additional term, but should be seen as the inclusive term for all the words and expressions used in psychotherapy to indicate the importance of 'inward" movement that is the creative basis of self development as well as therapy. The diagram below (next page) shows this idea.

DEVELOPMENT TERMS REPRESENTING THE INSTROKE



The diagram shows that development is an inward, and intake process. The instroke is self-development – both originally in the infant as well as in the patient. In object relations theory and self-theory, the developmental process is represented psychically by the interaction with, even the action of, the 'other'. With this diagram we can view the developmental process in terms of the dynamic of the instroke and shift the focus of development away from the object

to the self. This is the same position taken by Daniel Stern whereby he sees the self as the primary organizing agent of experience, not the "other".

This approach resonates with the research of Antonio Damasio who also presented at the Biosynthesis congress. Damasio's position is that emotions are created from inside – internal emotions – which produce cognitive and physical changes in the organism. There is a system for "generation" of emotions that is distinct from the system of "feeling" emotions. The generation system is for the internal emotions and the feeling system is for the external emotions – which the other person, i.e. the therapist, sees and senses from the outside. By consistently mobilizing the instroke, it is possible for the patient to contact himself at the level that Damasio calls the generating system, where emotions are being generated on a primary evaluation level. On this level, the experience is unconsciously evaluated as good for the organism or not good for the organism. This is known as attraction or avoidance and is the primary self experience. This is where the organism organizes - and re-organizes itself - in self experience. It is also the level we must help our patients to contact in psychotherapy producing the cognitive and physical changes Damasio describes in his description of internal emotion generation. It is the same point made by Schore in the quotation above.

According to Damasio, you cannot learn emotions. They are spontaneous internal responses to what he calls an "emotionally competent stimulus", a stimulus that is capable of triggering the internal emotions. In psychotherapy terms, mothers and fathers are the primary objects as early emotionally competent stimuli. The instroke brings the person "back" to this inner, internal emotional state where the organism experiences the "triggering" by the object and where Damasio's somatic and cognitive changes occur. For this level, he uses the term proto-self, and is similar to Schore's implicit self and the endo-psychic self. The traditional body psychotherapy approach of working with the expression of emotions is working with the external emotional states which are the expressive representations of the internal experience, Damasio's feeling generation system. In contrast, the instroke directly contacts the internal, unseen, emotional state allowing it to reorganize itself. This approach results in a range of important reformulations.

The Self to Self Relationship

One reformulation concerns the creation of interpersonal relationships. Interpersonal relationships can be reduced to the interaction between self and others. Without bringing the importance of interpersonal relationships into question, it is in fact the functioning of the instroke which makes a person able to build true relationships.

The main themes necessary for relationships are self contact, good borders and integrating feeling, sensation and words, all functional results of an instroke, organizing process. For the patient, by consistently mobilizing the instroke, the primary focus becomes the self to self relationship. First, the patient's relationship to the self is brought into focus and re-organizes and, as a result, relationships with others begin to change.

In *Autopoiesis and Cognition* the editors summarize the work of Huberto Maturana and Francisco Varela in the following quotation.

> [They]…have undertaken the construction of a systematic theoretical biology which attempts to define living systems not as they are objects of observation and description, nor even as interacting systems, but as self contained unities whose only reference is to themselves. … (Biological systems) are autonomous, self-referring and self-constructing closed systems – in short, autopoietic systems. …Maturana goes on to define cognition as a biological phenomenon; as, in effect, the very nature of all living systems.
>
> [They] … propose a theoretical biology which is topographical, one which from the "point of view" of the system itself, is entirely self- referential and has no "outside.

This position is in the same direction as in Erich Jantsch's The Self Organizing Universe. With existence, comes consciousness (cognition from the quote above). It's built into the biological system. A system is also self referential whereby its first response to any situation or information input is to return to itself and to evaluate the situation in terms of its own experience. It is the object of its own subjectivity. This is a different definition of narcissism.

Carl Rogers has written along a similar line in the 1950's.

> My main thesis is this: There appears to be a formative tendency at work in the universe which can be observed at every level. This tendency has received much less attention then it deserves. It is hypothesized that there is a formative directional tendency in the universe which can be traced and observed in stellar space, in crystals, in micro-organisms, in organic life, in human beings. This is an evolutionary tendency towards greater order, greater interrelatedness, and greater complexity. In humankind it extends from a single cell's origin to complex organic functioning, to awareness and sensing below the level of consciousness, to a conscious awareness of the organism and the external world, to a transcendent awareness of unity of the cosmic system including people.

In a different vein, the psychoanalyst Heinz Kohut talks about the "coherence creating force of the narcissistic stream" when it invests into the fragmented early self and brings order and structure to it. He does not comment on where this coherence creating force comes from, but it must arise spontaneously from within the infant. Although the infant is dependent on interaction with the object, it is not "given" to the child from outside. Order arises spontaneously from within.

An analogy is helpful here. In the physical realm, in order for the child to grow, the parent or some other caretaker must be present to offer food. Without this, the child will die. Under desirable conditions, the child accepts the food, digests and incorporates it and evacuates what is not needed. Once the food is taken in by the child, the parent's role in the growth process is finished. The child now is in control of what develops from the intake of the nourishment. Ingestion, digestion, incorporation, evacuation all occur within the child spontaneously. He organizes it himself.

As every parent knows, if the child is sick, distracted, stressed or otherwise not focused on the food being offered, the intake and incorporation process is altered. The child may be ill with a stomach virus and he will then pass the food through without incorporating much of it. If he is distracted, or stressed he may refuses to take the food in. All parents know it is impossible to feed a child who does not want to eat or cannot eat. What is necessary to do then is to try to calm, sooth or focus the child so that he can and will eat. It does no good for the parent to get frustrated and try to force the child to eat.

There are three points to be made with this description of parent/child interaction... One, the parent's role is essential in the physical development of the child. Second, the parent's role is limited in the physical development of the child. At some point the child takes control. It is his metabolism that determines growth – what he makes of what has been offered. Thirdly, the right conditions must exist in order that the child can benefit from what is being offered. In terms of this paper, the right condition is that parent and child are in a mobilized instroke state.

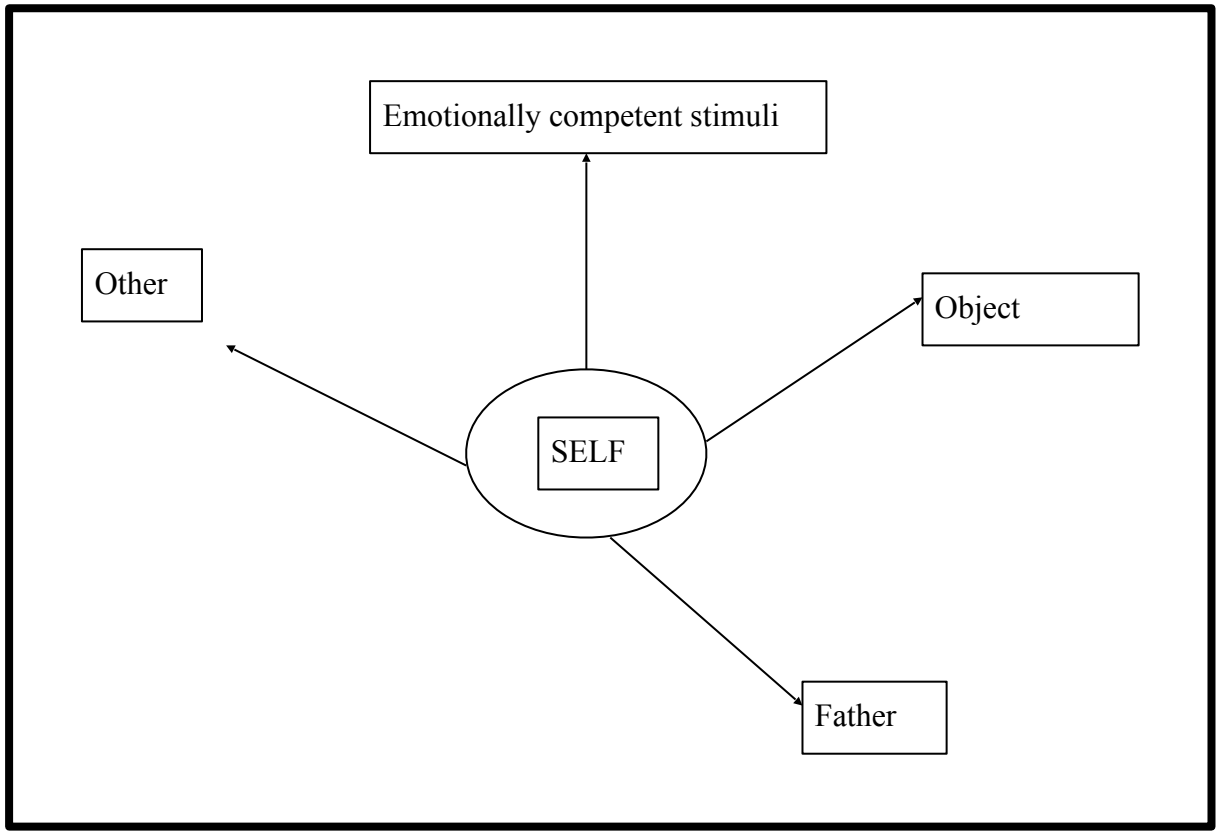
The analogy is that the same process is happening for the child on the psychic/emotional plane in the interaction with the parent and it is up to the child's "psychic metabolism" to digest, incorporate and develop. The psychic/emotional contact from the parent is offered, but what is offered is not necessarily what is experienced and incorporated by the child. Under ideal conditions, there is a state of resonance and the two are interacting on the same frequency. But usually, contact is offered by the parent and then it is up to the "decision" of the psychic metabolism process within the child to determine, to varying degrees, what he or she takes from the interaction. To use psychological developmental terms, the child is "creating" the object to satisfy its own desires and needs.

Considering the emerging information from different disciplines revealing more complex and self-organizing functioning in the infant than we knew before, it seems appropriate to re-think our concepts and theories about development and the therapeutic model. If the organism is self-starting, self organizing and self-referential, then it makes sense to develop a theory of development based on the self referral principle; a self-referential or self-relations theory in contrast to an object relations theory.

The principle of this approach is to move the focus from the "over" emphasis on the object (parent and later therapist) and more towards the self's experience of itself as a result of contact with the object. Development takes place in the self's experience of itself during the object event. Development does not occur by the contact with the object, although certainly contact with the object is necessary for development to occur. This is a change of emphasis, not exclusion. Human nature demands contact with other humans to be fully human. The creative role of the other is not being denied, merely re-defined.

As an example to illustrate the difference between these two positions, the object relations therapist Fairbain quotes a woman patient who demanded "I want a father!" He emphasized the word "father" and used this idea to expand his theory about the importance of the object in determining development and by extension defining the role of the therapist in the therapeutic relationship. He concluded that "…the aim of the drive is the object". The diagram below represents the movement outward to an external object as the goal of the drive.

OUTSTROKE ORIENTED DEVELOPMENTAL THEORY



In a self-relations theory, we would take the same sentence and emphasize the first two words: "I" and "want". In this model, "The aim of the drive is the self." Only when the self experiences itself in the object contact can the desire be fulfilled. When a need state persists the goal of the drive – the push toward satisfaction – becomes the object, and thus the self is never satisfied. The experience of the object must be incorporated in terms of the self's experience or else no contact and therefore no development has occurred. (See the section "The Return to the Self" for elaboration of this point.)

When translated into psychotherapy terms, these findings mean that by mobilizing the instroke, patients develop a differentiated feeling of their own self. They are then in a better position to communicate, make contacts, and develop and maintain stable relationships over time. It seems like a paradox that they must initially detach from others in order to be able to form interpersonal relationships. In a sense, it could be said that there is a return to the so-called 'undifferentiated' state when the organism was originally organizing itself, Balint's benign regression. In FA this process is not a regression but a progression, a "return to the self" as a result of the instroke. The ability to later make contact in interpersonal relationships is exactly what is triggered by mobilization of the instroke of pulsation.

The Endo Psychic Self

A second reformulation is the understanding of the original sense of self, called the endo-psychic self. (Davis 2006) On the psychic level, through mobilizing the coherence creating force of the instroke, the patient's perception is guided to a deeper level of consciousness – referred to by Schore as the unconscious, right brain, affect regulation level. It is the return to the self with the aim of arriving at self-knowledge and experience. Three main senses characterize this state: security, self-acceptance and curiosity. The same focusing process occurs on the somatic level. Through gentle touch, the energetic properties of the connective tissue are mobilized, establishing a deep contact with the essential endo-psychic self where it all began and where it is still seeking development. With this assured inner knowledge of self, security and existence, the patient is then in a position to go confidently out to the world.

Curiosity, a secure sense of self, well-developed borders, differentiation between self and others are all results of the coherence creating function of the instroke. Once the instroke is mobilized, it is possible to observe strong movement towards the centre, which is different in quality from a contraction. Some examples are the breathing becomes slower and deeper, the movements are slower and reveal a better body/mind integration, the voice softens and the topics of discussion becomes more self oriented and not focused on the other. The gaze becomes less forced and staring, more soft and inclusive. During the physical work, the person may go into a hypnagogic state where he drifts off but is aware of where he is. Often during these states they "review" a series of memories/images that pass continually through their consciousness. There is a curious, detached experience of these images. The instroke may deepen further into a "going away" phase where the person is not aware of where he is and later "comes back" into the room feeling alert, "cleaned out" clear and refreshed.

Another result of the instroke is a clarification of borders and even a spontaneous development of a bordering systems allowing the patient to differentiation between self and other – the self and the not self – recognizing who she is, what she desires and what she needs. After working with the instroke over a period of years, I began to hear more and more self-oriented comments from patients and more and more they would "forget" to talk about the person who was causing them all their troubles. Eventually subjective comments emerged as simply self-referential.

An example is a man arrives for his session and says: "On the way here to see you I cried the whole hour in the car, but then I stopped crying because I realized I now have someone who cares for me." At first I thought he meant me but when I asked who is caring for him, he replied "Myself". The patient experiences a relationship, initially with himself and then with others, in which the relationship bond is intensified and based more on the reality principle than the acting out of neurotic needs.

This representation of self development and self functioning is similar to the formulation of Allan Schore's right brain dominated "implicit self" where affect regulation is learned. He maintains that right brain affect lies at the core of the self and that until 18 months old the left logical, conscious brain is not fully functioning. It takes 3-5 years for the left brain to dominate. Both spheres of the brain need human interaction to develop. But before 18 months, before the verbal, conscious left brain begins to function, the baby has consciousness

and *subjectivity* – it knows itself. This implicit self is body-based, non-verbal, unconscious and emotional. For Schore, the unconscious regulates the conscious ego. Unconscious affect regulation is more important then conscious emotional regulation in both development and in therapy. Integrated, right brain, unconscious, implicit self functioning is more important than left brain understanding of emotions in the development of the self as well as the model for therapy. Subjectivity, what is referred to in this paper as the endo-psychic self, must be accessed in therapy for change to occur. Schore stated:

> The non-conscious self image must be at the core of change. The un-conscious, implicit self must be expanded in therapy for real change to occur.

In terms of Functional Analysis, the endo-psychic self is accessed and reorganized through the gathering, coherence creating force of the instroke. This is the pre-verbal, pre-logic state.

The Return to the Self – A Self Relations Theory

A third reformulation concerns developmental theory. As a result of the emphasis on the self's participation in its own development, it is a logical extension to formulate a self - referential or self-relations theory for development as compared to an object relations theory. One major principle is that the organism's primary relationship is with itself. During the pre- and peri-natal stages, the infant only knows itself. All events and experiences are experienced as self-experiences. There is subjectivity. The psychoanalyst Hans Loewald writes:

> The relatedness between ego and reality, or objects, does not develop from an originally unrelated coexistence of two separate entities that come into contact with each other, but on the contrary from a unitary whole that differentiates into distinct parts. Mother and baby do not get together and develop a relationship, but the baby is born, becomes detached from the mother and thus a relatedness between the two parts that originally were one becomes possible.

The original state of knowing only one's self is often referred to as primary narcissism. If narcissism is self love, there must be a self to love. And it must be the self that loves itself. It is this self to self relationship that forms the basis for all subsequent relationship starting at the phase of differentiation and continuing throughout life. A model of primacy of the self to self relationship represents a different definition of narcissism and is in line with the writings of Stern and Rogers.

In this model, the focus of development is not the 'other', parents and later therapist, but rather the self's experience of itself while experiencing the object; in a word, subjectivity. It is a matter of emphasis, not of exclusion. The object relations theorist Fairbain stated that "…the aim of the drive is the object". In Functional Analysis this is now rephrased as …"the aim of the drive is the self".

In addition to the change of focus, another theme in a self relations theory is to maintain an energetic model for development but not the conflict/drive or lack theories postulated by Freud, Reich, Kohut and others. The lack and conflict theories are combined into a comprehensive model that adds the element of 'desire'. If there is a drive, a push, a tension that needs to be discharged, it is a symptom that something is already out of balance and frustration exists. The self relations model postulates that the original impulse towards contact

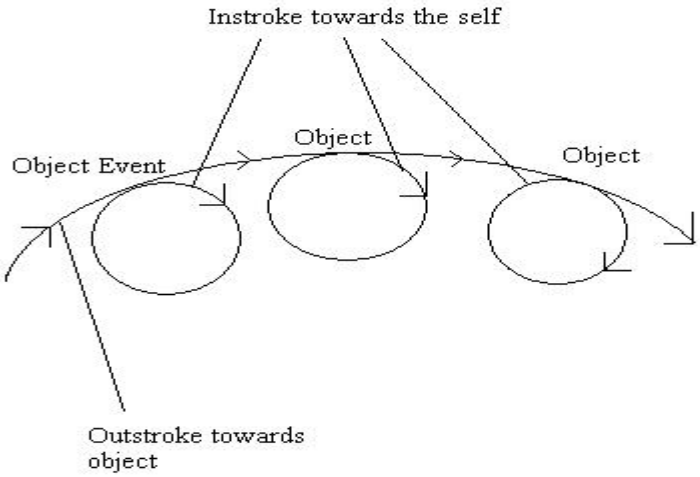
and satisfaction is not need, but desire. Desire acts as a vitalizer, an initiator, a motivator towards the object. FA recognizes the mutual "desire" impulse in the object as well. There is no objective object. When desire is continually unmet, it is transformed into a tension state, a need, resulting in a driven quality that implies a lack, a conflict, a frustration and a demanding quality that is not found in the original desire but is a characteristic of need.

The discharge of the tension of the need state does not satisfy the organism's original impulse as previously thought in classical, expressive body psychotherapy. Discharge of this tension only returns the organism to a state where the original desire can *possibly* be met and satisfied. The possibility of satisfaction - of completion of the original desire – is only accomplished through the function of the instroke whereby the organism is able to assimilate the experience of the contact. The same is true for the object, usually the mother and/or father. The mother cannot meet either the child's desire or her own desire for contact as long as she is in a "need" tension state. The instroke must also be functioning often enough within the mother to meet the infant's desire and for her own desire to be completed.

This is the same point made earlier in the discussion of psychic metabolism. Just as the child is not physically nourished by food offered by the parent but rejected by the child because he is not hungry, is ill, or is in a stressed emotional state, the same is true for emotional nourishment. The child must be in a proper receptive state. This is best accomplished by the mobilized instroke first of the parent whose calm soothing presence helps the child to become present and focused in the interaction. Once the tension is relaxed and calm restored, exchange and ingestion of nourishment is *possible.* This is called resonance.

Below is a representation of the dynamic of the unity of the two developmental theories: the outstroke, other oriented movement and the instroke, self oriented movement. The organism moves outward towards the object and makes contact. It then moves back towards its self in order to metabolize and incorporate the experience of the object. It then moves out again for renewed contact.

COMBINATION OF INSTROKE AND OUTSRTOKE DEVELOPMENTAL THEORY



Clinical Implications of the Instroke

One clinical implication of utilizing the instroke in therapy is that the therapeutic relationship is altered. Typically, therapeutic relationships are based on the patient's earlier relationships. To varying degrees, therapists look to duplicate the original, early relationships with the underlying premise that first relationships with mother and father are the primary ones. FA takes the position that the primary relationship is with one's self; the organism is self referential in the first response. Therefore, to work deeply, especially with early disturbance, there must be a return to the pre-verbal, right brain dominated endo-psychic self. The essential elements of a good relationship – security, contact, integrating and borders – are all products of a realized instroke. As a result, growth does not happen within the arena of the therapist/ patient relationship. The instroke represents the energetic model and the deepening of Rogers' client centered therapy.

Another implication is that for an empathy based alliance the therapist must support a "contactful distance" with the patient giving him space and time to return to himself, to re-organize and then to unfold outward into a newly created relationship. The therapist is a participant observer in the process emphasizing containment, empathy, security and presence.

The return to the self provides the inner security the patient needs to detach from object(s) as a way to develop further. In the therapeutic setting there is a simultaneous, parallel process where-by the patient is detaching from the transferential relationship with the therapist and at the same time detaching from the original object(s), the mother and/or father. Through the activation of the instroke, the attachment to the secure endo-psychic self replaces the therapeutic relationship as an anchor. The patient moves deeply into himself, detaching himself from the therapeutic relationship, re-organizes, and then moves outward again to establish a renewed contact. Only when the patient is able to pull away from the usual form

of contact and attachment is a creative re-attachment possible. This re-attachment is the natural resultant movement outward as the patient re-organizes a new relationship with the object. Detachment from the object also allows for development within the object. Given the possibility of a "distance" from the subject, the object also can evolve. As Jantsch points out, this is a state of dual, co-evolution, both within each organism – each is evolving in relationship to itself – as well as between each organism – the interpersonal relationship is evolving.

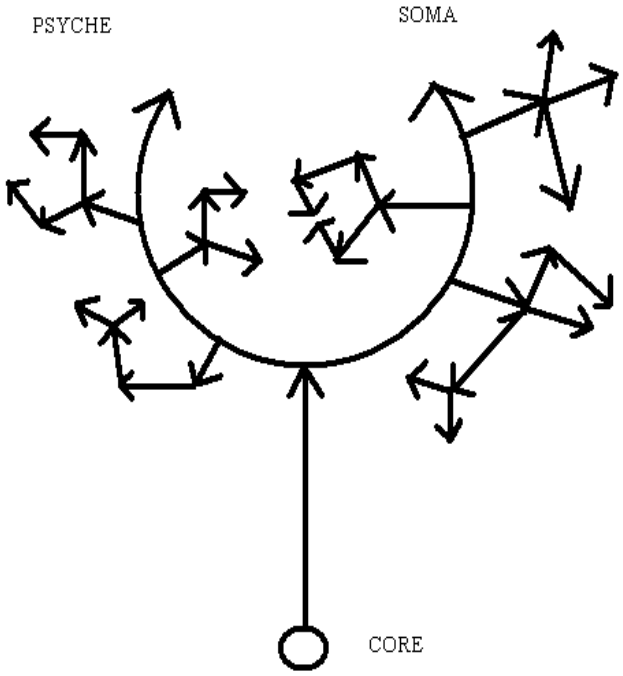
Detachment and re-attachment may be compared to Andre Green's emphasis on the de-objectualizing and objectualizing process. This is a natural and necessary process as the child/patient changes and evolves. In FA, the position of the psychoanalysts Green and Loewald - that the self/subject chooses the object, even 'creates' the object - is fully integrated. This position resonates with Damasio's emotionally competent stimulus - an object in the external world that is *capable* of triggering an internal response. The object may be capable of stimulating the subjective self – Schore's implicit self – but stimulation is determined by the subject. In this sense, the subject is creating the role for the object to play. There is no objective object. This is a re-phrasing of the point made earlier concerning psychic metabolism. The intake, the metabolizing of the object takes place within the subject. The presence of the object is essential but its influence stops there. Development is then determined not by the object, but by the infant's psychic metabolic process.

A third implication is that it is now understood that the patient can attach to himself, the relationship with the therapist originally providing the possibility for the patient to feel secure enough to detach from the therapist so that self attachment can happen. As a result, the therapist seems to be "not so important" in the therapeutic process. The therapist must be able to tolerate the detachment and be present for the re-attachment to occur. The detachment process can be experienced by the therapist as a distancing or loss of contact with the patient, a regression or a resistance. It must be seen functionally for what it is – a progression back to the self - and differentiated from other therapeutic phenomena. The therapist's narcissistic needs will be challenged in the instroke/detachment process.

A further implication is that to create an empathic alliance, the therapist must mobilize his or her own instroke process during the therapeutic encounter. Paradoxically when both patient and therapist are involved in their own instroke processes, contact, communication, and understanding increase. This model is the same one described earlier in terms of the mother/child relationship and is in line with Schore's position that right brain dominated empathy is the single most important healing aspect in therapy. In terms of the discussions in this paper, the instroke state of both the patient and the therapist is the most effective way to generate an empathy based, collaborative alliance.

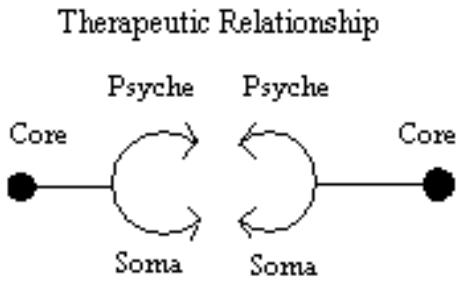
The diagram below is a combination of two of Reich's concepts. The basic antithesis of psyche and soma diagram is superimposed on his drawing of the character armor – all the physical and psychic defenses the person has. The prickly, labyrinth quality of the defense system is represented by the various arrows pointing outward from the essential, healthy psychic and somatic structures. The obvious intention of the defense system is to complicate, confuse and prevent contact on the healthy levels represented by both the psychic and somatic arrows and the deeper, more primary level of the undifferentiated single arrow from which

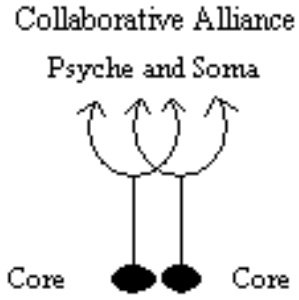
both the psyche and soma arise. The core, the sense of the implicit or endo-psychic self lies deep within, seemingly inaccessible. The classical model of therapy is to weave one's way through this foreboding labyrinth to contact the more genuine aspects of the person lying behind and within. It is fairly easy to get lost, fooled or confused. The patient is skilful at negotiating his own labyrinth; after all, he built it himself.



In the diagram the first drawing representations the modeling of the typical therapeutic relationship with the therapist and the patient "facing off". The second drawing represents the collaborative relationship.

NORMAL AND COLLABORATIVE RELATIONSHIP





Here, the typical therapeutic relationship is represented by the therapist and the patient "facing" each other. The labyrinth of defenses of both the therapist and the patient have been taken away to simplify the diagram, but both defense systems play a role in the relationship. All communications – conscious and unconscious, verbal and non-verbal, physical and mental - must be processed through the defense labyrinth of the psyche and soma of the therapist and the patient in an attempt to get into deeper contact – to the core functions of the implicit/ empathic self of both. Contact and communication must pass through a bewildering array of beliefs, feelings, emotions, senses, resistances, blockings, armorings, and transferences on the part of both the therapist and the patient. The potential for misunderstanding, misdirection and misinterpretation is enormous.

The alliance formulation, in Functional Analysis called aligning with the patient, allows for the patient/therapist contact to bypass the conscious and unconscious resistances and blocks located on the psychosomatic level and for the patient and therapist to meet more directly on the empathetic, endo-psychic level where genuine communication, contact and even genuine transference is possible. (Davis 1989) (Of course, it is some times necessary to take a counter position to the patient so that he or she has something to work off of or against. Resistance, defiance and opposition are also a part of the therapeutic relationship.)

Other clinical implications of mobilizing the instroke are that there is less transference, counter transference, blaming, projection and projective identification and more resonance. The patient becomes reflective, curious about himself and evaluates himself and his situation

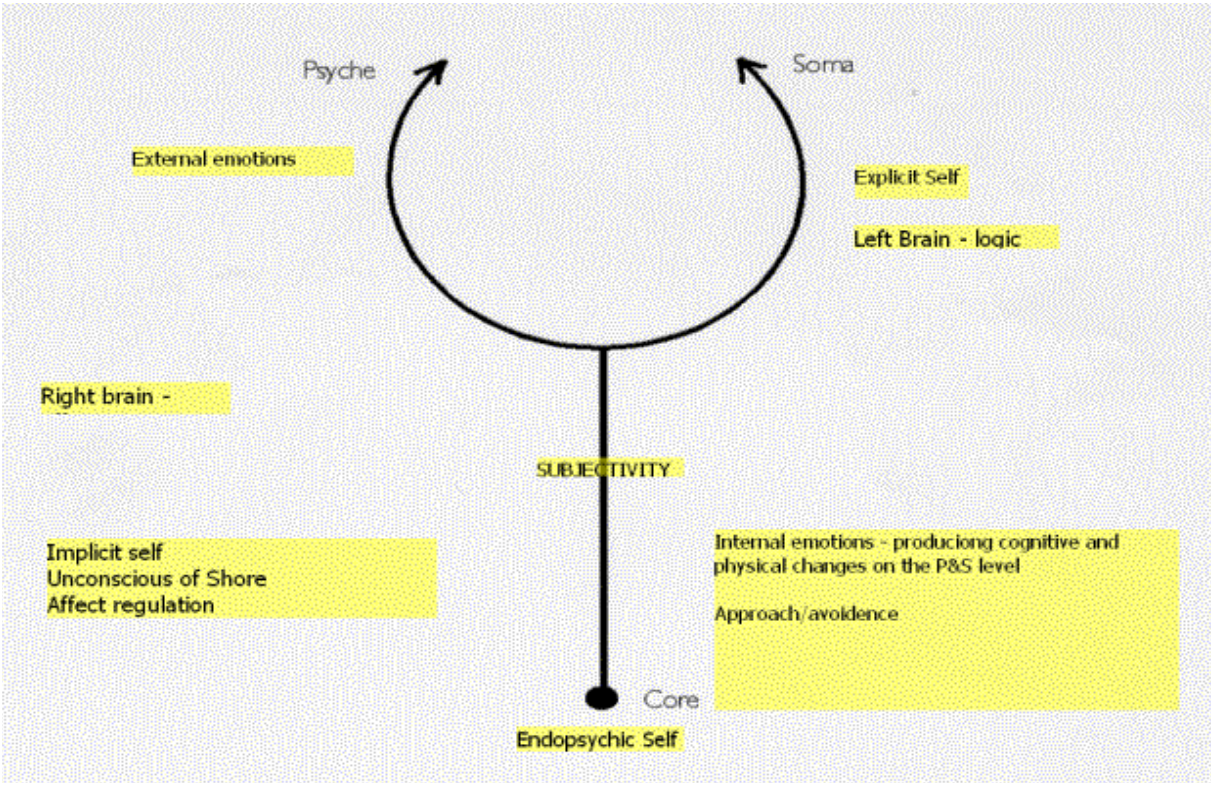
less in terms of others. As one patient said when having difficulty trying to explain an important sensation/insight; “Oh, its more important to me than it is to you.”

SUMMARY

In this paper I have tried to show that there is a building knowledge of information about the increased importance of the self’s role in its own development. Many terms, concepts and ideas overlap from a variety of disciplines converging into a clearer understanding of how the self develops. As a result it is necessary for us to review the basic premises of both development and therapy, especially in terms of the role the therapist plays in this process.

In addition, I have offered the idea that the mobilization of the instroke of the pulsation is the underlying function of all the various pieces of new information about self-regulation and that the mobilization of the instroke is the single most important way to integrate this new information into a comprehensive theory of development – a self relations theory – as well as forming the basis of an empathic, collaborative alliance in the therapy setting.

Addendum



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