Cephalic Shock as a Somatic Link to the False Self Personality

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Original printing in 1983 Robert Lewis, M.D.

I. INTRODUCTION

In this paper I will compare, on both theoretical and practical levels, my concept of cephalic shock with Winnicott's concept of the False Self. I am suggesting that the integration of these two clinical constructs will help to explain why the mind is experienced as the locus of the False Self in some patients. This, in turn, should clarify the mind-body duality in the Bioenergetic and Reichian traditions (i.e., that there is a group of patients drawn to body-oriented therapies because the mind-body split from which they suffer, is a response to pre-verbal trauma). I will quote at some length from two papers by D.W. Winnicott, the pediatrician and child psychoanalyst and from an earlier paper of my own: I do this because I believe that although relevant material has been published on both sides of the mind-body dichotomy which exists within the field of psychotherapy, each side reads too parochially.

II. DEFINITIONS

A. CEPHALIC SHOCK

A process by which a mind-body split is structured into the infant's body.

In 1981, in a paper entitled "Cephalic Shock, a Psychosomatic Basis of Premature Ego development", I refer to people who feel that they were never carefree children, which they were old before they grew up, and who, as adults, rarely if ever, feel peaceful enough to stop thinking compulsively. (Lewis, 1981, p. 1)

I believe I am describing here a frequent presentation of what Winnicott refers to as the False Self. The psychosomatic developmental hypothesis I offered in 1981, regarding the preverbal period was as follows:

Cephalic shock develops when, in response to the ongoing experience of sufficiently unempathic parental holding and handling in the first months of life, the infant (of a parent with a borderline personality), sensing the faulty parental empathy, registers dissonance. Thrown back upon an immature nervous system, the infant will have to find a way to **hold on, hold together, and hold against** the parent, who cannot provide it with auxiliary ego (i.e. to fight gravity prematurely and unnaturally). The dissonant handling creates a chronic state of disequilibrium or shock.

The infant braces as best it can against the shock. In the first weeks of life, the neuromuscular system of the head and neck is the most developed, the least helpless, and therefore must take the brunt of the shock. The head end is the part of the organism where the infant can best sustain a holding attitude against the dissonance it is experiencing. Since the voluntary muscular

response possible at this time is quite limited, the infant's autonomic nervous system must become involved in this holding against the shock to its ongoing being.

This becomes the no-peace-of-mind syndrome, because there is no piece of the head and mind within that is ever free of the burden of holding its world together. As soon as it becomes capable of thinking, the ego ability becomes part of the child's automatic cephalic process for holding on for dear life.

Picture a mother-infant dyad: The mother suffers from a borderline personality disorder. She relates to her infant as an extension of her own biology; she has an unconscious desire to engulf and/or be engulfed by the child. The infant senses this, and its motility is interfered with in a profound way. It is well documented that infants make and break eye contact with the caretaker, and in so doing, are dynamically active in self-regulating. This mother unconsciously sees her own parents when she looks at her infant. But, driven by its immature central nervous system and limited homeostatic capacity, the infant's visual gaze wanders repeatedly away from its mother. The latter experiences this as a personal rejection, and withdraws in a rage tightening up and averting her gaze when the infant wanders back visually.

In summary, if the mothering person is insecure ground, the infant first holds onto itself for dear life, and then tries to pull up and away from the parent. This includes lifting its head up too early and (mind as the locus of False Self) never quite having peace of mind again for the rest of its life.

B. THE FALSE SELF

In his 1960 paper "True and False Self", Winnicott refers to a middle-aged woman "who had a very successful False Self, but who had the feeling all her life that she had not started to exist." (Winnicott, 1960, p. 142)

Winnicott continues:

> "In seeking the etiology of the False Self we are examining the stage of first object relationships. At this stage, the infant is most of the time un-integrated, and never fully integrated; cohesion of the various sensori-motor elements belongs to the fact that the mother holds the infant, sometimes physically and all the time figuratively. Periodically the infant's gesture gives expression to a spontaneous impulse; the source of the gesture is the True Self." (p. 145)

For Winnicott, the good-enough mother is,

> "Personally satisfied in so .far as the infant is at ease. It is because of this identification with her infant that she knows how to hold he infant so that the infant starts by existing and not by reacting." (p. 148)

Existing leads to continuity of being a True Self. Winnicott elaborates,

> "The True Self comes from the aliveness of the body tissues and the working of body functions, including the heart's action and breathing. There is but little point in formulating a True Self idea except for the purpose of trying to understand the False Self because it does no more than collect together the details of the experience of aliveness." (p. 148)

Winnicott (1960) describes the following,

> "The mother who is not good enough…repeatedly fails to meet the infant's gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the False Self, and belongs to the mother's inability to sense her infant's needs…the infant lives but lives falsely. The protest against being forced into a false existence can be detected from the earliest stages. The clinical picture is one of general irritability." (p. 145)

C. MIND AS THE LOCATION OF THE FALSE SELF

In an earlier, exciting article, "Mind and its Relation to the PsycheSoma", Winnicott (1949) explores a particular presentation of the False Self. He defines psyche as the …

> "… imaginative elaboration of somatic parts, feelings and functions, that is, of physical alikeness…The psyche is not, however, felt by the individual to be localized in the brain, or indeed to be localized anywhere…The live body is felt by the individual to form the core if the imaginative self." (p.244) He continues, "The ordinary good mother being good enough, the infant becomes able to allow for her deficiencies by mental activity…What releases the mother from her need to be near perfect is the infant's understanding." (p 245)

What does Winnicott mean by the infant becoming able to allow for her deficiencies by mental activity?

I submit that he is describing an infant with an alert sensorium, slowly becoming able to make sense out of its environment (mother). Winnicott next contrasts this fortunate infant that can be mentally active with the creature whose homeostasis has been so threatened that his mentation becomes reactivity rather than activity. **I call this reactively bracing attitude Cephalic Shock**. The infant has been shook up to the point where it must hold onto itself; it is bewildered, chronically startled, and confused. Although it becomes increasingly able to think, it cannot comprehend,

cannot mentally grasp its insecure situation vis-à-vis its mother, so it reacts with hyperactive, compulsive mental activity.

Thus follows Winnicott's description of what I saw in the Brody-Axelrod films (1968) as the cephalic shock of dissonant, insufficiently empathic handling:

> In the ordinary course of events the mother tries not to introduce complications beyond those which the infant can understand and allow for; in particular, she tries to insulate her baby from coincidences and from other phenomena that must be beyond the infant's ability to comprehend. (p. 245) Certain kinds of failure on the part of the mother, especially erratic behavior, produce over activity of the mental functioning. Here...there can develop an opposition between the mind and the psyche-soma, **since, in reaction to the abnormal environmental state, the thinking of the individual begins to take over and organize the caring for the psyche-soma** *(my emphasis)*, whereas in health it is the function of the environment to do this. In health, the mind does not usurp the environment's function, but makes possible an understanding and eventually a making use of its relative failure...We find mental functioning becoming a thing in itself, practically replacing the good mother and making her unnecessary. Clinically this can go along with dependence on the actual mother and a false personal growth on a compliance basis. (p. 246)

Once the thinking has thus prematurely assumed the caretaking of the child, the mind can now be said to be the locus of the False Self. Winnicott (1960) spells this out:

> A particular danger arises out of the infrequent tie-up between the intellectual approach and the False Self. When a False Self becomes organized in an individual who has a high intellectual potential, there is a very strong tendency **for the mind to become the location of the False Self** *(my emphasis),* and in this case there develops a dissociation between intellectual activity and psychosomatic existence. (Pg. 144)

This is the particular presentation of False Self in the adult that I believe I describe from its inception in the infant, from a bodily point of view, as cephalic shock.

Finally Winnicott (1949) raises a question:

> In certain kinds of False Self organization, the mind-psyche is localized by the individual, and is placed either inside the head or outside it in some specific relation to the head...The question has to be asked why the head should be the place inside which the mind tends to become localized by the individual, and I do not know the answer. (pg 247)

Winnicott suggests several answers including that "the head has special experiences during the birth process". I have offered cephalic shock, a postulated psychosomatic genetic mechanism, as an answer to his question as to why the head is the place inside which the individual localizes the mind:

> The bones of the skull overlap at birth, and apparently move on beveled particular surfaces well after the fontanels are closed. This not so immobile bony, cranial structure (within which many of us dwell forever after) and the deeper structures of the head, must all be involved, on some level, in the holding attitude I describe if the body is truly a psychosomatic unity and duality. (Lewis, 1981, p. 8)

Winnicott (1949) speaks of "the mind furiously cataloguing reactions to a specific environmental persecution." (p. 253) This persecution may consist of a complex mix of birth process, dissonance in infancy, and other factors that are suggested by the clinical material of the particular patient. It may be subtle - almost intangible - during certain sub-phase development as in the cumulative trauma that Khan (1963) has delineated. What I am intrigued by is the connection between an early, physically palpable trauma, which I call cephalic shock, and the later development of a distorted characterological use of cognition.

I close this section with an observation by James (1960), in his classic paper on Premature Ego Development, of an infant in the process of developing mind as the locus of its False Self: In a "bewildered" (p. 294) infant, showing an attitude of "cerebral controlling" (p. 293):

> Even during the first fourteen days the infant was not only excessively wakeful owing to his perceptive acuity...but also reacted by means of such motor response as is available to a full-term infant. What should be stressed is that this 14-day infant in turning its head and eyes and reaching **gave the impression of a much older baby** *(my emphasis)* apparently forced by its instinctive need to act as though focusing and purposive, certainly anticipating and therefore forced to tolerate delay. (p. 289)

III. COMPARISONS

"Cephalic Shock" is a construct. I state (Lewis, 1983) that it was formulated from my work with adult and child patients, observations of the Brody-Axelrod films (mother-infant pairs at 6 months, 1 year, etc.) and my own intuition.

The False Self is a construct. Winnicott, who saw parents and children in pediatric, psychiatric consultation regularly for the forty years that he was a psychoanalyst presumably, arrived at his construct from some combination of reconstruction in child and adult analysis, direct observation of mothers and infants, and his creative intuition. I have not found any observations in his writings of the impingement to "the ongoing-beingness" of the True Self of an **infant** by a parent: the reactions to such impingements, according to Winnicott, collectively constitute a False Self. If Winnicott had published such observations, it would be easier (or harder) to establish that cephalic shock is indeed a variant of the False Self.

Several of his comments help to explain why Winnicott did not publish direct observations of the False Self in statu nascendi: He didn't like examples. In his introduction to Playing and Reality (1971) he says:

> In writing this book around the subject of transitional phenomena I find myself continuing to be reluctant to give examples. My reluctance belongs to the reason that I gave in the original paper; that examples can start to pin down specimens and begin a process of classification of an unnatural and arbitrary kind, whereas the thing that I am referring to is universal and has infinite variety. (p. XII)

In other words, regarding the development of False Self, the degrees and varieties of maternal failure are also infinite.

Another very practical reason may have been the enormous complexity of setting up the kind of longitudinal observational study necessary to demonstrate the hypothesized False Self resulting from the impingements in the first months of life.

Nonetheless, the following comment in "True and False Self" (1960) suggests that Winnicott had available some observations that would have illustrated his construct:

> When periodically I have been asked for a note on a patient who is now under psychiatric care as an adult, but who was observed by myself when an infant or small child, often from my notes I have been able to see that the psychiatric state that now exists was already to be discerned in the infant-mother relationship. (p. 142)

But finally, Winnicott (1957) states that direct observation of infants, while valuable, does not allow us to see the full inner significance for the infant of the event we observe. This significance evolves as the infant matures, and is often retrievable only from the later, retrospective account of the older patient. Therefore:

> The direct observer of infants must be prepared to allow the analyst to formulate ideas about very early infancy, ideas which may be psychically true and yet which cannot be demonstrated...Certain concepts ring true from my point of view when I am doing analysis, and yet ring false when I am looking at infants in my clinic. (p.112)

Cephalic shock is also a construct which is difficult to demonstrate, although it often rings true when I am doing therapy with adults, and when I view the Brody-Axelrod films (1968) of the mothers rated low on empathy and efficiency, and see the infants chaotically assaulted by dysrhythmic, gross mishandling. The same response draws me to Winnicott's unthinkable anxieties: they have an irreducibly physical quality. Winnicott's general description of holding is very close to the empathic handling which, when deficient, I postulate as leading to cephalic shock. Indeed Winnicott's descriptions of the first two of the three maternal functions of the "good enough mother" (i.e. holding and handling) cover the same issues I

describe in cephalic shock: profound falling anxiety, fear of fragmentation, disorientation and psychosomatic dissociation. These are Winnicott's (1962) "unthinkable anxieties". He thinks of the baby:

> As an immature being who is all the time on the brink of unthinkable anxiety. Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what the baby needs in the general management of the body. (p.57)

Winnicott feels that a slight failure of holding brings the infant to a sensation of infinite falling. Observers of infants note that the Moro reflex makes a newborn infant reach out its arms in a desperate grasping motion whenever it feels itself falling.

I note (1981) that:

> An infant will startle i.e., exhibit a Moro reflex, whenever a subtle change in its equilibrium occurs. The reflex will be triggered by sudden movement, noise or temperature change or even by its own energetic crying. The handling to which a borderline parent inadvertently subjects an infant, creates a chronic state of disequilibrium or shock, if you will, that is far beyond the shock that the infant can discharge via the Moro reflex. This is the unique shock of unempathic handling, a daily occurrence repeated perhaps hundreds of times a day in the course of feedings, diaper changes, etc. (p. 8)

What does cephalic shock look like in the adult patient? How do I diagnose this muscularly-anchored holding attitude of the head, neck and shoulder girdle, and in the process hopefully get the patient into better contact with his (I will use the masculine pronoun for convenience) head (as opposed to getting him out of his head)?

The patient presents with some variation of the theme that he cannot stop thinking - that he never or rarely experiences peace of mind - and that he lives in his head. He often points to an area low on the brow, between the eyes as being the locus of this perpetual cerebral motor. The patient has a frozen or shock-like appearance (i.e. the head, neck and shoulders are as one unit). The facial expression is mask-like with no play of expression: the eyes look vacant, glazed or terrified. The above signs may be grossly present and obvious or subtly and fleetingly present. Another of the infinitely varied presentations would be a head that looked like a fortress sitting on top of a more vulnerable, alive looking torso and limbs (i.e. any dissonance of physical expression which betrays the underlying mind-body dissociation).

To further explore this posited unnatural fight against gravity, I have the patient lie on his back, so that there is very little real need to fight with gravity. I gently support his neck with my hand, and observe the degree to which a subtle movement with each breath in and out is transmitted through the neck, physically unifying the head with the rest of the body. More or less cephalic shock will allow less or more movement.

I have already begun to assess the degree to which the patient can let me support the weight of his head. Typically, the patient caught in the cephalic attitude of self-holding will lift his own head automatically, without being told to do so, the moment I touch the back of his head. When I call this to his attention, he still is unable to give over to me more than a small fraction of the weight of his head and this only with difficulty. (An alternative would be to suggest that the patient lift his head several inches off the ground and hold it there until the muscles fatigue - and to observe with the patient what happens to him).

When I hold my patient's head firmly between my hands, he is stunned that I am actually supporting his head in a predictable, reliable manner, and says, "At last I can let go. I've been holding me all this time." As he lets go, he has very little sense of how heavy his head actually is, and is very afraid that it is much too heavy for me. After a minute or so he has a sense of peace, of being deeply understood – then a sense of profound mistrust, isolation, and feeling that he has never been understood. He asks me, incredulously, "You mean it's possible that I can be understood, helped?"

When I first rock his head from side to side, he is unable to relinquish control, when I make my movement less predictable, he feels terrified. We stop. He says, "It felt like I could lose my head, go crazy." Over a period of some months, this work continues amidst the other issues he brings to therapy. Slowly, he is able to explore his fear of insanity, his underlying not knowing and un-integration. The rocking of the head becomes a mutual kind of playing, sometimes frightening, sometimes sweet. "I've never been able to play," he says. He takes over the movement himself at times - in his own rhythm and intensity.

Throughout this process I am offering in the quality of contact in my hands, my eyes, voice, etc. - an invitation to give over to me some of the holding of the false, caretaker self, in this case to relax the muscles of the skull, face, jaw, and the shoulder girdle. To the extent that he relaxes this bracing that cut off his going-on-being, he risks the unthinkable anxieties, but finds his spontaneous gesture.

By now the reader has noticed that I have touched the patient - that I have interfered with the natural evolution of the transference - thereby encouraging regression, gratification, etc.

My contention, briefly, is that I have encouraged a "regression for the sake of recognition" (Balint, 1968, p. 146) (i.e. the recognition, for instance, that one's body has been cut out of consciousness, chronically engaged in an abnormal, self-holding, care-taking effort). The body ego issue being transacted in the transference is from a period earlier than that of the whole, relatively well-differentiated, objects for which the term "transference" has traditionally used. The experience of having one's head supported, or rocked to the point of dizziness may be gratifying or terrifying: the more important point is that it may be part of a process which allows repair of trauma for which there are no words or images i.e., when my patient is supported or held firmly (Winnicott would say held), he may feel, on a non or pre-verbal level, what was missing or deficient. Rather than an acting-out, a remembering is occurring - the memory however, is a

body memory. Even if one feels that this can be accomplished without direct body contact (i.e. by carefully attuned verbal work or pre-verbal sub-phase deficits) one's patient might report the following:

> I feel my depression is in my head...as though I've been wounded and bandages are wrapped around it (points to his brow). I feel like I have a headache all of the time, but I don't know it. The pain in my head alternates with good feelings in my body.

Your patient might be helped by your awareness that this communication is to be understood at least partially on a literal level (i.e. as pre-metaphorical statement about something in the patient's body); it is not "all in his mind", but rather in that part of his body referred to as his head. Furthermore, as is well known, if the reporting of bodily sensations, events is not of interest to the therapist or is understood only as a metaphor, the patient will stop reporting fundamental aspects of his process which he experiences in his body.

There are, to be sure, many potential complications or even dangers to an approach that may have the unconscious meaning for a patient that the good mother of symbiosis has appeared in the form of a therapist who will understand him without words and make good his unmet infantile needs. This topic, however, is well beyond the scope of this paper.

Winnicott (1959-64) also feels that therapeutic work with the False Self necessitates regression:

> In order to communicate with the True Self where a False Self has been given pathological importance, it is necessary for the analyst first of all to provide conditions which will allow the patient to hand over to the analyst the burden of the internalized environment and so become a highly dependent, but a real, immature infant. (p. 133)

I have tried to show, although in an overly simplified fashion, some of the physical dimensions of this "regression to dependence" (Winnicott 1959-64, p.128) Indeed, I feel that what Winnicott calls the "burden of the internalized environment" is on a physical level, the armature of cephalic shock.

Finally, I quote from Winnicott's (1970) description of the therapeutic regression that occurred in his 40-year old patient. The depth of his bodily approach is apparent:

> The detail I have chosen for description has to do with the absolute need this patient had from time to time, to be in contact with me...A variety of intimacies were tried out, chiefly those that belong to infant feeding and management. There were violent episodes. Eventually it came about that she and I were together with her head in my hands.
>
> Without deliberate action on the part of either of us there developed a rocking rhythm. The rhythm was rather a rapid one, about 70 per minute (c.f. heartbeat) and I had to do some work to adapt to this rate. Nevertheless there we were with mutuality expressed in terms of a slight

> but persistent rocking movement. We were communicating with each other without words. (p. 143)

My work on cephalic shock, like Winnicott's, should not be understood as a technique to be "done" to a patient for a corrective emotional experience that is actually experienced as one more impingement. Cephalic shock, as with any other aspect of the complex therapeutic process, is to be drawn on when the patient's material makes it salient (i.e. to enable one to better follow and facilitate the patient's need to regress therapeutically). The need dates, after all, from a time when, as Winnicott says, "Love can only be shown in terms of body care." (p.58)

IV. NEW PERSPECTIVE ON THE MIND-BODY DUALITY IN THE REICHIAN AND BIOENERGETIC TRADITIONS: CEPHALIC SHOCK LEADING TO THE MIND AS LOCATION OF THE FALSE SELF

If, as Winnicott states, the mind can become the location of the False Self in response to specific developmental pre-verbal trauma, and if cephalic shock is a valid description of one way this trauma can be structured in an infant's body...a crucial dimension is gained in understanding the mind-body split with which Bioenergetic analysis is so fundamentally concerned (i.e. the mind (located in the head) may deceive us, the body does not lie). Then follows the struggle to deepen our identification with our bodies. Lowen, (1975) explains the traditional Bioenergetic view on the body emphasis in the therapy:

> Words are the language of the ego in the same way that movement is the language of the body. Ego psychology is therefore concerned with the words a person uses...a dissociated ego and a dissociated intellectuality represent a loss of integrity in the personality. Ego psychology is impotent to overcome this problem, for its exclusive focus on the ego furthers this dissociation. One has to approach the problem from the side of the body and its feelings to institute a healing process. (p.329)

I feel there is much truth in this statement, that there is much irrational fear of the body hidden behind the truths of the "talking cure" therapies. But I feel that ego psychology may be even more helpful to us than Lowen allows. For example, Winnicott's suggestion that the mind can become the localization of the False Self, speaks profoundly about why many patients turn to a body therapy, themselves profoundly convinced that their words lead nowhere, and are dissociated from the deeper experience which they sense is possible. These patients are quite unable to lose the minds which torment them and which have always anchored their premature, compliant selves. They are desperate to regress, to feel something spontaneous in their bodies, to reach Winnicott's "spontaneous gesture", or the streaming and involuntary body movements that Reich described.

My experience in Bioenergetics has been that the mind is indeed often viewed as the False Self and located anatomically in the head. However, following Reich, this is understood to be a universal condition of civilized life (i.e. we are all neurotically armored). This armor maintains the repression of our sexuality and results in our psyches being dissociated from our bodies.

Following Winnicott, I describe another etiology for the mind-body split in which mind is experienced as the locus of the False Self. This etiology, the early and severe interruption of the child's ongoing being is seen as leading to a specific, if widespread, form of pathology (i.e. only those infants with sufficiently unempathic parenting later suffer the complaint that their minds block them from deeper contact with themselves, the universe, etc.).

I have offered (1981) in my concept of cephalic shock a description of how the basis of the mind-body split is structured in the infant's body.

The above differences in perspective can lead to very divergent interventions; the suggestion that the problem of the dissociated ego be approached from the "side of the body and its feelings" (Lowen, 1975, p.329), has often led in practice to an attempt to get the patient out of his head (False Self) and into his body (the repository of his repressed sexuality). It is almost as though the head (the locus of the False Self), already dissociated from the psyche-soma, is treated as though it were not a part of the body. To the extent that this is done with the patients I have described, it only deepens the existing split.

In conclusion, I hope I have added a dimension to the understanding of the mind-body relationship in therapy. Lowen (1975) discusses this relationship:

> Many of my patients have some difficulty in expressing themselves satisfactorily through language ... all my patients, however, have difficulty in fully expressing themselves on a bodily level, and this problem is the main focus of Bioenergetics. I have also found that the body problem underlies the verbal one, although it is not identical with it. (p.259)

I have attempted to show in this paper that in a certain group of patients the body problem underlies the verbal problem only because there was nothing verbal in the infant at the time the trauma was structured into its body. This group of patients does indeed descriptively (mind as location of False Self) suffer from a mind-body split; but genetically and dynamically what underlies their verbal problem, is a preverbal problem structured into their bodies (i.e. their body problem is a preverbal problem). They suffered cephalic shock as infants. As adults they experience their mind-psyches (which they locate in their heads) as the locus of their False Selves.

V. SUMMARY

In this paper I have

A. Proposed that cephalic shock is the physical or somatic side of the process which Winnicott (1960) describes as follows:

> If material care is not good enough, then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement (p.54).

B. Suggested that this somatic link helps to explain why the mind (experienced as the locus of the False Self) is located in the head by some patients.

C. Therewith attempted to clarify the specific preverbal problem that draws some patients to a body-oriented therapy.

REFERENCES

1. Balint,M. The Basic Fault, London: Tavistock Publications, 1968
2. Film: *Mother-Infant Interaction*. Produced by S. Brody & S. Axelrod, 1968
3. James, H.M. "Premature Ego Development" *International Journal of Psychoanalysis*. 1960, 41, 289
4. Khan, M. "The Concept of Cumulative Trauma" *The Psychoanalytic Study of the Child*. 18 (New York: Int. Univ. Press), 1963
5. Lewis, R. "The Psychosomatic Basis of Premature Ego Development", *Comprehensive Psychotherapy*. Vol. 3, 1981
6. Lowen, A. Bioenergetics. New York: Coward, McCann & Geoghegan, 1975
7. Winnicott, D. W. The Maturational Process and the Facilitating Environment, New York: Int. Univ. Press, 1965:
    a. "Direct Child Observation", 1957
    b. "Classification", 1959-64
    c. "Ego Distortion in Terms of True and False Self', 1960
    d. "Ego Integration", 1962
8. Winnicott, D.W. "The Mother-Infant Experience of Mutuality". Parenthood: Its Psychology and Psychopathology. Edited by E. James Anthony, Boston:Little Brown, 1970
9. Winnicott, D.W. Playing and Reality. London: Tavistock Publications 1971
10. Winnicott, D.W. "Mind and Its Relation to the Psyche-Soma". Through Pediatrics to Psychoanalysis. New York: Basic Books, 1975

