

# The Psychosomatic Basis of Premature Ego Development

Dr. Robert Lewis, M.D.

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HUMPTY DUMPTY SAT ON THE WALL  
HUMPTY DUMPTY HAD A GREAT FALL  
AND ALL THE KING'S HORSES  
AND ALL THE KING'S MEN  
COULDN'T PUT HUMPTY DUMPTY  
TOGETHER AGAIN

## I INTRODUCTION

This article should, only be read by people who feel that they were never carefree children, that they were old before they grew up, and who, as adults, rarely, if ever feel peaceful enough to stop thinking compulsively. Those of us who suffer from this condition, are confused **numbskulls**, so we tell ourselves and others that we need to get out of our heads, when, actually, we have never been **right in our heads**. If someone had the sense to look into our eyes and hold our heads firmly, maybe even to gently knock some sense into them, our brains would be less scattered, and our heads would be less in pieces and more together.

My main interest in this paper is to put forth a theory of early development that is both psychosomatic and consonant with the findings of mother-infant research and family studies done by ego psychologists over the past 20 years. The findings, to which I am referring, are consonant with the fact that the families that produce schizoid, borderline and schizophrenic offspring, are families in which there is cruelty and coldness. This fact has been focused on in the Reichian and Bioenergetic viewpoints. The cruelty and coldness has been focused on to such an extent, that **the larger, more central issue has been almost missed**. That issue is that the parents and families of schizoid, borderline, schizophrenic offspring are **insane**, some more, some less. The point is **not** that we live in a repressive culture: this is a fact, but it must not be used to obscure the fact that parents of patients with basic identity problems do cruel, inhuman, unbelievable things because they are terribly fractured people (i.e. they are not merely *ignorant*, they are missing large pieces of their own identity). They go in and out of realizing that they are in a different generation from that of their children (i.e. they are profoundly confused, disoriented in time and place). The disorientation and lack of inner cohesiveness is the profound deprivation that is transmitted from generation to generation. It has its somatic correlates. The deprivation is not just a lack of warmth: infants become people from having clarity and solidity against which to define themselves. These distinctions help me not to get caught with patients in the dilemma as to how much the parent or the child is responsible.

Let me give you an interesting analogy to illustrate the above. I was recently driving, and the road was covered with wet snow. The windshield wipers were not able to remove a film of dirt caked on the window; I was not sure of the ground below, and was looking through a kind of blur. I was "up-tight" and wondered what it would be like to be held in the arms of a parent whose eyes did not see you with clarity, because those eyes were clouded with their own blurred reflections from the past.

In summary, I am going to raise more questions than I answer. I feel that the preverbal period of development is a vast, relatively unexplored tundra, which probably holds some rich treasures. It may bring us closer to deeply structured (muscular, energetic, psychic) ways of being which we try to change over years of therapy, but which don't change very much.

Over the past few years I have found myself doing lots of things to patients' heads (i.e. rocking them, stroking them, holding them). Like everything we do as therapists, I know this must partially conform to a deep need of mine. I have always had the feeling that my jaw was worked with, but my head - its 3-D physical reality - was somehow not understood. On one occasion, my therapist, sensing an issue in me, commented on how much I had always wanted to "rest my weary head". I was deeply touched by this; I felt it was part of a vast issue that is not understood unless it is grasped as a preverbal, early mother-infant issue.

This paper, then, is an expression of my process, both as a person struggling to find my way, and as a therapist helping others in their struggle. I have elaborated clinical hunches into a fundamental psychosomatic developmental hypothesis that seems to bear up well in my clinical work over the past two years.

I have also been helped by recent developments in Ego Psychology. When I took my psychiatric residency ('65-'69) the findings of years of data-collecting and theory-building in mother-infant interaction and early ego development had not yet been integrated to a point where they could help us understand and correct the ego defects that are passed from generation to generation of adults that we diagnose as having Borderline Personality Organization (1). Many people participated in this development: D. Winnicott, M. Mahler, R. & G. Blanck, O. Kernberg, J. Masterson, T. Lidz and S. Fleck.

Wilhelm Reich was also interested in the preverbal period. He published an observation (2) of what he felt was falling anxiety in a three week-old infant. I differ with many of Reich\*s conclusions, but I quote his observation because it gives graphic immediacy to my central thesis:

At the end of the third week there was an acute falling anxiety. It occurred when he was taken out of his bath and put on his back on the table. It was not immediately clear whether the motion of laying him down had been too fast, or whether the cooling of the skin had precipitated the falling anxiety. At any rate the child began to cry violently, **pulled back his arms as if to gain support, tried to bring his**

**head forward** (*my emphasis*) showed intense anxiety in his eyes and could not be calmed down. It was necessary to take him up again.

The next day Reich notes that the right shoulder blade and arm were pulled back and less mobile than the left arm. "There was a definite contraction in the musculature of the right shoulder during the anxiety attack, the child had pulled back both shoulders, as if to gain a hold. This muscular attitude persisted now even in the periods free of anxiety." (Reich, p. 329)

## II HEADS UP, A MATTER OF UTMOST GRAVITY

The parent of a patient with a Borderline personality (schizoid is the inadequate term used in character typology) is a Borderline personality in his or her right. They will relate to their child as an extension of their own biology; they will have 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 early self-regulation will be interfered with by a mother who, for instance, unconsciously sees her own parents when she looks at the infant; driven by its immature central nervous system and limited homeostatic capacity, the infant's visual gaze will wander away repeatedly from the mother. The Borderline mother may perceive this as a personal rejection, and withdraw in a rage, avert her gaze when the infant wanders back, or, in a multitude of ways, interfere with a rhythmic, dyadic exchange in which the infant uses its eyes freely to take in the world. (3)

The child's entire psychosexual and ego development must be understood from the above perspective if people with Borderline conditions are to be helped more effectively. Traditionally, orality, for example, refers to gratification of needs for contact and nourishment. The infant also explores the world through its mouthing of objects, and learns about itself as it practices hand-mouth-eye coordination. A parent with a Borderline personality will interfere with all of these aspects of orality, both psychosexual and ego.

But I am suggesting that this interference will be qualitatively of another order from the restraint, frustration, even rejection of a parent that has intact ego boundaries. Firm restraint, incidentally, as every pediatrician knows, will often help a hyperactive newborn to organize itself. To the extent that the Borderline parent sees the child as an extension of itself, everything that it does will be a rejection of the infant's biology. I mean this very much in the sense that an infant would experience a tragic deprivation, if its parent(s) had an organic disease that caused it intermittently to go blind, deaf, and lose the orientation and coordination that its central nervous system provided. These parents are not able to affirm the child's sucking rhythm, hand-mouth coordination, anality, genitality, or any other aspect of their individuality, unless it corresponds to their own organism. But one misses the point, if one describes the parent as

rejecting. The infant grows up trying to learn about life and itself from a half-blind, half-numb person, who cannot sense the separate life force, and unique rhythm in its offspring.

Bear in mind that I am oversimplifying a big subject here. Some parents are grossly psychotic; others are not institutionalized, in spite of the fact that their thinking, their bodily sense of gender and overall identity, and their ability to distinguish themselves from others are selectively and bizarrely distorted. The family into which the infant enters, usually has a working equilibrium, which transmit bizarreness and impaired integrity to its offspring; a husband will not challenge the disorganized thinking of his wife, because she bolsters his tenuous sense of sexual identity. This material has evolved during twenty years of research and observation on mothers and infants and families. These findings have, in the past ten years, been correlated with the clinical problems of the child, adolescent, and adult Borderline patient: an exciting literature is now available that makes it possible to help a large part of the clinical population that was doomed to custodial care - because it was not understood. Incidentally, none of my words should be taken to imply that all infants are the same, that they should be handled the same way, or any other simplistic notions. Sophisticated neonatologists estimate a range of three to four weeks of physiological age in full-term forty-week newborns. Some infants are quiet and sleep almost continuously; others are dynamite, and scream a lot. Tremendous flexibility and inner cohesiveness is demanded of a mother under the best of circumstances.

Back to our infant...

We are exploring the rather uncharted area of what it means to the infant to be handled by someone who goes in and out of recognizing its separateness: this is occurring at a time when the infant has no consciousness of another as distinct from itself. The first word that comes to mind is bizarre. I don't think we can overstate this; to say that the infant senses an assault on the integrity of its organism is perhaps true, but this is still looking at the matter from too much of an adult perspective. It would perhaps be clearer to say **dissonance**, lack of resonance, disharmony, is laid down in the cells, autonomic nervous system, and energy centers of the infant.

This "dissonance" is the basis, I propose, of **falling anxiety** and **premature ego development**, or what we in Bioenergetics call the inability to get out of one's head - an attribute that seems to cut across all character structures. It is this dissonance and the resultant falling anxiety and premature ego development, **structured into our bodies**, that prevent the quality of grounding we strive for in Bioenergetics.

How does all this happen? The parent or caretaker is the auxiliary ego for the infant during its prolonged period of total dependence. The parent senses inner needs of the infant and gratifies them; the parent is a buffer between the external world and the infant. Sudden noise, temperature change, positional change are avoided or tempered by a reasonably attuned parent. "Reasonably attuned" covers a broad spectrum: there is a tremendous... range of what constitutes adequate empathy as a particular mother and infant get to

know each other. This question of the parent as auxiliary ego is well covered in the literature of ego psychology. The parent is not just gratifying the infant: She or he is really helping it to organize itself. (4) This positive and specific function of helping the infant to control and modulate its movement and feeling is taken for granted in a reasonably healthy mother-infant dyad. With a borderline parent, the infant is thrown back on its immature nervous system, a system that simply is not ready to maintain homeostasis. **There is no deeper issue than this;** it is the first and deepest life and death issue once the umbilical cord is cut.

As powerful and flexible as the newborn infant is in negotiating its relatedness with the parent, if the latter has a Borderline Personality Organization, the infant will experience the dissonance I have spoken of: it will have to find a way to **hold on, hold together and hold against** the parent who cannot provide it with auxiliary ego, a parent who is missing big pieces of its own ego. If anyone questions this, study the films by Brody-Axelrod on mother-infant interaction (5): one is stunned and barely able to sit through these films in which the infant is chaotically assaulted by dysrhythmic, gross mishandling at the hands of mothers who love their children and are consciously trying to do their best by them.

So the infant, as I have said, has to hold on, together, and against this threat, to provide a rudimentary ego for itself before it should have to (i.e. to fight gravity prematurely and unnaturally). This occurs when the infant's neuromuscular system is too immature to respond effectively to a state of emergency. What must be registering, for instance, in many of the infants in Brody's film, is that they are in danger, they are being handled in a manner that is at the limit of what they can tolerate biologically; **they are not secure.**

An infant will startle (i.e. exhibit a Moro reflex) whenever a subtle change in its equilibrium occurs; sudden movement, noise or temperature change or even its own energetic crying, will trigger the reflex. The handling to which a borderline parent inadvertently subjects an infant, creates a chronic state of disequilibrium or shock, if you will, that is way beyond the shock that the infant can discharge in 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.

The infant at birth and throughout infancy is **all head**; the average adult head circumference is fifty-four centimeters - it is thirty-five centimeters at birth, and practically full size (forty-six centimeters) by the end of the first year. But this is not just a question of relative weight and size: the organism develops along a longitudinal axis from the cephalic (head) end to the caudal (tail) end. Coordination, expressing maturation of the neuromuscular system, is greatest at the head end, and progressively less towards the feet. The first gross motor developmental milestone is the infant's ability to lift its head.

I believe the infant braces as best it can against the shock. In the first weeks of life, the neuromuscular system-around 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. The innervation of the diaphragm is from cervical roots three through five of the spinal cord, basically nerves deep in the structure of the neck. This, I believe, is the direct anatomical connection between diaphragmatic and cephalic spasm, a connection that profoundly affects the breathing. Since the voluntary muscular response possible at this time is quite limited, the autonomic nervous system must become involved in this holding against a chronic state of shock, perhaps creating the sympathicotonia (excessive sympathetic nervous system tone) that Reich describes. The bones of the skull overlap at birth, and apparently move on beveled articular surfaces well after the fontanelles 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. Since Reich, we have tended too quickly to dismiss the central nervous system as "regulatory", and looked to the solar plexus and other energy centers. I think we have missed something. The hypothalamus, cerebrospinal fluid pulsation, central regulatory nuclei, the **vestibular apparatus**, seem to be of fundamental importance in understanding and working with people's most basic terror of loss of equilibrium. **The three-dimensional head, and the fragmented images within it are, in my opinion, the psychosomatic core of the preverbal period, the first eighteen months of life.** This is the earliest, perhaps subtle, but immense hang-up I am describing. We might call it 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. I will devote a future study to research and data on central nervous and other somatic aspects of the cephalic holding I am describing. I receive clinical confirmation every day in my office from patients who comment when I work with their head and neck, "I could never let my head go, because there was no one there to hold it." Others are stunned that I am actually supporting their heads in a predictable, reliable manner. The images and words that come when I support or **stand under** them in this early, developmental way have to do with a profound mistrust, isolation and feeling that they have never been understood. They often ask me, incredulously, "You mean it's possible that I can be understood? Helped?" As I have said, if you want to have an effect on basic, preverbal issues, such as Erikson's "basic trust", working with the head is the foundation. Incidentally, although he did emphasize the eyes, Reich's view differs from mine, in part, I believe, because he viewed the infant from the amoeba model: my model is more a developmental neuromuscular one, in which the head comes first.

Let me summarize and elaborate a bit more on the simple but, I feel important, hypothesis I am setting forth in this paper. When Borderline parents raise an infant, it becomes a child with premature ego development, and then in adulthood, a Borderline person (it is in a state of shock) who suffers severe falling anxiety and has a relatively immobile diaphragm. It goes into cephalic shock in the first days or weeks of life when it senses that it is not secure; it is in a bizarre kind of danger because its parent is out of contact with its own self and in its own state of shock and is therefore out of touch with the infant, **even when the parent is touching and holding it.** What makes it even more impossible physiologically for the infant, is that this "contactlessness" is **intermittent and unpredictable**; remember that the parent is Borderline, not psychotic. If the lack of empathy were constant or almost so, the child would die or be

psychotic itself. What happens instead is that the infant deals prematurely with gravity. Once it can move its head, the infant can change its position in space and begin to cope actively with gravity; **if the mother is insecure ground** it will have to do before it is ready. When that infant first looks out and focuses on the parent's eyes, it sees eyes that do not see it with constancy: its mother's eyes, its frame of reference, are unconsciously and intermittently seeing images of her own mother and the infant's grandmother. This is bizarre, as is all the contact when the parent's boundaries are blurred with those of the infant. The mother's body may even be quite warm and relaxed as she holds the baby, and is enveloped in a fantasy of symbiotic reunion with her own mother. But she may "forget" that she is the adult and that, rather than her mother holding her, her infant is in **her** arms. If the infant cries, squirms or does anything dictated by its own biology, it will disturb this mother's distorted attempt to get the peaceful security she also missed out on. This mother will feel pain, rage, etc., and handle the child accordingly, being quite unconscious of what is going on. Bear in mind that this is only one example and that there are infinite variations on this theme.

But the theme remains that of the mother being insecure ground. The infant first holds onto itself for dear life, then tries to pull up and away from the parent: I repeat, this includes lifting its head up too early and never quite having peace of mind again for the rest of its life I find this a very helpful way of understanding the analogy of the unripe fruit that Dr. Lowen uses (6) to illustrate the attitude of the schizoid organism towards the ground: "The seed of a fruit that is prematurely detached from the tree does not root itself easily in the earth".

The cephalic bracing I am postulating is tremendously important, not only as a primary event, but because everything that follows is somehow affected. This is similar to the Organizer concept in biology: it involves critical timing. Later, the child becomes able to move away from the mother by crawling; it pulls itself up vertically, away from the ground, with its arms, and finally supports itself on its legs. These experiences cannot be the same for an infant, already in shock and profoundly holding up and away from the mother with the musculature of the head, neck and shoulder girdle.

In other words, this issue subsumes all aspects of the infant's locomotion and psychosexual development. In an infant there is normally a powerful maturational drive to use its emerging motor skills (i.e., to kick, crawl, stand, walk (7)). If the infant has been fighting the insecure arms of its parents, any biological ability that will heighten its independence (i.e., the ability to move volitionally, may become unnaturally burdened by the need to escape that parent). This will often take the form of challenging gravity prematurely i.e., holding the head up early, crawling early, or skipping the crawling stage and walking early. A profound somatic conflict is set up because the infant's spontaneous motility, establishing its separateness becomes equated with mother's hostility or withdrawal of affection. No one to my knowledge has definite answers about this early period of life, but considering how important the concept of grounding is to Bioenergetics, it certainly behooves us to study the conditions under which our patients stood up from the ground. If the infant really is bracing its head, everything else it will do with that

segment of its body (i.e., reaching out with eyes, snout and mouth for life) is burdened by the fight against gravity. If the shoulder girdle, as its innervation permits, becomes mobilized in this exhausting antigravity effort, the arms can no longer freely let the hands take objects endlessly to the mouth in view of the eyes (i.e., basic body ego-building and exploration of external reality are flawed). This is a different mechanism from that described by Drs. Lowen and Pierrakos, where the emphasis is on the armoring that results when libidinal, psychosexual impulses are frustrated by neurotically armored parents and no protest is allowed.

The "hang-ups" (8), that Dr. Lowen has written about from the psychosexual point of view, are characteristic holding patterns, involving the shoulder girdle and neck musculature. They can be seen with additional understanding as part of the premature and unnatural bracing against falling anxiety that becomes chronically structured into the body. For example in the "noose", the spastic neck musculature that blocks self-expression is also holding against the specific threat of annihilation I have delineated: of necessity, the transmission of sound, emotion and body awareness are sacrificed. The same issue is at stake in every part of the body which can react to the early homeostatic shock of unempathic handling i.e., the jaw is holding not only against oral frustration and its consequences, but holding in the way an adult jaw might if one's limbs became paralyzed while swimming in deep water.

I am really proposing a different psychodynamic etiology and pathophysiologic mechanism for the Borderline state (or schizoid state). Let me state the difference explicitly; the infant of the Borderline parent, the future Borderline patient, because of the cephalic shock, never has that much feeling in its body. The fight for its life that it wages at head, neck and diaphragm, take too much energy. The slow, pleasurable process, during which the body coordinates, integrates and, in this sense is inhabited by the spirit of the infant, never occurs. This is another view from that of Dr. Lowen's (in *The Betrayal of the Body*) in which the spirit is seen as abandoning the body.

I believe there is data from patients that would lead one to believe that the patient, at a certain point, did abandon the body and retreat to the head. I understand this data to come from a period later in development than the critical early weeks and months of cephalic shock. The patient is putting into adult language, the feeling that their body is not their own; that it was invaded by the parent(s); that there was no biological peace for them. This is exactly what one would expect, since, as we have said, the parent sees and unconsciously relates to the child as an extension of its own body. The older, the more conscious, the more verbal the child becomes, the more it will retrospectively talk of giving up on its body and retreating into its head. This is probably true of its later development (i.e. from approx. 2 years on), but it may also be what is known in psychoanalysis as "Retrospective Distortion". It is developmentally a much less likely hypothesis for the earliest period of life, when the deepest shock is structured into the infant. The later development must not obscure the crucial early issue.

I don't believe these unfortunate infants have ever been anywhere but in their heads. As soon as they become capable of thinking, this ego ability becomes part of the automatic cephalic process for holding

on for dear life. The later process of abandonment may occur when the child's anal function, general locomotor ability, and genital function are dealt with by the parent with blurred ego boundaries.

My psychodynamic formulation differs from those, with which I am familiar, in the psychosomatic tradition of Reich. In his monograph on the psychopathic personality (9) Dr. Lowen mentions the situation in which a mother looks to a child for mothering and fulfillment. He talks about the threat of insanity to a child when the natural order is turned upside down. His focus is on the distorted Oedipal situation in which a child becomes burdened with the sexual feelings of a parent.

I believe that to truly comprehend such a disturbance of the natural order, one must understand the specific ego defects of a parent ('Borderline'), that would cause its sexual feelings to burden its child: these defects amount to a particular kind of insanity in which boundaries between the generations are lost because the parents are grossly confused about their gender and overall separate identity. So this reversal of the natural order is a much broader issue for me than that of psychopathy. It cuts across characterology, and is the essence of the pathology of the preverbal period. It does not appear in the Oedipal period, unless it has been present from birth, and caused the premature ego development I have described.

The borderline parent does not feel mild aversion while cleaning its child of feces; it may relate to the child as though its body were feces: distinctions and boundaries are lacking. The child (part of the parent) may have shocked the parent by producing something foul-smelling from its own body (i.e., it has moved independently); the parent will experience rage, abandonment, etc.

A male patient will tell me as he comes in touch with genital sensation, that his father wanted him to take his (the father's) genitals, as soon as he was able to stand vertically (presumably this verticalness meant to the desperate father that his little son was ready to lift from him the awesome burden of his genitality). The patient is in terror and twisted bizarrely as he senses how this meant his father had abandoned him to incest with his mother. **This bizarre blurring of identity, and loss of the generation gap, is what the Oedipal situation is made up of for the Borderline patient.** Basic body feeling is correspondingly sexualized. Again, to say that a parent was seductive or competitive is not informative enough. The patient may need you to understand that his father had so brittle a gender identity, that he unconsciously wanted him (the young boy) to have sexual intercourse with his wife (the boy's mother) and relieve him of the function of which he was incapable; or the boy may need you to understand that the mother related to his anus as if it were her hated vagina, and to his penis as her prized body part. How does this translate into bizarre body sensation and holding patterns in the pelvis? You will find the answers **with the patient, if you are not afraid of the issues.**

Since we are talking about the complexities that arise as the child leaves infancy, let me make one more important point: there is a double aspect to the distorted gravitational situation of the child of the borderline parent. Not only are they struggling from earliest infancy to carry themselves, **they are carrying**

**their parents.** If a parent feels as though they are inside you, burdens you with their sexual feelings, feels abandoned when you crawl away from them, then **you are carrying them.** The earliest feeling, which many patients express when I support their head, is "I'm too heavy for you – I'll hurt you." As it gets older, not having had an opportunity to form a clear boundary between itself and its parent, **the child holds on in a common membrane, as it were, both supporting itself and the blurred parent. The child's holding against spontaneous movement, has always supported the mother's illusion of symbiotic fusion.** This tremendous antigravity stress is responsible for the profound fatigue and underlying exhaustion of the Borderline patient. If I gently but firmly take the weight of such a patient's head in my hands for a few minutes, they often go to sleep, or tell me they feel profoundly exhausted: they may also have feelings of support, peace, sweetness.

One patient who had a bad cold and was worried about a conference at which he had to speak, for an instant, felt himself let go, with an attitude of "who cares what happens", the next instant he had the fleeting terrifying sensation of a tremendous weight coming down on him, like the weight of a building. He instantly tightened up, and began to worry again. Another patient's divorced mother seemed to be about to remarry, and her teenage son reported the sensation of a tremendous weight being lifted off his body - from his back, his shoulders, chest, everywhere. He literally ran down the street leaping and jumping for joy. This matter of extreme gravity, begins with cephalic shock, has infinite subtle variations, and will not always show up as broad, squared shoulders that are held hip **the burden is on the head and the heart.** I have no doubt that this stress situation predisposes to organic illness, but that is beyond the scope of this study.

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