# SUPERVISION IN REICHIAN ANALYSIS

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Abstract

Research-based clinical-analytical supervision models can contribute to clinical-analytical research in body psychotherapy when validated by therapeutic evidence evaluated over time in numerous supervision sessions conducted worldwide with psychotherapists from various backgrounds and schools of psychotherapy. This article proposes an 18-step post-Reichian supervision protocol based on the interdependence and contemporaneousness of the ontogenetic, evolutive stages, the bodily "relational" levels and the character traits, deposited in the Self by the interactions with biological-biographical history. In line with the lenses of "Embodied Mind" (1972), and "Enactive Mind" (1991), the article proposes a new lens – the "Trait Mind" (2015), which orders ontogenesis according to its becoming over time. It also offers the new operational concept of "Embodied Activation" added to the concept of "Embodied Simulation" that is translated in the Setting to the appropriate trait and bodily relational level counter transference applied and realized by Character-Analytical Vegetotherapy of the Relationship (CAVR).

*Keywords:* character-analytical vegetotherapy of the relationship, clinical supervision, embodied simulation, embodied activation, appropriate analytical-therapeutic project

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## Introduction

Wilhelm Reich developed Vegetotherapy while living in Oslo (1935-1939) as his contribution to psychoanalysis. Character-Analytical Vegetotherapy (CAV) acts on the autonomic (vegetative) nervous system (after which it is named), on the muscular system, on the neuroendocrine system, and on the energetic pulsation, which are the more direct expressions of emotional, affective, and instinctive life. From a Reichian analytical perspective, CAV tends to create "eutony," meaning well-balanced muscle-tone and well-balanced tone throughout the other above-mentioned sub-systems. It induces neuro-vegetative phenomena such as muscular activity, breathing, autonomic nervous system function, and nonverbal interactions a well as emotions, which constitute messages-expressions of the language of the body that are absolutely necessary for the reading of personality aspects. The Verbalization of the sensations, of the emotions, and of the free associations produced, as well as the diagnosis of the object relations of the patient, represent the successive steps of this methodology.

Reich (1933) delineated seven corporeal levels and defined them as the set of those organs and groups of muscles that are in functional contact amongst themselves and reciprocally capable of inducing an emotional-expressive movement. He initially identified seven consecutive, top-down levels. Reordering them in a bottom-up direction on the negentropic arrow of time, provides a different sequence that starts from the sixth bodily relational level, (umbilical area), and goes to the second (mouth), the fourth (chest and arms), the third (neck), the fifth (diaphragm), the seventh (pelvis and legs) and then to the first (eyes, ears and nose); therefore, with the bodily level corresponding to associated, functional dominance of successive prevalent evolutionary phases over the life story of the individual.

Character-Analytical Vegetotherapy (CAV) was specifically systematized compared with the seven corporeal levels by Ola Raknes and Federico Navarro. Navarro assembled Reich's main techniques (exercises), which he named 'actings', and introduced new ones, defining ways to use them (time, rhythm, direction) with patients. In essence, he developed a new clinical methodology.

Thus, CAV investigates the body's psychic and energetic significance through this series of 'actings' that function on these seven corporeal levels (most of which are ontogenetic movements). These 'actings' are for the appropriate evolutive stage and bodily level (the fractal elevators of internal time) in double directionality. They join the "then and there" to the "here and now", the depths to the surface, the unconscious deposited in the corporeity to the metacognition deposited in the pre-frontal cortex (PFC), implicit memory to explicit memory, the bodily levels to the areas of the corresponding encephalon, and the body to the arrow of time of relationships. Through 'actings', Vegetotherapy informs, forms, and reforms the mind with insights of a new order that are also based on feeling.

With the indispensable appropriate intersubjective-intercorporeal frame (which bears in mind the embodied simulation marked yesterday 'from outside' of the real, even pre-subjective, story of the person, today, through its 'actings'), CAV performs an 'appropriate embodied activation' for that patient, for his story, for his trauma and for his unease. It modifies the patient 'from inside' his life experiences and his trait mind, with its relational style, starting from his bodily levels that are the peripheral areas which bear those marks incised by the arrow of time of his relationships.

At the Italian School of Reichian Analysis (S.I.A.R.), we integrated Navarro's CAV with the time of the biological-biographical evolutive stages and with the appropriate intersubjective-intercorporeal frame for the patient in the analytical-therapeutic setting. resulting in what we call Character-Analytical Vegetotherapy of the Relationship (CAVR). We see this as an appropriate, intelligent structural coupling of CAV with the Analysis of the Character of the Relationship and, thus, with the Trait Mind of the Relationship. We offer the combination of these two fundamental elements of therapeutic intervention as an advance in body psychotherapy, which creates a new way to complete the appropriate analytical therapeutic project guided by the ontogenetic Trait Mind.

In this paper, we detail the 18 fundamental steps (see figure 1) practiced in our model of clinical-analytical supervision in Reichian Analysis. Our teaching and supervision process is aimed at practicing, psychotherapists from various schools of body psychotherapy thought and from other currents of psychotherapy, organized nationally and internationally, who study their own complex cases, in group settings. Proposed outcomes from this rigorous training process are said to transfer to clinical care in the participant's own patient care practice.

**SUPERVISION IN REICHIAN ANALYSIS**
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1. Case History from an Analytical-Psychodynamic Perspective
2. Remote Pathological Case History
3. Current Pathological Case History
4. Socio-Economic Case History
5. Prevalent Fixations
6. Diagnosis of Prevalent Traits and of Prevalent Transitions
7. Diagnosis of Prevalent Bodily Levels and of Prevalent Evolutive Brains.
8. Prevalent Fractal Aetiopathogenesis
9. Scene Analysis and Relational Diagnosis
10. Clinical-Psychopathological Diagnosis
11. Differential Diagnosis
12. Analysis of the Explicit and Implicit Questions
13. "State, Trait and Bodily Level" Transference
14. "State, Trait and Bodily Level" Counter-Transference
15. The Degree of Progression of the Analytical-Therapeutic Relationship
16. The General, Targeted Analytical-Therapeutic Project
17. The Validation of Negentropy Over Time
18. Character-Analytical Vegetotherapy of the Therapeutic Relationship

*Figure 1 – Guidelines for Supervision in Reichian Analysis*

The aim of the paper is to provide a clear outline of our procedure, or 'protocol', for our method of group supervision. It is written with a reader in mind who possesses a foundational understanding of Reichian Analysis and its specific terminology. The following definitions are offered to clarify the core terms used within our protocol:

- *Object Relations* defines the how of the relationship a subject has with their world, which is the complex result of their specific organisation of personality. It should be interpreted in terms of an inter-relationship and reciprocity (excluding-including, persecutory-welcoming). In Reichian Analysis the object, which may be partial or whole, is real. It is present in the biological-biographical history of the person and has marked, even on the bodily level, a prototypical how of trait.
- *An Evolutive Stage* is a period of ontogenetic evolution in which the Self receives imprintings and incised marks from the partial object of that time. It is an interval between two stage transitions and is marked by clear biological boundaries. The evolutive stages are inscribed in the background of the three successive fields of the other-than-Self (the fourth, cosmic, field is a "meta-field" for the evolutive stages – "The stars are always there, before and after us").

- *A Character Trait* is the history that we each have from that particular stage. It is an overlapping set of patterns and modes of behaviour, which were received from the relationship with the partial object at that time.
- *Relational/relationship Bodily Level* is the somatic source. It is the area of the body in which the imprintings of the relationship with that stage's partial object are marked, and it is the first receiver of the relationship with the other-than-Self. It is also the peripheral interface of the evolutive stage that has been passed through; it is the solid substrate which is the terrain from which the relative trait thought and trait mind emerge.
- *Our Encephalon* is the result of the recapitulation of phylogenetic evolution within the ontogenetic process. It is the central interface where the imprintings from each stages' partial object relationships arrive, penetrating from the periphery, and are deposited.
- *Negentropy*[1], in accordance with the theory of complexity, deals with a negative variation in entropy from an original value, such as the birth of an individual, the origin of life, the beginning of biological evolution or the birth of a relationship.

In Reichian Analysis we believe the connection between object relations, evolutive stages, stage and field transitions, character trait, relational/relationship bodily level, evolutive brain and brain areas is fundamental— this connection represents a turning point because their interconnection defines the specific Trait mind in that ontogenetic time for that person's biological-biographical evolution. The successive, imbricated trait minds, constitute the series of platforms on which the enactive, embodied mind of the self is successively organised and structured, along side the ontogenetic, biographical-biological development of the individual. It allows us to bring biology back into psychoanalysis, to bring the body into psychoanalysis, and psychoanalysis into the body, and, so, to three-dimensionally design every analytical-therapeutic 'project' for the trait mind.

In the first part of the analytical-clinical supervision, the psychotherapist provides a detailed description of the case history. Four different viewpoints from the anamnesis are evaluated: analytical-psychodynamic, remote pathological, current pathological, and socio-economic.

Next, the 'incised marks' determining Character, the evolutive stages, and dominant personality traits, the bodily levels and stage and prevalent field transitions, the evolutive brains and object relationship styles are identified, even for 'beyond threshold' pathology. Analytical-characterological, clinical-psychopathological, and relational diagnoses are made; a differential diagnosis is also examined. Finally, the explicit and implicit questions expressed in the narration of the case are considered.

During the second part of the group supervision process, the patient's psychodynamic state, and bodily and trait transferences are clarified. The same is done for the psychodynamic, state, trait and bodily level counter-transference of the analyst-psychotherapist. Subsequently, the degree of progression of the analytical-therapeutic relationship is then defined. In the group supervision protocol, the psychodynamic state counter-transference of traits and bodily levels expressed in the group are also evaluated.

Based on this information, appropriate psycho-corporeal guidelines are proposed to integrate psychic content or levels of experience (body, sensations, emotions, thoughts, and

[1] The words negentropic and negentropy were deleted based on research into common word usage. In 1943 Erwin Schrodinger gave a "famous lecture, 'What is life?'" and said that life is something that feeds on negative entropy. In 1950 Leo Brillouin noted that negative entropy was abbreviated as negentropy. He coined the term but it is not found in common usage.

imaginations). Clinical interventions are specifically designed to leave the psychotherapist with 'incised-marks' that are reproducible in the patient's trait mind within the therapeutic relationship to support inter-subjectivity and intercorporeity, thus proposing a more sustainable style of interpersonal relationships (object relations) in the here and now.

**Supervision in Reichian Analysis: An 18-Step Protocol Outline**

There are five modes of data collection within our process:

(1) We listen to the content of the patient's story (narrative of the case history).

(2) We listen to how the words are said (the language of traits)

a. Information is concealed in the patient's way of expressing words

b. Emotional attitudes may be concealed in the patient's word choice, the sound of his voice, facial expressions, posture, gestures, movements, the color of the skin, breathing and ANS functions.

(3) Transference and counter-transference
The importance of awareness of transference and counter-transference reactions, and of the consequent behavior of the analyst, is stressed.

(4) Identification of the bodily levels involved in the narration of the case by the analyst
The analyst whose case is being examined learns to identify through their own corresponding bodily levels what their patient is feeling.

(5) Identification of the bodily levels involved in the narration of the case by the members of the group.

The group members observe and learn to identify their own bodily levels involved in the narration of the case.

We hold the case history to be fundamental and indispensable because it necessitates the careful collection of the 'incised marks' (which are determined by the emotional and relational impressions and that may be positive or negative) derived from the object relationships, from the how of evolutive stage transitions and from the atmosphere of the other-than-Self fields of that person. These form our Character (etymologically Character is our 'incised marks'), which is our combination of traits, which are stratified in the segments of the evolutive stages, and marked on the bodily levels corresponding to those stages.

Step 1: Case History from an Analytical-Psychodynamic Perspective

May genes be considered as the "intelligence of the living" and like "time-capsules" in which 'incised marks' have been deposited by relationships throughout evolutionary phylogenesis?

Taking genes as being historically-incised "character", the case history, from an analytical-psychodynamic viewpoint (Ferri, 2012), involves the careful collection, from the person's narration, of the other 'incised marks' from ontogenesis such as:

- The how of the scene from when the person came into the world and the why they came into the world: "In which implicit project in the scene?"
- The dialogue between the embryo-foetus-new-born and the mother in the primary object relationship, its density and the thickness of its reciprocity "from the intrauterine to weaning – from inside to outside, from water to air, from darkness to light, from the uterus to the breast, from the umbilical to the lips," is a genuinely biological dialogue. It represents a fractal prototype for subsequent dialogues along the arrow of evolutive time and is also the terrain for

and, probably, the main factor in determining resilience, which will be decisive in the person's capacity to endure future adaptive stress.

- The how and the when they came out into the light (birth), which will resonate with and influence the possible modalities of the various "birth-passages" during their life.
- The how and when of their weaning, another incised mark, which will resonate with and influence the possible modalities of their separation from the "first-field" mother, and from their own future "pair-relationships".
- Birth order (first-born, middle, youngest or only child).
- The how of the relationship in the "second-field" family, with the father, and with their siblings and other family members.
- The Oedipal scene, which is an extraordinary cross-roads and turning point for the vectors which determine trait patterns.
- The leader of the couple, the leader of the scene and their personality traits, which will influence the terrain of our relationship with authority.
- The respective positions of the parental relationship, the family atmosphere and its dominant subsystems.
- The how and the when of puberty and adaptive stress specifically in third-field—sociality.

Step 2: Remote Pathological Case History

Next we consider the Remote Pathological Case History, which will reveal the pathologies the person has been affected by during their life, but which do not directly concern the reason or reasons for their current visit. Some questions follow for clarification:

- Which remote pathologies has the patient had?
- At which evolutive stage?
- In which enlarged systemic scene?
- Which bodily level or zones-apparatus were involved?
- What resilience and what vulnerability are derived from it?

We define resilience as our capacity to adapt under stress. We believe it is directly related to the evolutive stages and bodily levels. Thus, in our opinion, it defines the degree of vulnerability of each stage and level.

Step 3: Current Pathological Case History

The Current Pathological Case History is then examined, which will clarify the motivation for the current consultation, which may be beyond-threshold symptoms or syndromes, or may be normal difficulties in dealing with events in their lives, or the untroubled desire for greater awareness of themselves in the context of their lives. A series of explanatory questions follow for clarification:

- Does the patient display anything that is clinically 'beyond threshold' symptomatologically?
- Which are the first 5 main symptoms?
- Which portrayal of these, even corporeally, is expressed?
- When and where did they appear?
- Are they connected to any external concomitant events?
- Does beyond-threshold pathology emerge due to structural vulnerability of the personality?
- Which trait (or traits) does the vulnerability belong to?

Step 4: Socio-Economic Case History

The Socio-Economic Case History is considered, which should be interpreted as paying attention to other significant historic-biographical variables that have contributed to determining that person in their unique, unrepeatable being:

- Gender and sexuality
- Weight and weight variation
- Regional culture
- Religion
- Education
- Economic ease or difficulty
- Occupation
- Home Relocations
- Social status

Step 5: Prevalent Fixations

We examine the marks incised by the object relationships and by decisive other-than-Self variables along the arrow of time, which establish the prevalent fixations in the story of the person. There are six stages of development to consider: the intrauterine stage (as autogenous and tropho-umbilical stages); the orolabial stage; the muscular stage; and the first and second genito-ocular stages. Therefore, understanding the brain's role in human behaviour, thought, and emotion is necessary.

Brief descriptions of our three brains follow:

The large nuclei at the base of our brain forms the reptilian complex; it is considered the most ancient formation in the brain. Certain functions including defence of territory, competition for rank within the group, copulation, and ritualised or compulsive sequences, can be attributed to it. Everything that is not recognised is treated aggressively and is therefore seen as being hostile. We are in an area that is close to entropic zero (disorder or uncertainty) and difference is threatening to the living system (MacLean, 1981, 1984, 1990; Valzelli, 1976).

The limbic cortex, which first appeared in ancient mammals, has functional prevalence in ontogenesis from the third or fourth month of intrauterine life onward, as indicated by the sucking reflex and the production of prolactin (the quintessential maternity hormone in mammals). It adds the emotional-affective dimension with the care of the young and of the species, as well as audio-vocal communication (the call of separation), and it introduces play. It is responsible for what an individual feels or experiences (Ibid).

Most of the evolutive stages and the greater part of character formation, with all the associated baggage of 'incised marks' received from the object relationships, even from pre-subjective time, are inscribed on the arrow of limbic time. This represents "the place of the world of relationships" and is the dominant time of fundamental importance in the analytical-therapeutic setting (Ibid).

What the individual knows or recognises is a function of the neopallium, or 'new cloak'—the unmyelinated neurons forming the cortex of the cerebrum, which wrapped itself around the limbic system two million years ago. It developed in response to the three-dimensional stereoscopic vision necessary for the upright stance. The neopallium or neocortex, is responsible for space and time, for before and after, for cause and effect, for higher, logical, meta-relational and

meta-communicative cognitive processes, for the consciousness of the Ego, and for the awareness of the Self (Ibid).

Certain significant areas of the brain should be borne in mind for appropriate supervision in body psychotherapy. Knowledge of these central areas and their correlated psycho-dynamic themes permit us to propose appropriate actings (which produce embodied activation of the psycho-dynamic themes in the corresponding peripheral areas—the seven Reichian levels).

Brief descriptions of the significant areas of the brain follow:

The prefrontal cortex (PFC)—the anterior part of the frontal lobe—belongs to the neopallium. The dorsal-lateral portion (seat of the working-memory) governs the organisation of complex behaviour, such as abstraction and meta-cognition; the mesial portion plays a role in cognitive-emotional motivation. Lastly, the orbital portion has the task of controlling instinctive urges. The PFC is the seat of ethics and decision-making processes. It plays an extraordinary role as the centre regulating voluntary movement, of the eyes in particular, which have always been mirrors of the soul, even in psychopathology. (Mancia, 2007); (LaBar, & LeDoux, 2007).

The almond-shaped amygdala, a mass of grey matter deep within the midbrain of each cerebral hemisphere, manages fear and is part of the limbic system (MacLean, 1990). It is situated above the brainstem and is an integrative centre that evaluates the emotional value of events, providing the right degree of attention, and starting the process of storage as memory. The amygdala may be considered the main archive of implicit memory. It can react even before the prefrontal cortex knows what is happening, and it can send impulses to the locus coeruleus. It would seem that fears of annihilation-castration from external dangers are deposited here (Ibid).

The locus coeruleus (or blue dot) is a nucleus situated in the brainstem. It is the source of most of the action of noradrenaline (NA) in the brain, being the main site for its synthesis. It is the site responsible for reactions of fear in extreme situations. Activation may be provoked either by impulses from external dangers to the Self via the amygdala or by impulses arising from internal dangers to the Self via the anterior cingulate gyrus (Ibid).

The anterior cingulate gyrus is the anterior area of the limbic lobe, situated above the corpus callosum. It elaborates the dangers in the normal course of day-to-day life at an unconscious level and is a sort of silent alarm that becomes apparent when we are aware of "a strange feeling about I don't know what" when encountering a danger which has not yet revealed itself to the consciousness of the Ego. It would seem that fears of exclusion-abandonment, of angst from separation, and from external object losses are deposited here; however, they are recorded as internal dangers (Ibid).

Step 6: Diagnosis of Prevalent Traits and of Prevalent Transitions

We identify the prevalent traits and the how of the prevalent transitions from one evolutive stage to the next and from one field to another, in the person's characterological make-up. These traits may be intrauterine, oral, muscular, hysterical, genital, and their relative sub-types. Identifying the specific trait patterns of the person means drawing closer to defining the Trait Mind for that trait in that person.

The prevalent transitions are birth, weaning, Oedipal and puberty.

So we must ask:

Which combination of traits and fields define the person?

Which transitions from one stage to the next predominantly defines the person before us?

How do these combinations of traits interact with each other and with the specific transitions in the person's structural make-up?

For example, we may identify a prevalent oral trait, which owes its prevalence in the character structure to difficulty during the period of weaning, which represents the transition from the first-field mother to the second-field family. Suffering during this transition, leading, as it does, from the oral stage to the muscular stage, may lead to consequent inhibited expression of successive, non-prevalent muscular traits?

Step 7: Diagnosis of Prevalent Peripheral Bodily Levels and Prevalent Evolutive Brains

If the Object Relationships pass, primitively, through the bodily-sensorial periphery before also being deposited in the central nervous system and the corresponding areas of the brain, we must also ask:

- Which combination of bodily levels and evolutive brains are prevalent in the person before us and in their structural make-up?
- Which bodily level does the person use most in their relationship with us?
  (Somatically, the person may predominantly express themselves through the abdominal area, with the mouth, with their chest and arms, with the diaphragm, with their neck, their eyes, or with their legs and pelvis.)
- And which brain are they facing us with? Is it limbic, the pre-frontal or the neopallium?
- Which areas of the brain are they presenting to us - with alarm from the amygdala, with the abandonment of the anterior cingulate gyrus, or with panic from the locus coeruleus, for example?

Step 8: Prevalent Fractal Aetiopathogenesis

A decisive sign incised during a stage of development must, surely, leave a pattern and an implicit trait question. The form of the resulting character trait may be compared to a fractal. In accordance with the theory of complexity, a fractal is defined as being "a pattern of the whole which is repeated, similar to itself, on different orders of magnitude." When we observe a fractal form it always presents the same global characteristics on whatever scale we are considering. For example, the theme of inclusion, which is so dear to the psychotherapeutic world and which has its origins in the intrauterine stage, will always appear to be similar in its architecture even through its various expressions of differing stages of development and prevalent bodily levels.

"It is thought that fractals, in some way, have correspondences with the structure of the human mind ... this is why people find them so familiar" (B. Mandelbrot, cited in Gallio, & Masciarelli, 2013, p.153).

So we must ask:

- Which prevalent fractal aetiopathogenesis led to the recursiveness, to varying degrees, of the style of relationship of the person?
- Which prevalent fractal aetiopathogenesis led to the recursiveness of their psychopathological beyond-threshold?

Step 9: Scene Analysis and Relational Diagnosis

The scenes in which the patient has lived must be considered in order to complete the Relational Diagnosis. The analysis of the scene involves enlarging the careful observation to the whole psychodynamic horizon of the field around the person, not only in the 'here and now', but also of the fields in the 'there and then' of the historical environments during the patients' stages of evolutive development. The analyst must highlight any similarities, and, at the same

time, evaluate the how, and the current state, of the patient's relationships with meaningful close relationship figures and his position in those relationships (up, down, meta, symmetrical, or in alliance) (Ferri, 2012).

Step 10: Clinical-Psychopathological Diagnosis

The clinical-psychopathological diagnosis takes into consideration the available diagnostic systems including the following: DSM-V; ICD-10; as well as by the PDM. Obviously all of the diagnoses taken into consideration, from a complex perspective, must be convergent because they represent different lenses to achieve high-definition supervision - a single, disparate reading should not be taken in isolation until it is confirmed from additional perspectives to obtain a three-dimensional, spherical overview of the object in its entirety.

If the patient displays clinical psychopathology, remembering that in Reichian Analysis the symptom is a 'beyond-threshold' of trait, we ask:

- What intelligent sense does it reveal to us?
- What kind of economy is it supporting?
- What outcome does it indicate to us?
- How does it relate to the then and there?
- How does it relate to the here and now?

Step 11: Differential Diagnosis

Careful attention paid to the case history (anamnesis) on the arrow of evolutive time allows us to evaluate both the psychopathological risks and the vulnerability of the patient and, with the symptomatological-syndromic beyond-threshold presented, to concur on the definition of the spectrum in the differential diagnosis and on why it is this pathology itself and not one of the other possibilities.

Step 12: Analysis of the Explicit and Implicit Questions

The explicit questions, which are the reasons why the patient has turned to the therapist, can be directly extrapolated from the material collected during the previous steps. However, importantly, we can also identify the implicit questions that have been stratified along the arrow of time and that emerge from the narration of the case and from the representation of the phantasm by the psychotherapist.

The verbal expressivity and linguistic competence represent the subjectivity of the person. They reveal to us the explicit questions that they are aware of, but, importantly for the psychotherapeutic questions, there are also implicit questions that they are unaware of, unconscious questions, which have been deposited throughout the story of the person in their traits and trait minds. These often belong to the implicit memory, which cannot be accessed by the subjective memory.

Step 13: "State, Trait and Bodily Level" Transference

Transference defines the process with which our unconscious desires and our implicit questions express themselves within the scope of the analytical relationship. It represents the repetition of infantile prototypes of object relationships.

Step 14: "State, Trait and Bodily Level" Counter-Transference

Counter-transference defines the analyst's sub-conscious reaction to the patient being analyzed and, in particular, to their transference. It represents the ground over which the

questions of the analysis are spread.

In Reichian Analysis we pay great attention to transference and counter-transference. We break them down into sub-types, using the special 'observational lenses' provided by the Analysis of the Character of the Relationship. From a complex perspective they define the degree of progression of the analytical-therapeutic relationship:

- Transference of state, characterological trait and of bodily level of the phantasm of the patient analysed.
- Counter-transference of state, characterological trait and of bodily level of the analyst (and of the group in group supervisions).

From a complex perspective they define the degree of progression of the analytical-therapeutic relationship, which is explained in great detail in the following step.

Step 15: The Degree of Progression of the Analytical-Therapeutic Relationship

Analysis of the Character of the Relationship is fundamental in the Reichian Analysis setting. It permits highly-specific structuring of the analytical-therapeutic relationship.

We consider the Architecture of the Relationship to be the privileged partner. It is Architecture "which contains" any therapeutic act, from listening to the transferential elaboration of a trait and from the interpretation of a dream, a gesture or a liberating fantasy to the suggestion of a Vegetotherapy acting or, even, the simple prescription of a psychotropic medicine.

We consider the relationship to be "a living form", the third participant, in addition to the analyst, and the patient being analysed, which is able to create triangulation and to expand the dialogue to a 'trialogue'.

The relationship responds to the laws of living systems – it has its own character, its own evolutive stages, its own trait mind and its own 'incised-marks', which are all influenced by the analyst-analysed meeting, by the analyst-analysed meeting, by the compatibility of their respective incised marks, by their traits' implicit questions and by their respective trait minds.

It is our specific approach and contribution to the theme of intersubjectivity and intercorporeity and of the appropriateness of the relational frame in the setting and should clearly be interpreted epistemologically with the language between traits and trait minds.

The language of traits is a meta-meta language, in the sense that it includes both body and verbal language, and is above them. It includes de-codification of trait mind, of trait intelligence, of trait thoughts and, even, of their ground, which is expressed by the various corresponding bodily levels that have been marked over time by the object relationships of the various stages. It pre-supposes the capacity of the Self to simultaneously interpret them, which is something our pre-subjective Self automatically does. Our Ego doesn't normally interpret this language in that it is attracted to the contents, (Watzlawick, Helmick Beavin, & Jackson, 1971) since it is not used to connecting to feelings and even less so to meta-cognition based on feeling-thought.

The language of traits is a language of the Self-system, while the other two are sub-systemic languages of that Self – the phylo-ontogenetic history will tell us of their continuity over time and of their current contemporaneity. In communication and in relationships the language of traits is expressed contemporaneously with verbal language and body language, which represent sub-systemic indicators of trait (Ferri, 2014).

Reichain Analysis is based on Character Analysis of the Trait Mind – a guiding fractal of a greater order of magnitude and we enter the world of intersubjective-intercorporeal relationships.

By using this special lens that Reichian Analysis represents, we discover that, as well as verbal communication and body language, with which traits express themselves on the outer

surface of interactions, traits also reveal this other, third, trait language, which is unknown and extraordinary. It is expressed by the implicit questions of traits that automatically elicit answers / implicit questions in the other than Self from their own "baggage" of traits.

It is on the basis of this dialogue between one unconscious and the other, between these fractals, between these meta-messages of the respective Selves, that people construct possible communications. If these communications are confirmed over time, then they can evolve into relationships, but also simply into sensations of sustainability, of alliance, of liking, and of pleasure in being together.

However, when there is incompatibility in the dialogue between the implicit questions and the answers (which always contain their own implicit questions) of the various Selves' traits, then there may be antipathy, unsustainability and symmetrical reactions, with little or no possibility of any communication and even less of a relationship.

There is also, of course, the whole intermediate range of the spectrum between these two extremes of polarity. Each of our entropic-negentropic directions, silhouetted in the background, are outcomes of energetic dialogues and the grounds for our feelings. They are decisive factors that govern our sub-conscious choices, an apparent oxymoron.

Step 16: The General and Targeted Analytical-Therapeutic Project

The observational lens of the 'trait mind' orders the ontogenesis of the biological-biographical history of the person, which reveals a series of highly-appropriate implications for the psychotherapist, so facilitating elaboration of general and targeted projects.

Defining the Ubi sum — where I am, the Ubi est — where he is, and the Ubi sumus — where we are, is used in our protocol for intelligent structural coupling between traits and for appropriate projects in the analytical-therapeutic setting.

The relationship will develop from the meeting between the analyst's traits and the traits of the patient being analysed and, like strands of a new piece of DNA, they will permit a new, complex living system – this relationship, its self-organisation, its self-poiesis, its development its progression, and its own negentropic intelligence. "Negentropy deals with a negative variation in entropy from an original value, such as the birth of an individual, the origin of life, the beginning of biological evolution or the birth of a relationship" (Schroedinger, cited in Che cos'è la vita, 1995, p.67).

The relational architecture sees the analyst in a position determined by functional, dynamic, empathic collocation on the trait of his own personality and on the corresponding bodily level. In this way the analyst can meet and contact the internal time of the patient being analysed, helping him to move on from his position of trait and bodily level (or at least to read them).

The relational architecture also requires the appropriate how of the analyst, which is determined by the analogue of the position and generates the right atmosphere for evolutive insights of the patient analysed.

The position and the how are foundations of a relational architecture and of a counter-transference of trait and of bodily level, which are appropriate for the patient and for any beyond-threshold disturbance.

This makes appropriate intersubjectivity-intercorporeity possible, or, in other words, 'today's functional therapeutic embodied simulation', which is able to form and/or to reform any patterns from 'yesterday's dysfunctional embodied simulation', with embodied simulation defined as "a specific mechanism through which our body-brain system models its interactions with the world" (Gallese & Ammaniti, 2014, p.2).

In the Reichian Analysis interpretation of counter-transference, a degree of flexibility in the analytical position is present, which permits functional, empathic contact in co-evolution and in complexity.

Some explanatory questions follow to clarify what we are saying:

- When we meet a patient, which bodily level resonates and which trait is calling out to us? Does it touch our chest, our solar plexus, our pelvis or our eyes? Does it make us stretch out our necks, seal our lips or contract our shoulders? Are we on a phallic-narcissistic trait, on an oral trait, anal, hysterical, intrauterine or genital? And which is the most "therapeutic" in the structural coupling with this person?
- When we encounter a psychotic state, which trait and which bodily level does it resonate with? Where is the psychotic emptiness? Isn't it also in the deeply visceral? And, with which counter-transference trait/state proceed? Is it the most therapeutic in the relationship?
- When we encounter a depressive state, which bodily level and which trait does it resonate with? Isn't the depressive withdrawal also in the crushed chest while exhaling?
- Isn't the persecutory alarm of paranoia also in the persecutory terror in the shoulders?
- Isn't the obsessive person's fixedness also in the rigid look in their eyes?
- Isn't the borderliner's anger also in that chin stuck provocatively out to constantly challenge the other?
- How does the anxiety of unsustainability of a tired chest resonate with our own breathing?
- How do the pallor and the terrified expression of panic surprise us?
- Which trait and bodily level counter-transference do we proceed with in these specific psychopathologies? Are they the most appropriate for these disturbances?

(Ferri, & Cimini, 2012, p.187)

Step 17: The Validation of Negentropy over Time.

In this way the setting is set out as a field, or a small biosphere, which is capable of intercepting the negentropy, and we validate the negentropic evolution of the person being analysed, of the analyst and of the analyst-analysed relationship, over a period of time (the usual period is around 6 months, on average the time it takes for new trait patterns to emerge or to repair important affective losses).

In an elementary mathematical code, for example, considering on a scale of self-evaluation from one to a hundred, well-being to be from eighty to a hundred, we photograph the initial state "value" from zero to a hundred and we review it at six months to evaluate the entropy, negentropy or stasis of the condition of the patient and of the psychotherapeutic relationship.

Step 18: Character-Analytical Vegetotherapy of the Relationship

Given that the Analysis of the Character of the Relationship is *our* intersubjective-intercorporeal frame in the current setting, and which represents appropriate therapeutic **embodied simulation,** then we can affirm that Character-Analytical Vegetotherapy of the Relationship represents specific **therapeutic embodied activation in our model.** The CAV actings, in structural coupling with embodied simulation (which arrives from outside onto the bodily self), lead to the emergence of new and modified trait patterns (from within the bodily self, outwards). Through 'actings', Vegetotherapy informs, forms, and reforms the trait mind.

Generally speaking could all body psychotherapy be considered to be a form of therapeutic embodied activation? Could body psychotherapy complete general psychotherapy through activation of the cortical-spinal pathways?

"When the action is performed or imitated, the cortical-spinal pathways are activated… when the action is imagined, the motory-cortical network is activated... the action is not produced" (Gallese, & Ammaniti, 2014, p.28).

After all data is collected and diagnoses are made, the appropriate Vegetotherapy 'actings' for the patient are proposed by the supervisor leading the group training and these actings are performed by the analyst presenting the case. The analyst-therapist will, thus, be incisively-marked by the Analysis of the Character of the Relationship and by Character-Analytical Vegetotherapy, which is considered valid:

- Both for the appropriateness of the intersubjective-intercorporeal frame to be transferred in the setting to the patient presented (which is to say to fix the position and the how for that specific analytical-therapeutic relationship),
- And to re-propose alternative, suitable, more sustainable, relational and psycho-corporeal styles on the patient being analysed and, at times, real, new, relational prototypes toward negentropy.

## Conclusion

This work was born from an observation made by Wilhelm Reich in 1933, which represented a challenge in psychotherapeutic research: "A certain analytical situation has only a single possible optimal solution and, in a specific case, only one use of a technique is the correct one" (Reich, 1933, p.28). This affirmation has accompanied four generations of analysts in a fascinating debate on the most appropriate development of the setting, to design a project targeted on the life story of the person and his disturbance. This work, which includes the addition of the latest developments in the field, Analysis of the Character of the Relationship, and Character-Analytical Vegetotherapy of the Therapeutic Relationship, represents a further contribution in response to that challenge, in line with, the lenses of embodied mind, enactive mind and *our* new lens – the Trait Mind.

The clinical-analytical model of supervision represented in this work is partly inspired by the theory of complexity, which makes "possibility" (Prygogine, 1997) one of its research guidelines, and which is clearly far from self-reassuring certainties. The briefly-illustrated 18 steps simply define a high-complexity field of investigation, in which moving intelligently should give rise to an increase in appropriateness of the narration and the supervision based on the evidence supplied. Its primary aim is to propose research into the common factors that can be found in different styles of supervision and to create a dialogue between separate currents of psychotherapy, which could lead to useful reverberations on a practical level. The attempt to include a widening of horizons is not extraneous to the model, oscillating, in full awareness, between science and pseudo-science. This modality is well known to those occupied with epistemology in the world of the mind, which "don't have a well-defined falsificationist code of honour, not by fault or misadventure, but by necessity" (Rossi-Monti, 1984, p. 46)... the world of the mind is, still, in fact, more complex than the code. The attempt to make an innovative contribution is also not extraneous to the model, implicitly risking a certain degree of self-referencing, but always bearing clearly in mind, on one hand the fallacy of a counter-position between intuition and reason and the indispensable role of the first in the progress of science (Russell, 1972), and, on the other hand that "There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy" (Shakespeare, 1601, Hamlet, Act I, Scene V, p.159-167).

**BIOGRAPHY**
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