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Beata Mirucka

THE PSYCHOTHERAPIST ATTENTIVE TO THE EMBODIMENT OF THE PATIENT. ANALYSIS OF FRAGMENTS OF PSYCHOTHERAPEUTIC DIALOGUE

Department of Psychotherapy and Health Psychology, Institute of Psychology,
The John Paul II Catholic University of Lublin

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Summary

The aim of this article is to present ways of using the psychotherapist's attentiveness to the phenomena of embodiment. In the first part, the author's conception of the embodied subject is outlined, according to which the experience of the body is continuously elaborated in the form of three basic mental representations: body image, body schema and body sense. Body image, referring mainly to exteroception, includes perceptions, beliefs and emotions directed towards the body. Body schema is based primarily on the organisation of proprioceptive information, the source of which is the acts of moving and displacing in space and mastering the body. Body sense, on the other hand, a representation shaped by interoception, concerns the depiction of bodily states, processes and behaviour; it encompasses the overall experience of the physical condition, which is fundamental to the subject's mood and emotional state. The triad of mental bodily representations forms an inseparable whole, the level of integration of which is disrupted, especially in situations of trauma. The second part of the article exemplifies the work of a psychotherapist sensitive and attentive to the phenomena of embodiment. In the excerpts from the dialogues quoted, the ways of identifying particular representations of the body and then combining them in an increasingly positive image of the patient are shown. The work proposal presented is aimed at positively transforming the traumatic experience in such a way that it becomes an integral part of self-consciousness and thus makes life's tasks less and less difficult.

Introduction

The fantastic nature of Leonardo da Vinci's drawing 'Homo ad circulum', or Vitruvian Man, lies, among other things, in the way in which the phenomenon of embodiment is depicted. We see and feel at the same time. We recognise: the image of a body perfect in its proportions and shapes, characterised by the striking beauty of the whole figure. At the same time, we perceive an impression of movement, achieved through the duality of the muscular limbs. We can feel and almost see the man energetically throwing his legs out to the side and then retracting them again. His arms seem to flutter like wings. We feel the

pulsating energy, and his intense yet intimate gaze allows us to reflect, as in a mirror, his emotions. We can feel the deepest essence of ourselves, standing naked in the place where our world meets the macrocosm [1].

Leonardo da Vinci's artistic depiction of corporeality highlights a psychological account of this phenomenon, in which three aspects of the experience of the human body are contained in three concepts – mental representations: body image, body schema and sense of body [2]. Since existence in the material world is founded on being corporeal, the body can be an essential object of human experience as well as becoming itself – an embodied subject [3]. This significant difference in one's relationship with one's body is related to the way in which the bodily self functions, which, as an overarching, central psychic instance, is responsible for the shaping and overall elaboration of bodily experience [4]. The body self manifests itself in the functions of capturing the complex reality of the body (in the so-called subjective self) and the mental representations of the body (in the so-called object self), which together comprise the complex system that regulates pre-reflective and reflexive bodily awareness [5-8], including its key overarching dimension, the bodily identity [2].

Body mental representations are the direct result of the body self. These are shaped over the course of a person's life, from the simplest ones to more complex, multimodal mental structures. The most important mental representations of the body self include (a) the sense of bodily states (body sense), (b) the body schema and (c) the body image. All of these develop on the basis of somatosensory perception: interoception, proprioception and exteroception, using these three sensory modalities of the body to varying degrees. While the body schema derives its form mainly from the elaboration of proprioceptive information and the body image from exteroception, the sense of the body arises largely from the organisation of interoceptive sensations. These become crucial in the formation of this third – no less important than body schema and body image – mental representation of the body [2].

The first of the mental representations of the body – the body image – the most visual one, because it is based on visual perception, concerns – most simply – the external appearance. Thanks to it, the subject is able to identify him/herself and others, although – as it turns out – it has little in common with a snapshot taken at a specific moment in life [9]. Why? Because the body image contains the entire past history of a person's being, associated with various opinions and emotions relating to their attractiveness. For example, a father's sentence said to his growing daughter: 'you look very sexy', combined with his seductive gaze, can make a very significant imprint on the internal image – body image – of this teenage girl. What for others is a natural area of physical identification of femininity, for her is likely to become an overlooked aspect of herself.

The second representation of embodiment, the body schema, is a set of motor programmes and includes small and large motor skills. It ensures not only efficient movement or the performance of precise manual manipulations, but also spatial orientation. Without a functioning body schema, it would be impossible to determine: up – down, left – right [10].

In the film *Scent of a Woman*, the main character – a blind, retired colonel played by Al Pacino – drives a red Ferrari with bravado and dances the tango with masterful skill,

because he has an exceptionally developed body schema. It is this representation that makes it possible to wield the body like an ingenious tool and to develop a sense of control, agency and effectiveness. Trauma patients – as van der Kolk writes about them – are surprisingly clumsy and uncoordinated in their movements. Even in casual conversation, they seem constrained, as if lacking natural facial expressions or gestures. They often report disturbances in spatial orientation; they lose their way easily, wandering even in familiar places [11].

The third mental representation – body sense – refers to the way in which bodily states and processes are perceived. It is formed mainly on the basis of interoception, through which a person can perceive all somatic sensations or notice subtle changes in bodily processes; register muscle tension, fatigue, pains, feel the pulse and heartbeat, or subtle signs of internal organ work [12]. A sense of the body can be evidenced by the following statements: 'I am aware of pain in my neck area', 'I feel my muscles relaxing. Despite trying to relax, I am still tense'. Body sensation also refers to the quality of attention directed towards bodily sensations and states, ranging from being highly attentive to one's sensations to ignoring them altogether. Body sense indicates not only how bodily information is received, but also how it is used; for example, in decision-making situations.[1]

In integrated embodiment, the body as an object constitutes a kind of medium quo, which does not focus on itself, does not distress, does not disturb the basic unity of body and mind, nor does it block the free flow of the stream of consciousness of one's own experiences.[2] When, on the other hand, under the influence of difficult experiences, especially trauma, a person protects himself from so-called unbearable feelings by means of the unconscious act of anaesthetising himself, corporeal integration is weakened or even lost. This means that, at the most basic level, there is a significant change in the perception of bodily sensations, the way one experiences one's body and, consequently, one's relationship with one's body. It ceases to be subjective: 'I and my body are one', in favour of an object relationship: 'my body is a ballast that limits me' [14]. Psychotherapeutic work appears then to be necessary, aimed at restoring the lost psycho-physical unity and thus broadening awareness, especially of those experiences to which the patient's severe psychological suffering is related.

Attentiveness to the patient's embodiment in psychotherapeutic dialogue[3]

Based on the author's theory of the embodied subject [2], the following is an extract from psychotherapeutic work during which – thanks to the therapist's enhanced attentiveness to the patient's corporeality – traumatic experiences could be gradually transformed.

1) The role of body sense in decision-making was described in great detail by Antonio Damasio in the somatic marker hypothesis [13].

2) For the reader interested in a more detailed discussion of issues of embodiment, and in particular mental representations of the body, I refer to the book *Podmiot Ucieleśniony* [The Embodied Subject] [2].

3) The dialogue was created on the basis of real psychotherapeutic conversations. The patient's details have been altered so that she cannot be identified.

The therapist, working in a psychodynamic paradigm, successively integrated interventions into her work resulting from the conceptualisation of embodiment as the basic and at the same time most primordial form of the subject's consciousness. She used methods to isolate and at the same time integrate bodily representations. She did this especially when typical methods of analysis seemed insufficient, because they encountered the patient's resistance as a natural defence against her psychological suffering.

Ms A. was 47 years old at the start of her treatment. She complained of recurrent, very severe toothaches. The dental diagnosis, however, did not reveal any underlying cause for the reported complaints. It was not so much the somatic sensations of unknown origin that were the patient's main concern, but the sense of dissatisfaction with her life and herself, which had intensified since her 24-year-old daughter had moved out of the house.

The patient was an only child for the first seven years of her life. In her recollection, the moment her brother was born ended her mother's physical aggression regularly used against her in the form of severe beatings with a belt. Ms A.'s brother was treated for substance abuse from an early age. He died a tragic death shortly after reaching the age of 30 because he overdosed on drugs.

Ms A. became pregnant at the age of 18. At the time, she was in her high school graduating class, which she had already completed as a single mother: in the first month of her pregnancy, she was abandoned by her boyfriend, the father of the child. Until then, she had been in a very intimate, romantic relationship with him, lasting from the beginning of high school. Separating from him was a difficult and completely incomprehensible experience for her.

She had never been married. She had the experience of a seven-year informal relationship with a man whom she left on her own when his infidelities came to light (one year before she started therapy).

The patient's extremely difficult family experiences were the source of her psychological trauma, which most likely took the form of relational trauma. Repeated emotional abuse from early childhood, combined with her mother's physical violence, constant fear and insecurity in her relationship with her father, who regularly started brawls in states of alcoholic intoxication, and constant fear for the life of her younger brother, who was addicted to hard drugs, made up a long list of challenges that the patient had to face during her life. Their level of difficulty was so high that mentally processing them significantly exceeded her available coping and adaptive skills. The consequences of the psychological trauma experienced manifested themselves clearly in, among other things, her reduced ability to read emotions, reduced resistance to stress, permanent anxiety, combined with a strong tendency to blame herself and a persistent sense of shame experienced in social relationships. In addition, Ms A. suffered mainly from loneliness and a very reduced sense of self-worth. She struggled with intense depressive states, for which she received psychiatric treatment.

The therapy covered three years. The presented excerpt from the psychotherapeutic dialogue is from the final stage of the work (about four months before the end of the process).

At the time of the end of the therapy, the patient was no longer taking antidepressants (she had stopped drug treatment six months earlier in agreement with her doctor).

Fragments of dialogue from Ms A.'s session:

P.: *Lately, I'm still lacking in strength. I feel exhausted, tired and more often than not, I feel my heart is pounding.*

T.: *You've been focusing on your somatic complaints.*

P.: *Yes, but I have thoughts in my head about what I could do to feel better, to make my life more meaningful. Until now I wanted to occupy my head with something else. But now I don't want to put it off anymore. I want to know what to do. I feel it's important for me now.*

T.: *What exactly is important to you?*

P.: *For me to find a way for the rest of my life. I would like to feel it, how I should direct my life further. Because this life right now doesn't suit me anymore.*

T.: *Now you know it very precisely: 'this life that I am leading now does not suit me'. And your tiredness or these palpitations are very possibly also a sign of this, a signal confirming this truth: 'this life I am leading now does not suit me'.*

In this initial exchange, the patient boldly introduces an important theme – dissatisfaction with life, or rather the search for a way to change it. She begins her narrative with somatic complaints, which suggests a lack of access to the emotions experienced. Since she emphasises the cognitive aspect of the experience, I follow without forcing the topic of emotions (without asking, for example: 'What are you feeling about this', 'What are you experiencing in your body when you say this', etc.). Such a question, when asked at this point, would betray a deficiency in my empathy as a psychotherapist and, consequently, would probably undermine the therapeutic collaboration.

P.: *Now I allow these thoughts in, I don't push them away completely, I let them circulate. I used to push them away because it's not time, because I can't do anything with my life. I think now I can. I have to think about what I would like.*

T.: *You create space within yourself to feel your desires. To find within yourself the answer to what this life is supposed to be now, yes?*

P.: *Yes... I always thought I had no problem being alone. But after all, I've never been alone like I am now. I never thought I really needed people.*

T.: *You recognised the need.*

P.: *Yes, although it's hard for me to admit that I need daily contact with another human being, with a close person...*

T.: *When you say that, I can see that you swallow your saliva differently.... something is going on in you?*

The patient starts swallowing her saliva more intensely, straightens up in the chair and changes the direction of her gaze. I record these bodily changes and communicate them to the patient. I do not leave them unspoken, because at this point in the session they seem to be an important signal of her experiences. Not noticing them and not verbalising them would be a sign of ignoring the patient's non-verbal messages. Nor do I still ask: 'What's going on in you?' I just say that I can see that something is going on in her. Such

an intervention at this stage of the work reduces the tension that the patient has revealed in the words: ‘it’s hard for me to admit’.

P.: *I didn’t think I needed it that much. My mother always said that a man was not necessary in a woman’s life. I lived under the belief that it wasn’t essential to life. And yet I think that for me it is necessary.*

T.: *What does it feel like when you say: ‘I need to be in a relationship with a man’.*

P.: *I don’t know what to call these feelings....(pause)*

T.: *What are these feelings ...?*

I crystallise and clarify the nature of the patient’s need by inserting in place of ‘I need this’ the phrase: ‘I need to be in a relationship with a man’. The patient herself identifies and verbalises this need in a fragmented form. At the same time, I decide to ask the question about feelings again, because the patient with her earlier words: ‘I need it so much’, with the emphasis placed on ‘so much...’, suggests to me that she has admitted emotions, feelings to herself. Most likely, the awareness of bodily sensations has already opened the way to her own emotions.

P.: *I think I felt such a relief, but I also felt such a fear, whether it would work out. I tried all the time not to allow the idea that I could share my life with someone. So that I wouldn’t be disappointed, so cheated. That’s hard to unlock now. I am so blocked, but I already allow myself to think: how nice it would be to share my life with someone.*

T.: *We can explore what you call ‘blocking’.*

Before I start more exploratory work with the patient, I want to get her consent and thus strengthen her motivation.

P.: *Yes*

T.: *Let’s pay attention to the sensations in your body. Where do you feel them when you talk about the blockage?*

P.: *In the heart* [reflexively puts her hand on her heart].

T.: *What if you would allow yourself to go into these sensations, to feel them even more.*

P.: *It is hard for me to do this...*

T.: *It is this blockage.... Maybe you could tell me about your heart, how you are experiencing it now?*

P.: *I’m holding this heart and it wants to break away like this. It doesn’t want to be there alone, blocked. It’s like it’s giving me signs that it doesn’t want to be there by itself.*

T.: *It is giving signs...*

P.: *It is demanding that I finally release it, that I let it live.*

The patient separates her desire, thereby distancing herself from it and placing it in a part of her body – her heart. Such a mental, unconscious procedure allows her to diminish the sensation of her desire, but at the same time to some extent fragment herself and partially objectify herself. She states: ‘the heart does not want to be alone’, instead of – ‘I do not want to be alone’.

The next part of the session was about just that – discovering the reasons for this mental treatment. The conversation focused more and more on the topic of betrayal and the fear of it (I skipped the presentation of this part). The next part of the session already reveals a different level of awareness of the patient.

P.: *I don't allow any changes in my life. I've blocked it all out so tightly. Maybe that's why I'm still so tired. I'm still tense. I even block my body so tightly.*

T.: *Hmm... to stop change.*

P.: *Now that I think about it, I don't know why I'm so afraid of change. And why I shouldn't try, let go of this life of mine so that it goes its own way. And not to block it all the time.*

The theme of blockage returns, but this time it concerns not so much the thoughts (the cognitive aspect of functioning), but the fear, which the patient places clearly in the body, speaking of body blockage. I therefore move directly to exploring this bodily blockage.

T.: *How do you experience this blockage in your body?*

P.: *My body is tense all the time, even though I have a lot of movement, I exercise a lot. I am not relaxed like I should be relaxed. This can last for a while after exercising, but then my body gets tense again. It's like I don't want to let go, I just block myself all the time.*

T.: *You changed the way you talk about this tension. At first you said:* '*The body is tense*' *and then immediately afterwards* '*as if I don't want to let go*'. *The body itself, you yourself. As if it was a bit independent of you – it just happened.*

I point out the disjunction in the patient's experience of self, the lack of identity between body and self. My next interventions will be aimed at rebuilding in the patient the experience of a more coherent bodily self.

P.: *Maybe so.*

T.: *And this tension .... In what area of the body is it felt by you?*

P.: *Maybe here, in the chest, it involves the whole shoulders, the upper part of the torso...*

T.: *The back too?*

P.: *Yes, when I walk I even assume a hunching position. This is beyond me. I walk with my head to the ground, as if I am nailed by all this, these problems.*

The patient moves from sensations of tension in the torso (body sense) to movement (body schema) to finally show the whole figure (body image). She activates the three mental representations of the body, which may signify her expanding her bodily awareness and, consequently, her feelings. This is shown in the following excerpt from the session.

T.: *As you talk about this, I imagine your figure in tension. Please tell me if I am seeing this correctly. It's as if this tension makes you more hunched over, bending down to the ground, resulting in your breathing being less free...*

P.: *Yes, shallow, less deep...*

T.: *Shallow .... I imagined you in this tension bent over and I don't know where you are then with your gaze...*

P.: *In the ground!*

T.: *In the ground. Not in the future, but in the ground.*

P.: *Yes. And let me tell you, this week I noticed how I was walking. And I said to myself: I have to walk with my head up, I can't give in to gravity.... I just have to start breathing. Because what if I walk, I move, but if I don't let my body breathe, it's like I'm sitting on the couch.*

T.: *It's like you're not allowing yourself to breathe and therefore you're not allowing yourself to see your future.*

P.: *Yes.*

T.: *Yourself in the future.*

P.: *I would even say that I hide within myself so that I don't lean out – only to wallow in my past problems, my sorrows. As if I were celebrating this life and tormented body of mine within myself. And yet I keep coming back to it ...*

T.: *This gaze on the ground, this celebration of a difficult past...But if we now imagine you upright, if you feel it more, what you have been practising yourself in the last week – this movement of straightening up and directing your gaze towards the future, what do you want to see in this future, what do you want to see in it?*

P.: *I don't know.... I would like to see such clarity, such a happy life. Happy, but peaceful. I always liked to laugh and I laughed a lot. And it was such a balance, though, that got me through a difficult time. And now I don't have joy at all.*

T.: *Joy, humour, laughter...is that what revitalises you and unblocks you? Moved and invigorated by joy. What kind of image of you is that?*

P.: *So warm. I can feel the colours. It is in spite of everything – life.... the world seems better.*

T.: *A warm and colourful image, sensual and concrete.*

P.: *Yes, I feel so alive really. I have a very positive feeling. That's how I feel, as if the world has changed for me. It will allow me to forget, not to dwell on those heavy, bad things.*

T.: *So that you will be more in the present than in that heavy past.*

P.: *Yes.*

T.: *Let's take a closer look at you animated with joy.*

P.: *I see her running .... I don't know why* [the patient's face visibly changes].

T.: *I think you beamed at those words 'running'.*

P.: *I think it's synonymous with moving forward, that I will move forward after all. If I release this clamp, I will move forward. Running ... that's how I felt it. That I'm finally going to see this world, I'm finally going to allow myself to enter my life.*

T.: *Running ... What are you running towards in this picture?*

P.: *It occurred to me that I was running towards someone. But I immediately wanted to hide it so I wouldn't feel it* [laughs].

T.: *But you felt it.*

P.: *Yes, such a sense of security, freedom and safety. As if someone grabbed me by the hand.*

T.: *What is that image like when you are held by the hand?*

P.: *Such a kind of unity, an inner strength of mine. I am so strong, that I can do a lot, that I can cope with everything.*

T.: *Relaxation appeared on your face.*

P.: *I used to dream when I was a child that my mother would love me. Those are dreams. I was able to do that. I dreamed and I didn't have suicidal thoughts. I dreamed that things would change, I had a sense of life. That allowed me to get through the difficult stuff.*

I haven't dreamt for a long time now, I don't allow myself to dream. I don't see, I didn't see those images that are somewhere inside me. I don't see that my life is not over at all, that it can only just begin.

T.: *That you have so many proposals, so many positive scenarios for this life of yours.*

In this last part of the therapeutic dialogue, there is a shift from a focus on bodily sensations to an image of the whole figure, animated by joy and releasing its energy to act, to move. With the activation of all three representations of the body: image, schema and sense, there is a merging into a coherent imagining and feeling of the bodily self. I hold the patient's attention on her integrated self-image, i.e. I return to it three times to thereby intentionally reinforce it in her. Integrated in the three mental body representations, her image presumably activates her positive memories. The patient begins to free herself from the constraints of past traumatic events and from the fear that blocks her. She shows the courage to direct her gaze towards her future. She dares to name her need to share her life with a close male friend and recognises new possibilities – hope for a better life. Attentiveness to her physicality in this session seemed a welcome and quite effective psychotherapeutic intervention.

Four weeks later the patient said:

P.: *I feel that I have changed. I try to respect myself. I don't have to prove anything to anyone. I am more accepting of myself. Now, when I look in the mirror, I don't focus on my wrinkles, which used to cause me a lot of fear and trepidation. Now I look myself in the eyes and it is becoming more common to smile at myself.*

The psychotherapeutic dialogue presented above exemplifies the work of a psychotherapist trying to be very attentive to the patient's embodiment, especially at those moments in her process of desired change when it seemed necessary to elaborate and accommodate difficult emotions related to traumatic experiences. Expanding awareness of the patient's bodily sensations and impressions, contained in concrete representations (image, schema and sense of body) helped, on the one hand, to reach more gently into the emotions and feelings associated with the trauma, and on the other hand, to integrate the bodily self with the psychic self in one coherent sense of self.

The patient's increased bodily awareness, expressed in a holistic view of herself as an experiencing subject, seems to represent an important achievement in her psychotherapeutic process, improving her to function better. This was expressed relatively emphatically in the decisions made by Ms A. shortly afterwards, relating to a change in the nature of her professional work. From being a babysitter and office cleaner, she retrained as a tourist guide for a renowned travel agency. At the same time, she welcomed with greater calmness and even pleasure the fact that her daughter had moved out of the house, which she was now able to interpret as a positive sign of her maturing and becoming independent.

The work proposal presented here reveals a relatively wide spectrum of possibilities for the psychotherapist to use especially his own, but also the patient's, attentiveness to the phenomena of embodiment. It differs from other methods of body work known in the literature (e.g. Alexander Lowen, James Kepner, Babette Rothschild [14-16]) primarily in the understanding of the phenomenon of corporeality and, consequently, in the psycho-

therapeutic goals to be achieved. Focusing on bodily sensations (as in Lowen's or Kepner's body work proposals, among others), combining them with the other elements of experience dissociated as a result of trauma (as in Rothschild's model of SIBAM dissociation), in this author's idea is only the initial stage of the process. The main intention is to lead the patient from treating the body objectively to experiencing the self as an embodied subject. The individual stages of this goal lead through the gradual activation of all three mental representations: body image, body schema and body sense, until their final integration into a coherent experience of the bodily self. Ultimately, rebuilding and strengthening the ability to experience oneself as a psychosomatic unity becomes a prerequisite for transforming the traumatic experience in such a way that it can become an integral part of self-consciousness and thus make it less and less difficult for the patient to fulfil life tasks.

Conclusion

Leonardo da Vinci's Vitruvian Man depicts the unity of three aspects of embodiment: body image, body schema and body sense. Without stopping at any one of them, imperceptibly, as if without much effort, he transports the person viewing the drawing into a space of emotion and into the very centre of the mystery of human nature. Despite the clear physicality and sensuality of the representation, it easily introduces the inner world – the microcosm – inscribed in the outer world – the macrocosm – symbolised by the circle. Physicality and psychicity, body and mind seem to be in perfect harmony with each other. The psychotherapist, attentive to the embodiment of the patient, painstakingly dissects the mental representations of the body, looks at them with curiosity and then creatively integrates them into an integrated body self, keeping the masterful representation of the 'Homo ad circulum' or embodied subject on the horizon of meaning.

References

1. Isaacson W. Leonardo da Vinci. Insignis; 2017.
2. Mirucka B. Podmiot ucieleśniony. Psychologiczna analiza reprezentacji ciała i tożsamości cielesnej. Warszawa: Wydawnictwo naukowe Scholar; 2018.
3. Merleau-Ponty M. Fenomenologia percepcji. Warszawa: Wydawnictwo Alethei; 1962/2006.
4. Mirucka B, Sakson-Obada O. Koncepcja ja cielesnego, czyli próba przekroczenia fragmentarycznego ujęcia cielesności. Przegl. Psychol. 2013; 56(1): 9–28.
5. Bucci W. The referential process, consciousness, and the sense of self. Psychoanal. Inq. 2002; 22(5): 766–793.
6. De Vignemont F. A multimodal conception of bodily awareness. Mind 2014; 123(492): 989–1020.
7. James W. Psychologia. Kurs skrócony. Warszawa: Wydawnictwo Naukowe PWN; 1892/2002.
8. Legrand D. Pre-reflective self-consciousness: on being bodily in the world. Janus Head 2007; 9(2): 493–519.
9. Slade PD. What is body image? Behav. Res. Therapy 1994; 32(5): 497–502.

10. Gallagher S. Body schema and intentionality. In: Bermudez JL, Marcel AJ, Eilan N, eds. The body and the self. Cambridge: Bradford Books; 1995. pp. 225–244.
11. Van der Kolk B. Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy; Warszawa: Czarna Owca; 2018.
12. Bermudez JL. The paradox of self consciousness. Cambridge, MA: MIT Press; 1998.
13. Damasio AR. Tajemnica świadomości. Jak ciało i emocje współtworzą świadomość. Poznań: Dom Wydawniczy Rebis; 2000.
14. Rothschild B. Ciało pamięta. Psychofizjologia traumy i terapia osób po urazie psychicznym. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2014.
15. Lowen A. Duchowość ciała. Warszawa: Jacek Santorski & Co. Agencja Wydawnicza; 1992.
16. Kepner JI. Ciało w procesie psychoterapii Gestalt. Warszawa: Wydawnictwo Pusty Obłok; 1991.

Email address: beatamirucka@kul.pl