Title:

Using Resonance as a Therapeutic Technique. Assessing the Accuracy of Resonance and the Impact of the Identity-Oriented Psychotrauma Theory (IoPT) in an Online Setting

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Master Thesis

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Abstract

The “Intention Method” of the Identity-orientated Psychotrauma Theory (IoPT) is a therapeutic method that uses resonances to reveal unconscious psychological processes. Yet, it is to be proven if the resonances are an accurate reflection of the life experiences of the client. Therefore, the study examined the accuracy and the emotional and psychological impact of resonances in a therapeutic setting. The sample included 43 clients from 16 different nations who are currently in psychotherapeutic treatment based on the IoPT. The researcher observed 50 therapeutic sessions and evaluated the expressed resonances as coherent or incoherent with the life experiences of the clients. Additionally, any visible psychological or emotional changes during the session were noted. These changes were then interpreted in relation to the expressed resonances. Results showed that resonance is an accurate means to uncover suppressed psychological conflicts, and improve the psychological and emotional well-being of the clients. The results implicate that the IoPT has the potential to establish a new form of psychotherapy in which unconscious inner conflicts, suppressed feelings, and false identification can be directly processed.

Keywords: psyche, trauma, resonance, Identity-orientated Psychotrauma Theory, psychotherapy

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1. Introduction

Investigations about traumas have a long-lasting tradition in psychology and psychotherapy (Breuer & Freud, 1895). Trauma can be defined as an experience of an overwhelming and life-threatening situation where the stress response is unable to secure the health of a person, causing the body to shift into a state of tonic immobility and causing the psyche to split (Levine, 2010; Ruppert, 2012). Because the psyche is unable to process the experience it dissociates from all relating feelings and perceptions. These psychological processes are split off from the entirety of the psyche forming an independently functioning psychological structure (Ruppert, 2021). Due to the division of the psychological wholeness, the emotional well-being, behavior, and perception of the trauma victim are affected negatively (Van der Hart, Nijenhuis & Steele, 2006). Therefore, it is important to find valid and robust psychotherapeutic techniques that aim at revealing and reintegrating the split-off psychological processes.

The Identity-oriented Psychotrauma Theory (IoPT) developed by professor dr. Franz Ruppert is a therapeutic technique that uses resonance to tap into split-off psychological processes. The IoPT is based on a large theoretical framework on current trauma theory which focuses on the development of the "I" in regard to important attachment figures (Bauer, 2019; Brisch & Hellbrügge, 2003; Bowlby, 1969/1975/1980; Ruppert, 2021). During a therapeutic IoPT session, called a self-encounter (SE), the client transfers his inner psychological processes onto other group members through resonance. The "resonators" are then able to express what the client is resisting to feel. Empathizing with him/herself embodied in another person, the client can process the traumatic experiences (Ruppert, 2019).

Resonance is the key component of the "intention method" of the IoPT. The term "resonance" is multi-layered as it describes a phenomenon that can be experienced on several dimensions including the physical, musical or *interpersonal* dimension (Rosa, 2016). Resonance stems from the latin word "resonare" meaning "resound". If two bodies are able to resonate they can communicate through resonance (Hunt & Schooler, 2019). The phenomenon of resonance was first used by Bert Hellinger known as part of "family constellation therapy" (Hellinger et al., 1999).

During a self-encounter, the client's inner psychological process and suppressed feelings are projected onto other subjects, called resonators (Ruppert 2012). Through resonance, clients who have no prior knowledge of each other can intuitively feel and express what the other person has experienced, felt, and suffered from. Thereby, unconscious psychological processes which have been

suppressed can be revealed and represented by the resonator. If the client sees the traumatic experience s/he has suffered from, a connection with his/her suppressed feelings is enabled. Appendix D provides a vivid depiction of a self-encounter. With the intention method, it is now possible for the first time to directly access the unconscious.

Considering the immense mental, psychological and physical impact of unconscious, suppressed feelings and perceptions, psychotherapy needs to address hidden inner conflicts (Levine, 2010; Van der Kolk, 2014; Broughton, 2011). The conscious use of resonance might be a reliable, new form of psychotherapy where unconscious psychological processes are openly revealed and thus, they can be used in a psychotherapeutic setting. However, to date, there is no empirical evidence that proves that the resonances are accurate. In the therapeutic setting, it is of utmost importance that the therapist can rely on the expressed resonances. They must accurately reflect the life experiences of the clients or otherwise, the client is identifying with life experiences that are not part of his real identity causing confusion and damaging his/her emotional well-being.

The current research examines the accuracy level of the resonances which are presented by resonators during a therapeutic IoPT session. The research question is the following: Are the expressed resonances of subjective experiences as well as objective facts coherent or incoherent with the life experiences of the clients? Furthermore, using qualitative means, the current research investigates the qualitative aspects of the therapeutic method. Observing and protocoling the therapeutic sessions, the study tries to find out if the self-encounter will lead to a better understanding of the inner psychological processes of the client and if an improvement in the emotional well-being will be visible.

2. Literature Review

2.1 Psyche

First, it is necessary to understand the constitution and functionality of the psyche before examining psychotherapeutic techniques. According to Ruppert (2021), the human psyche is an interaction of matter, energy and information. The main function of the psyche is to process information and perceive the inner and outer reality as it is (Ruppert & Banzhaf, 2017). The psyche receives external and internal stimuli, and processes and saves this information to form an accurate picture of the environment (Bauer, 2019). With the help of an elaborate system of hormones, immune responses, neurotransmitters and genetically mediated cell-to-cell communication, the psyche processes incoming information to meet the subjective needs of its organism by transforming the perceived information into a purposeful action (Ruppert, 2021). Concluding, the psyche establishes the contact between the inner and outer world and forms an overall perspective of the world (Ruppert, 2017). Thus, it is a prerequisite for survival to receive and process incoming information (reality) unbiased.

According to Bessel van der Kolk (1994) and Peter Levine (2010), traumas have a detrimental effect on how the human psyche perceives and processes internal sensations as well as the external environment. Because unbearable psychological processes are split-off from the entirety of the psyche as a consequence of trauma, important psychological skills such as perception, feeling and cognition are restricted in their functioning (Ruppert, 2021). A damaged psyche is unable to form an accurate overall perspective of the environment (Schore, 2012). This will decrease the chance of survival because the ability to perceive and process the whole spectrum of stimuli accurately is inhibited (Van der Kolk, 2014). Consequently, it is necessary to develop an understanding of when and how these damages occur.

2.2 Trauma

As mentioned above, trauma can be defined as an overwhelming, life-threatening situation where the victim is so overwhelmed, helpless, powerless that s/he freezes, dissociates and is unable to process this experience (Broughton, 2011). The feelings and perceptions that overwhelm the victim in this situation need to be shut off and suppressed because the prolonged stress exposure could be fatal (Garbe, 2016; Broughton, 2011; Sapolsky, 2005). This mechanism ensures the survival of the victim with the cost that a part of the psyche is split off from its totality (Levine, 2010). The suppressed part

dwells in the unconscious as the victim has no conscious access to the suppressed feelings and perceptions. This can go as far as the complete denial of the traumatic experience (Schore, 2012). Psychotherapy needs to reveal these traumatized parts to facilitate healing.

The current research, focuses on traumatic experiences in relation to important attachment figures early in life, meaning mostly from conception till three years old (Ruppert, 2012, Schore, 2012).Therefore, henceforth in this text, the term 'small child' will refer to children up to three years of age, and thus the developmental period from conception to three years. These traumas are often called "silent" because they might not be visible to an outside observer because of their subjective nature. Three main categories which build upon each other can be differentiated: First the "*trauma of identity"* is inflicted when a small child is not wanted by its parents. When a child is not wanted by its parents, most often it is also not loved *("trauma of love").* Lastly, the *trauma of violence* happens when a child is not only neither loved nor wanted but also physically or sexually assaulted. The main force behind all listed traumas is the missing love and emotional separation from the attachment figure leading to an inner separation from the self which can be defined as the conscious part of the "I" (Jung, et al., 1964).

Using a vivid example of the trauma of identity, the mechanism of cause and effect of traumas and how they affect the perceptiveness of the psyche will be illustrated. If a small child is not wanted by its parents, it undergoes massive stress because it instinctively knows that without support it cannot sustain itself (Ainsworth, 1978). The rejection triggers a stress response that mobilizes short-term energy through the release of adrenaline and cortisol. Blood flows to the extremities and a fight or flight behavior is induced. This mechanism requires a lot of energy (Siegel, 2012; Levine, 1997). When the stressor is successfully overcome the physiological measures return to homeostasis. Yet, fighting or fleeing is futile and the prolonged stress would harm and eventually kill the small child (Ruppert, 2018).

To prevent death, the body turns into a hypo-aroused state of tonic immobility (Levine, 2010). The nervous system stops all movement and lowers the heart rate through the release of opioids and the activation of the vagus nerve (Porges, 2001). Psychologically, all related feelings and perceptions are suppressed and numbed (Levine, 2010; Schore, 2012). The child is overwhelmed, powerless and unable to escape from a possibly lethal situation. Thus, the situation can be defined as traumatizing (Schore, 2012; Phillips, 2013). The trauma victim might dissociate completely from the situation losing contact with his/her emotions that are frozen (Levine, 2010).

In response to a physically or emotionally unavailable mother, the baby will adapt in any way possible to secure the attachment (Bowlby, 1969, 1975, 1985). The more a baby is rejected the more it tries to bond with its mother. In the therapeutic process, the attachment behavior increases the difficulty to break free from unhealthy attachment and focus on the self and its needs. Adding to this, the natural needs which cannot or will not be met by the mother will be denied because they lead to stress and exhaustion (Ruppert, 2018). The psychological part of the baby which yearns for love, secure attachment and maternal care is split off from the entirety of the psyche. The psyche is now fragmented.

This trauma survival mechanism enables a recovery of the stress level to a sustainable level. Now, the psyche of the small child is no longer threatened by an emotionally unavailable mother. Additionally, to prevent realizing and feeling the pain of not being wanted, the psyche of the baby will modify the perception of reality (Ruppert, 2018). The own perceptions and sensations are unbearable and need to be adapted to secure the attachment to the mother. Instead of feeling the rejection, the mother will be perceived as loving and caring. Because the mother still does not return the love and affection, the small child will blame itself for being "wrong" or "not worthy of love". Blaming itself, the small child can feel securely attached as it regains perceived control over the situation. This way, stress levels are reduced.

In conclusion, to survive a traumatic situation, the psychological integrity is split. This affects the perception of reality and it has a negative impact on the self-worth of the trauma victim. Because the related feelings, perceptions and needs are suppressed, psychotherapy faces the difficulty that the clients are not aware of the root cause of their psychological conflicts or emotional difficulties (Unfried, 2013). A valid psychotherapeutic instrument that reveals unconscious inner psychological conflicts is needed.

2.3 Fragmentation of the identity

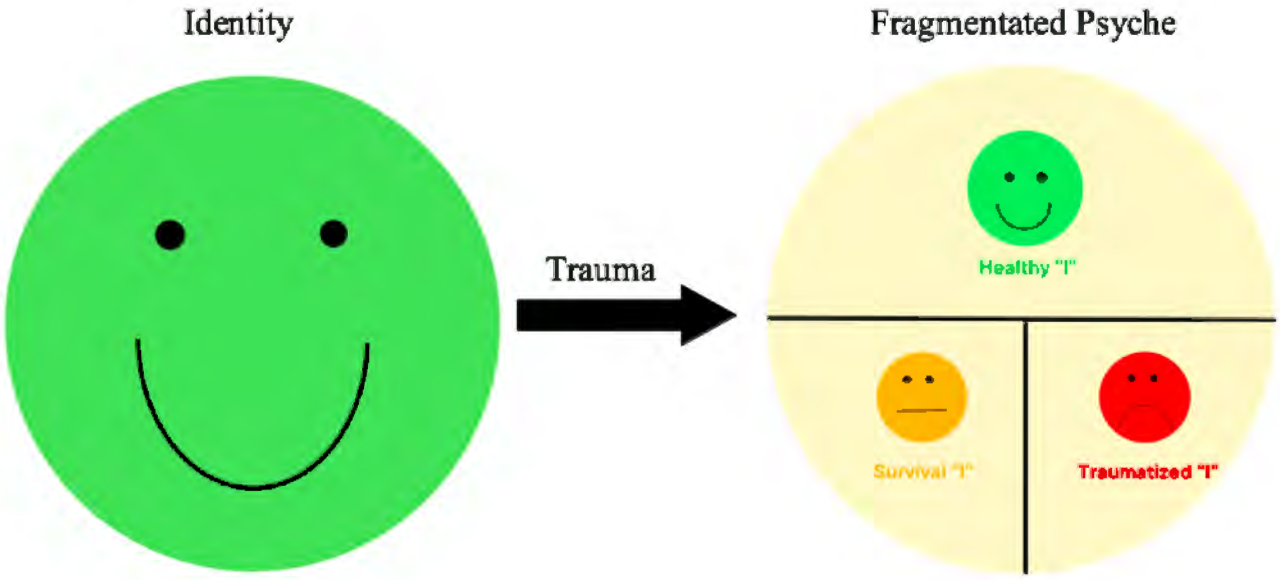
Due to trauma, the central control instance which can be named "I" is fragmented into independent parts. After the split, the psyche has fragmented its "healthy I" or "self" into three distinct parts each serving a different function within the traumatized person (Broughton, 2011). One healthy part (HP), a traumatized part (TP), and a survival part (SP) (*Figure 1*). The HP is trying to live a healthy life, being autonomic as well as in symbiosis with others. It has its own free will and is in good contact with its body. On the contrary, the TP lies dormant in the unconscious trying to make itself seen by causing different psychological and physical symptoms (Ruppert & Banzhaf, 2017; Bauer, 2014;

Merchant, 2015). The purpose of the SP is to counteract the impulses of the TP preventing the emergence of past emotions and feelings. The survival part fears that these feelings might be overwhelming and potentially lethal, hence survival. As soon as old wounds are triggered an automatic defense reaction is reflexively activated. The SP then uses survival strategies to block feelings through survival strategies such as trivializing or belittling the traumatic experience.

As a result of the fragmentation of the psyche there is no central control instance any longer but several independently functioning psychological structures all striving for control of behavior. The Identity-orientated Psychotrauma Theory takes this into account giving each psychological structure the chance to express itself. During the therapeutic process, the aim is to acknowledge the survival strategies and see the feelings and emotions behind them. If a client is able to overcome the resistances the SP poses he might be able to empathically connect with his/her TP leaving the SP superfluous.

Figure 1

Fragmentation of the psyche



Note. The right circle is copyright owned by Franz Ruppert. The whole figure has been adapted by the researcher. The figure illustrates how the integrity of the psyche is fragmented after a trauma has occurred.

Trying to improve emotional well-being, the IoPT focuses on the concept of identity. Ruppert (2021) defines identity as the sum of all conscious and unconscious experiences a person has made during his/her life. Certainly, traumatic experiences are included within this definition. But more often

a trauma victim excludes traumas from his/her identity because the SP wants to protect the self from overwhelming and harmful feelings. Because the SP banishes the TP from one's consciousness, one cannot find their true identity and their unfulfilled needs. They neglect their suppressed inner parts and look for a less painful replacement in the outer world (Ruppert, 2012). As these vital parts of the identity cannot be substituted, a constant feeling of emptiness and sadness is encountered.

Rather than integrating missing psychological structures and feeling one's helpless victimhood (TP), the SP forces clients to flee into identification. By identifying with a job, nationality or football club, external attributions, belief systems, […], or attachment figures, a traumatized person tries to fill out the hole where the "self" should have been. Replacing trauma-related feelings is a survival strategy where the trauma victim dis-identifies with him/herself. Due to the encountered pain, the traumatized identity is rejected and the self-concept coalesced with the identification object. Through the intention method, one can detach from unhealthy identifications and re-experience one's own identity. Regaining a sense of what the self truly is, is a key aspect of the IoPT. Therefore, it is necessary to gain a deeper understanding of how a sense of "I" is developed and how the self-concept can be distorted.

2.4 Resonance

Before examining how a small child develops a sense of what "I" is, it needs to be discussed what resonances are. "Resonare" is latin and means "resound" or "covibrate". In physics, the term "resonance" describes a phenomenon where one body induces another body to covibrate (Rosa, 2016). In social science, resonance describes a process where one person induces a feeling in another person. For example, if a person sees another person in fear, the first person might be able to resonate or covibrate with the expressed fear. This means that the fear of the second person elicits a feeling in the first person as a reaction.

By exchanging affects and emotions i.e. resonances, the people communicate preferences, attitudes, feelings and beliefs (Bauer, 2019). This information is not transmitted physically, chemically or biologically. Research has shown that independent of the loudness of the voice and the way of speaking, the non-material content of what is being said had a biological effect on the brain and the srandelf-concept (Somerville, Kelley & Heatherton, 2010). Thus, resonance is a subtle and indirect way of communicating what one person feels, thinks and believes without any biological, chemical or physical markers.

Resonance manifests through *affects* and *emotions* (Rosa, 2016). Through affects, the environment and other people are felt. It is a *passive* reception of resonances. Through emotions, one's own feelings and resonances are *actively* broadcasted to the world (Rosa, 2016). A traumatized person has lost the ability to fully be affected by him/herself or his/her environment, in fear of encountering harmful resonances, the SP tries to block certain upcoming affective states. The trauma victim loses contact with her/his body, other people and the environment. As long as s/he does not process his/her traumas, the relationship with oneself and with others will be coined by indifference and repulsion.

Resonances are unpredictable and they cannot be controlled or manipulated (Rosa, 2016). Resonance answers are autonomous and idiosyncratic forms of expressing one's own voice, feelings and emotions (Rosa, 2016). If one tries to manipulate or trick someone into resonating a certain feeling, resonance is disabled and it becomes mute. Resonance between two people is encouraged through *empathy* and *acceptance* for who the other person is and for what s/he does. Implicitly feeling, thinking and experiencing what the resonance partner is communicating without trying to change it is the purest form of resonance and the key to a successful integration of suppressed parts (Rosa, 2016; Ruppert, 2021).

As the basis of resonances are affects and emotions, any form of cognitive activity distorts the accuracy of resonance (Rosa, 2016). Any cognitive disturbance in form of evaluation, judgment, thought or diagnosis compromises the therapeutic success. As soon as resonators start to think about what they should do or say, or as soon as they guess what might have occurred during the client's life, they leave the resonance and distort the self-encounter. This opens the window for errors. Cognitive evaluation and diagnosis could then possibly lead to a wrong analysis and misguided intervention of the psychotherapist. IoPT therapists need to be aware of this risk, yet it is difficult to notice when a resonator is resonating and when s/he is using his/her mind.

2.5 Self-development

The following chapter will provide an overview of how the identity of a small child develops through resonances. Exploring who oneself is, is the aim of a self-encounter. Resonances lay the foundation for the self-image and unfortunately, they are at the root of most traumatic experiences. They are the cause but also the key to rediscovering one's identity and consequently, healing traumatic experiences. Regaining a clear sense of identity, people will be able to solve psychological conflicts and improve emotional well-being (Ruppert, 2012).

At the beginning of its life, a small child is incapable to sustain itself and it is dependent on an attachment figure who takes care of its needs, meaning sustenance, safety and emotional connection (Bowlby, 1969). With the use of mirror neurons, the baby can imitate movements and facial expressions, reciprocate loving devotion and initiate other forms of non-verbal contact with its attachment figures (Bauer, 2014). Through this resonant form of communication with its attachment figures, especially the mother, the baby develops a sense of what is "myself". Experiencing that its actions have an effect on others and receiving a resonance reaction, the baby slowly develops a distinction between what is "I" and what is "you". This happens within the first three years (Bauer, 2019). The philosopher Joachim Buber describes this process aptly: "Through the thou a person becomes I" (Buber, n.d).

This form of self-development can be seen when a small child falls down and does not yet know whether the fall hurt. It looks to its mother for orientation as it sees the world through its mother's eyes. The self of the newborn is outsourced and entangled with the self of the attachment figure (primarily the mother) as a form of extended mind (Clark & Chalmers, 1998). The identities are intertwined. It is as yet incapable of understanding and reflecting its own and others' feelings, needs, mental states, beliefs, intents or desires (Fonagy et al., 2018). The ability to mentalize starts to develop in infancy through emotional mirroring and responding (resonance). Consistently receiving emotional feedback on its feelings through mimicking, body language, touch, eye contact and gestures, the infant learns to make sense of its feeling and the world around it.

The quality of the resonances that the baby receives predicts how it will perceive itself and its environment (Bauer, 2019). If the resonances communicate to the baby that it is neither wanted nor loved, the baby will develop the belief system that it is worthless and unlovable. These belief systems are deeply engrained into the self-concept (Lipton, 2016). Throughout its life, the baby will perceive and interpret situations through the filter of his/her trauma biography (Lipton, 2016; Ruppert, 20). It will engage in internal derogatory and devaluating self-talk. The negative attributions that are projected through resonance are accepted as reality and internalized by the child. They have become part of its *identification* and self-concept (Tronick, 2009).

Thus, the feelings, beliefs and perceptions of the parents lay the foundation of the baby's self-concept (Schore, 2012). The baby cannot protect itself from harmful or benefiting resonances as it has no chance to make a clear differentiation between its inner world and the outer world (Verny & Kelly, 1981; Lipton, 2016). Under these circumstances, a healthy self-development is impossible.

These non-verbal messages to which a person is subjected from conception till death build the neuronal foundation of the self-concept (Bauer, 2019).

These resonances about the self and the world remain present in the traumatized person and later, they are passed onto successive generations (Wolynn, 2017; Stoffel, 2018). Transgenerational transfer describes the process where unconscious and unbearable traumas are not processed by the parents and therefore, are passed on to the next generation through projection (Unfried, 2013; Stoffel, 2018; Wolynn, 2017; Moré, 2013). Information, values, attitudes, feelings, patterns of behavior and survival strategies are unconsciously passed on from one generation on to the following (Moré, 2013; Bauer, 2019). Children are subjected to the traumas as well as trigger the traumas of their parents (Miller, 1979). In order to stop this endless cascade of victims becoming perpetrators a reliable technique to treat traumas needs to be found.

It is hypothesized that a person can suffer from the influence of trauma of the past three generations (Ruppert, 2021; Wolynn, 2017). Rachel Yehuda and her colleagues demonstrated with her research that the offspring of traumatized persons *internalize* feelings and physical symptoms they did not experience themselves (Yehuda et al., 2016). Even during pregnancy, the genetic expression of the baby is influenced by the thoughts, feelings and beliefs of the mother (Bail, 2007; Lipton, 2016; Isosaevi et al., 2017). Therefore, psychotherapy does not only need to address what traumas happened to the client but also, the traumas of the client's mother need to be taken into account. This issues a great challenge as these foreign traumas only exist in the unconscious of the client. Resonances pose a viable solution to overcome this challenge.

2.6 Implicit body memory

The first step towards facing this challenge is to listen to what the body is signaling because the transferred feelings, attitudes or behavioral patterns are stored in the implicit body memory, especially in the amygdala (Van der Kolk, 1994, Bauer, 2014). The function of the amygdala is to connect emotions with experiences and to recognize and evaluate stimuli. It implicitly stores affective states, mental images and body reactions (Bauer, 2014). It is connected with the hippocampus which organizes and arrays the experience temporally and geographically, evaluating the stimuli and passing it on to the cortex for long-term storage (Van der Kolk, 1994). During a traumatic situation, the body releases the stress hormones cortisol and endorphins to diminish pain and make the situation more bearable. As a consequence, the hippocampus cannot organize the experience and cannot transfer it to the cortex for long-term storage. This is called hippocampal amnesia where no *explicit* experience

but only affective information fragments exist (Van der Kolk, 1994). This poses a serious problem to the current research as no clear verification of the accuracy of the expressed resonance can be given.

Yet, even though a victim might not have conscious access to the whole traumatic experience, the cells in the body stores all perceptions and sensual fragments (Ruppert & Banzhaf, 2017; Merchant, 2015). Because the traumatic experience could not be processed it becomes scattered and jumbled (Wolynn, 2017). The psychotherapist and neuropsychologist Joachim Bauer (2005) proposes that everything a person experiences throughout his/her life on a physical, psychological and mental level leaves an implicit engram in the cells via neural networks in the cortex and limbic system, especially the amygdala which is involved in implicit affective learning (Panksepp & Biven, 2012). Although the psyche turns off conscious perception in response to unbearable emotions, the traumatic experience will still be stored unconsciously in these neural networks as disorganized memory pieces, distinct affective states and body sensations (Van der Kolk, 2014, Wolynn, 2017).

The implicit imprint increases the sensitivity for danger evaluation in future situations (Bauer, 2014 p.44). A neutral situation is compared to past experiences and a traumatized person is more prone to react with heightened physical arousal (Van der Kolk, 1994; Panksepp & Biven, 2012). If the stimulus is *remotely* similar to the traumatic experience, the brain evaluates the situation as a real danger and the person is emotionally triggered. The amygdala signals that the person is reliving the trauma rendering traumatized people unable to differentiate between what is past and what is present, or what is perception or what is projection, leaving the victim with intense emotions of fear and panic without being able to connect them to the cause (Unfried, 2013; Panksepp & Biven, 2012). Van der Kolk (2014) explains that: “[T]raumatized people chronically feel unsafe inside their bodies. The past is alive in the form of gnawing interior discomfort. Their bodies are constantly bombarded by visceral warning signs” (p.97). These warning signs can be used as a signpost during a self-encounter because they lead the client towards his/her traumas.

Ruppert and Banzhaf (2017) and Miller (2012) agree that the alarm signals of the body are a trigger for subjacent traumatized parts that want to make themselves seen. Thus, physical symptoms can be seen as a consequence of the split of the unity of the body, the mind and the soul (Ruppert, Banzhaf, 2017). Maria Magdalena Macarenco (2022) provided evidence that the reintegration of trauma has a significant benefiting effect on patients with Hashimotos disease, a thyroid deficiency. These results are in accordance with the assumption that traumatic experiences are the cause of physical diseases/complaints (Maté, 2011; Felitti et al., 2019; Gluckman & Hanson, 2004; Macarenco

2022; Fonagy et al., 2018; Bauer, 2014; Morter, 2019). Also, Van der Kolk (2014) and Levine (2010) highlight the importance of including the body in the therapeutic processes.

Concluding, the intention method is the appropriate technique to overcome the difficulties that arise when working with traumatized clients. Because the IoPT uses the signals of the body as a guide to reveal the traumas, suppressed feelings can be processed. Even though conscious perception is turned off during a traumatic experience, the body saves all relating information. Though disintegrated, the physical and psychological signs of the body are necessary clues during a self-encounter. IoPT therapists can use the upcoming information fragments to facilitate the reintegration and support the client to restore a coherent sense of identity. Following, it will be discussed in more detail how the intention method works practically.

2.7 Intention method

The “Intention Method“ is done in a group as well as individual sessions (Ruppert, 2021). Focusing solely on group sessions, the intention method is structured as follows. First, the client is responsible for developing his or her own “sentence of intention“. The sentence of intention should contain the reason the client seeks psychological support. This can be either a psychological or physical symptom or another information fragment that leads to the trauma. It can be written down as a whole sentence, single words, drawings or letters. How the client formulates the sentence of intention is fully his/her own choice and the therapist should not intervene. The sentence builds the framework for the therapeutic session as it draws the focus to the (unconscious) problem.

The client then proceeds to select a maximum of three parts of the sentence which can be a single word, a drawing, a question mark or any other information unit. Then, the client chooses one group member per information unit. The chosen persons, called resonators, go into resonance with the word and the intention of the client. That means that they resonate with the inner psychological processes of the client that are contained in the information unit. This can be described as intuitively feeling upcoming affective states. Yet, the intuitive feeling can be better described as a “qualitatively different sensory-perceptual-affective way of knowing, characterized by somatic sensations so that it is felt as absolute concrete and holistic” (Merchant 2015 p. 604). This form of knowledge combines the fragments and restores a holistic picture of the experience.

Resonating can be described as the process of intuitvly empathizing with the suppressed processes of the client. As soon as the resonators have begun to resonate with the inner processes and affective states of the client, the client can observe the emotional well-being and the behavior of the

resonators and then, interact with them. The interaction is not predetermined. The client decides what and how fast s/he wants to explore his/her parts. The client usually starts by asking questions such as, “How are you feeling?” or “Do you know how old you are?”. Interacting with his/her parts represented by the resonators, the client has the chance to listen to his/her unconscious psychological processess and directly ask questions about past traumatic experiences.

In IoPT, a clear differentiation between role play and representing has to be made. While in role-play, certain information about the family members is known, representations do not require any prior knowledge for the accurate portrayal of psychological processes (Broughton, 2011). A role play is associated with a predefined character that tells the actor how to behave. On the contrary, the aim of the resonator is to represent the resonance the client emits. Resonators can express, say, feel or move however they are feeling is accurate. Unlike role play, the resonators intuitively sense what they want to express without cognitively thinking about what they should say or do.

Interacting with his/her own inner parts, the client can now gain insights about traumatizing past events and how these events relate to his intention. With the help of resonators, the client can connect with his/her self and all expressed feelings. When the client is able to empathetically resonate with his parts and feel what they are feeling, healing can take place. Again, the focus is not primarily on cognitive understanding but on connecting with the suppressed feelings. Even though cognitive understanding of what has happened is important, healing takes place when feeling occurs.

With the IoPT, Franz Ruppert has developed a technique where clients can break free from all harmful resonances that have been projected onto them. Internalized resonances that distort the self-concept can be released. The clients can actively face their TPs that have been suppressed and denied. Feelings of utmost horror, fear or disgust were actively banned from consciousness and can now be brought to the surface for reintegration. In conclusion, emitting and receiving resonances, the unconscious can be consciously accessed. However, it has not been proven that the resonances accurately reflect the subjective feelings and objective facts of the client. Practical experience has repeatedly shown that resonance is an accurate means to reveal unconscious psychological processes and improve the well-being of clients. (Schweitzer et al., 2015; Ruppert & Banzhaf, 2017). Yet, empirical evidence that proves the accuracy of resonances is needed.

3. Hypothesis

The current research examines the accuracy level of the resonances which are presented by resonators during a therapeutic IoPT session. The research question is the following: Are the expressed resonances of subjective experiences as well as objective facts coherent or incoherent with the life experiences of the clients? Furthermore, using qualitative means, the current research investigates the qualitative aspects of the therapeutic method. Observing and protocoling the therapeutic sessions, the study tries to find out if the self-encounter will lead to a better understanding of the inner psychological processes of the client and if an improvement in the emotional well-being will be visible. Additionally, the predictors for incoherent resonances are explored.

It is hypothesized that the resonators provide an almost flawless (>90%) accurate representation of (1) the subjective inner states as well as (2) coherent objective information about the life experiences of the client. Moreover, it is hypothesized that (3) the therapeutic session will lead to a better understanding of the inner psychological states and processes of the client and (4) that an improvement in the emotional well-being of the client will be visible.

The first two hypotheses are based on observations conducted by Franz Ruppert (Ruppert, 2022). During self-encounters, he investigated whether the resonances that were expressed by the resonators were confirmed or disconfirmed by the clients. Using a checklist, he noted how often resonances were confirmed or disconfirmed. He found that a minimum of 90% of the information expressed by resonators were confirmed by the clients (Ruppert, 2022).

The third and fourth hypotheses are based on the findings by Anna Hermann who conducted interviews with IoPT clients (Hermann, 2022). Six clients who have been in treatment with the IoPT intention method were questioned about their experience with the intention method and about the emotional, cognitive and somatic components of the therapeutic method. The researcher found that all six clients benefited from the gained insights and confirmed the positive impact of the therapeutic technique. They reported an increase in quality of life and they approved the accuracy of the external representations of their subjective experience (Hermann, 2022).

4. Method

4.1 Design

The current study combined several research designs to answer the research question and test the hypotheses. First and foremost, this study was explorative. In trying to answer the research questions,

the study used mixed methods. It included a quantitative as well as a qualitative design. The accuracy of resonances was assessed quantitatively with a binary checklist during live self-encounters in an international sample. Additionally, the effect of resonance on well-being and understanding was assessed through observations. Individual cases were observed and studied during IoPT sessions. The content of each sessions was noted down in a protocol and important passages were highlighted (Appendix D).

4.2 Participants

Participants in this study included 50 clients who are currently in therapeutic treatment with the IoPT intention method. Four clients were excluded because of language difficulties (*N*=4) and three because of withdrawn consent (*N*=3). Thus, the final sample consisted of 35 females (81.4%) and 8 males (18.6%). The age ranged from 28 to 72 years (*M*= 50.86). It was assumed that all participants have suffered from a traumatic experience because they chose a trauma-orientated therapeutic treatment. Based on the assumption that everyone has experienced a trauma varying only in form or degrees of intensity (Kreiner, Schrimpf, Gahleitner & Piehl, 2015; Ruppert, 2018) no further inclusive criteria concerning trauma were addressed. The sample included the entire population, meaning subpopulations with distinct characteristics such as various forms of psychopathologies.

As all therapeutic sessions were held online via Zoom, this enabled the researcher to observe international clients and IoPT therapists. The sample contained participants from 16 different nationalities. Due to language constrictions, the researcher was only present in psychotherapeutic sessions where English or German was spoken or translated.

I obtained a convenience sample. Participants were recruited via an open call for participation in the IoPT community. Franz Ruppert is the founder of the IoPT intention method and he has created a large network including therapists from all over the world. He forwarded the request for participants to IoPT therapists who sent me an invitation to join their online group.

The therapists that guided the therapeutic session met the following criteria. They had an IoPT apprenticeship provided by Franz Ruppert or an IoPT licensed trainer and they had a minimum of 3 years of experience in practice.

4.3 Material

The quantitative data was collected with a self-made checklist that was specifically tailored to assess the accuracy of resonance concerning subjective dimensions as well as objective facts following the

theoretical framework. As this was a pioneer study that empirically examined the accuracy of resonance there were no validated and reliable questionnaires that suit the purpose of this study. The researcher of the current study was compelled to develop and use his measuring tools as there were no valid standardized measuring tools.

The researcher was present during each IoPT session and kept a checklist (see Appendix A). The binary checklist tried to assess the accuracy of the information represented by the resonators. The items could be either approved by ticking the "coherent" column when the client confirmed that the expressed resonance was coherent with his/her life experience or negated by ticking the "incoherent" column when the client disconfirmed the accuracy of the resonance. The rules for a resonance (dis)confirmation can be found in Appendix B. Whenever the resonances were (dis)confirmed but did not meet the rules for (dis)confirmation they were noted as "vague" (dis)confirmations. Expressed resonances that were not commented on by the client were not evaluated. The checklist consisted of 74 items subcategorized to the different forms of trauma (Ruppert, 2021). While 51 items addressed the subjective experience of the client, 23 items related to the objective facts which could be verified by the client.

After the self-encounter, participants were asked to fill out a short self-derived questionnaire about basic demographics. The questionnaire contained 4 items assessing the gender, age, nationality and the time the client has been working with the IoPT.

Addressing the qualitative aspect, the researcher created a protocol for every therapeutic session. In this protocol (Appendix D), the researcher noted the course of the process, the feelings, resistances, the expressed resonances and the relating (dis)confirmations, the interpretation and interventions of the therapist and a summary of the process. It was tried to assess in-depth how the clients felt throughout the session and if and when their emotional state changed. In addition, the protocol was used to assess in a non-binary way how the clients perceived the accuracy of the resonated information and to explore specific qualities of the IoPT.

4.4 Procedure

Due to the sensitivity of working with traumatized clients, cautious measures were necessary to ensure that no harm will be caused. Therefore, I first discussed the research with the therapists who invited me to join their group. They received the informational letter (Appendix E) and the informed consent (Appendix F). While I was present in the group, I had enough time to introduce myself and explain my research to the clients extensively. Because it was a great concern, special emphasis was

laid on the fact that the participants fully understood my research, that they knew that they have the ability to withdraw their consent at any time and that their data will be processed anonymously. Complementary, the informational letter and the informed consent were posted in the chat. As all therapeutic sessions were held online via Zoom a signature was not feasible. The researcher asked the participants verbally if he was allowed to observe and take notes during their therapy session before the process started. If the participants agreed the researcher silently observed and filled out the checklist as the treatment continued as usual. After the session had been completed, I asked the client to answer a short questionnaire about his or her demographic data (Appendix C).

4.5 Ethics

There was no need to prove the ethical applicability of the study by an ethical committee because the treatment was as usual and the researcher only took notes. During the process, the researcher did not interact with the client nor did he interfere with the therapeutic process in any way.

4.6 Statistical analysis

As the current explorative study was obtaining binary quantitative data, basic descriptive statistical analyses could be conducted. First, the number of coherent resonances and the number of incoherent resonances were summed respectively. Then the mean, median, standard deviation, and frequency of resonance (dis)confirmations were calculated. The data was analyzed using IBM SPSS Statistics (Version 28) predictive analytic software.

To rule out the possibility that resonance does not work and the results can be explained by chance, the experimental data was compared with theoretical data that was based on a chance model. For the comparison, the chance model of a coin toss (binominal distribution) was chosen because the binary outcome corresponds with the research setup. Due to the risk of confirmation bias (Lewicka, 1998), a confirmation bias of p=.5 and p=.8 was assumed. The random distribution of the coin toss was computed with the software Mathematica (Version 13.1; Wolfram Research, Inc.). Comparing the experimental data with the theoretical data of the coin toss, it can be answered how likely it is that the same results or more significant results could have occurred by chance.

4.7 Qualitative analysis

Assessing the qualitative data, the researcher tried to gain a deeper understanding of how the self-encounter revealed inner psychological conflicts and how it affected the clients. It was observed and noted how the emotional well-being and the subjective inner states of the client changed throughout

the self-encounter. Emotional and psychological changes in the resonators were also interpreted as they were a reflection of the client's inner states. The qualitative data was analyzed by gathering and collecting the relevant data from the protocols. For the purpose of detecting patterns, saliences and correlations the data was organized. The self-encounters were summarized and all expressed resonances were listed. Important insights and emotional outbursts were highlighted and analyzed in relation to the precedent resonances. It was tried to discover possible survival strategies and explain them in the context of the traumatic experience. This process was supported by discussing the self-encounters thoroughly with the attending therapists. After dissecting the data, the researcher drew his conclusions.

4.8 Results

The current research investigated the following research question: Are the expressed resonances of subjective experiences as well as objective facts coherent or incoherent with the life experiences of the client? The final sample consisted of 43 participants (Table 1). Testing the hypothesis that >90 % of the resonances are coherent with (1) the subjective inner states of the client and (2) objective information about the life experience of the client, the coherent subjective resonances (∑=219) and coherent objective resonances (∑= 18) were divided by the total amount of incoherent subjective resonances (∑=227) and incoherent objective resonances (∑=19). The first and second hypotheses were confirmed as 96.5% of the subjective resonances and 94.7% of the objective resonances were coherent with the life experience of the clients (Table 2). On average, 5.51 coherent resonances and .21 incoherent resonances were expressed during a self-encounter. The median number for coherent resonances was five compared to a median of zero for incoherent resonances (Table 3.)

Table. 1

Participant Demographics

Item	*N*	*%*

Gender		
Male	8	18.6
Female	35	81.4
Age		
20-29	1	2.3
30-39	7	16.3
40-49	11	25.6
50-59	14	32.6
60+	10	23.3
Nationality		
German	17	39.5
Russian	3	7
Austrian	1	2.3
Scottish	1	2.3
Norwegian	5	11.6
English	1	2.3
Finnish	1	2.3
Turkish	2	4.7
USA	1	2.3
Belarusian	1	2.3
Bulgarian	1	2.3
Romanian	5	11.6
Dutch	1	2.3
Iceland	1	2.3
Mexican	1	2.3
Ireland	1	2.3
Years of Experience with IoPT		
0-1,9	12	27.9
2-3,9	12	27.9
4-5,9	6	14
6-7,9	8	18.6
8-9,9	2	4.7
+10	3	7
Therapist		
Franz Ruppert	19	44.2
Catherine Xavier	4	9.3
Godehart Hanning	7	16.3
Matha Thorsheim	4	9.3
Vivian Broughton	2	4.7
Jenny Hansen	1	2.3
AnneKatrin Holm	1	2.3
Ewelyn Hysing Olsen	2	4.7
Elena Pfarr	1	2.3
Hedwig Nießen	2	4.7

Table 2.

Means, standard deviations and frequencies for (vague) coherent and incoherent resonances in relation to Gender

	Male (N=8)			Female (N=35)			Total (N=43)			
Variables	*M*	*SD*	f_i	*M*	*SD*	f_i	*M*	*SD*	f_i	%[a]

Coherent resonances	3.75	2.12	30	5.91	3.98	207	5.51	3.78	237	96.3
Subjective	3.5	2.27	28	5.46	3.99	191	5.09	3.79	219	96.5
Objective	0.25	0.46	2	0.46	0.74	16	0.42	0.7	18	94.7
Incoherent Resonances	0.125	0.35	1	0.23	0.49	8	0.21	0.47	9	3.7
Subjective	0.125	0.35	1	0.2	0.47	7	0.19	0.45	8	3.5
Objective	0	0	0	0.03	0.17	1	0.02	0.15	1	5.3
Vague Coherent R.	0	0	0	0.4	0.6	14	0.33	0.57	14	.
Vague Incoherent R.	0	0	0	0.06	0.24	2	0.05	0.21	2	.

a. Percentages of expressed total, subjective or objective resonances; vague resonances were not included due to their ambiguity.

Table 3.

Descriptive statistics of resonances

		Coherent Resonances	Incoherent Resonances
Mean		5.51	.21
Median		5.00	.00
Mode		2.3	0
Std. Deviation		3.782	.466
Variance		14.303	.217
Minimum		0	0
Maximum		19[a]	2
Sum		237	9
Percentiles	25	3.00	.00
	50	5.00	.00
	75	8.00	.00

a. 19 is the only outlier.

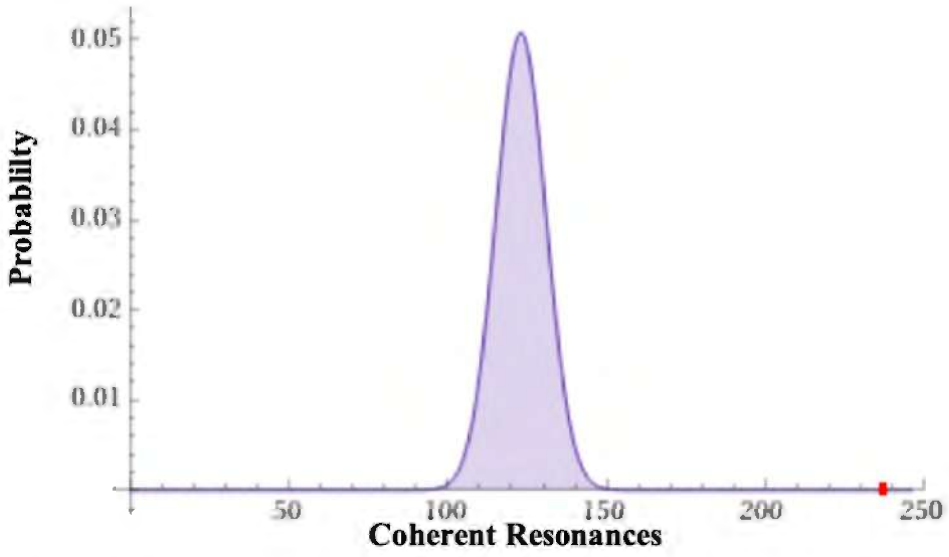
4.8.1 Binominal distribution

To rule out the assumption that the findings happened by chance, the results were compared with two theoretical binominal distributions. First, a probability of .5 was assumed (Figure 2). Results showed that the results could not be explained by the chance model (*p-value*= 7.2 x 10^{-59}). Due to the risk of confirmation bias, a probability of .8 was assumed (Lewicka, 1998; Figure 3). Results indicated that with a higher probability of .8 the results could not be explained by the chance model (*p-value*= 5.1 x 10^{-14}).

In conclusion, hypotheses one and two were accepted. The results revealed that almost all resonances (>95%) were coherent with the subjective inner states (96.5%) as well as objective information (94.7%) about the clients. It is highly unlikely that the findings occurred by chance as they could not be explained by the chance model.

Figure 2

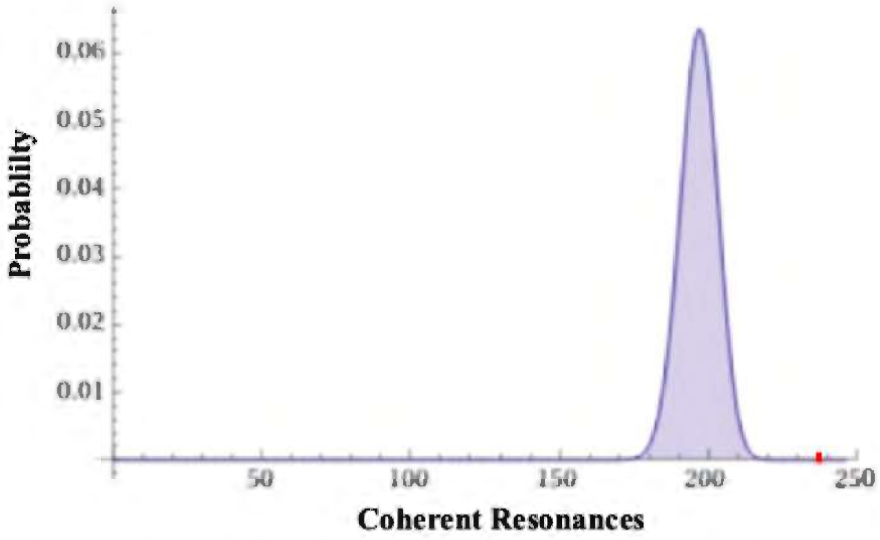
Binominal Distribution



Note. This figure demonstrates the likelihood that 237 or more resonance confirmations accured by the chance-model assuming that the probability for a resonance confirmation is .5.

Figure 3

Binominal Distribution



Note. This figure demonstrates the likelihood that 237 or more resonance confirmations accured by the chance-model assuming that the probability for a resonance confirmation is .8.

4.9 Qualitative results

To examine the third and fourth hypotheses that the self-encounter will lead to a better understanding of psychological states and an improvement of the emotional well-being, the protocols of the self-encounters were evaluated. Through self-encounters, the clients were able to understand the inner psychological conflict that is expressed within their intention. Most of the time, they were able to see the circumstances of the traumatization and how it has affected their self-concept and emotional well-being. Through the accurate portrayal of their inner states by the resonators, the clients were able to interact and explore themselves. Often, this interaction enabled the clients to empathize with their suppressed feelings and it facilitated the reintegration of split off processes. If clients genuinely connected with their traumatized parts, heavy emotional reactions took place. These intense feelings expressed themselves mostly in crying and screaming.

Yet, sometimes the resonances were either incoherent or they were met with high resistance and the client was then unable to break through them. They were not able to build a connection with their parts leading to stagnation within the process where no emotional-improvement was visible. Though the emotional connection was not always made, every self-encounter provided some sort of insight into their inner conflicts.

5. Discussion

The primary purpose of this study was to find out if the subjective and objective resonances that are expressed by the resonators are coherent or incoherent with the life experiences of the clients. Moreover, it was investigated to ascertain if the self-encounters led to a better understanding of the inner psychological states and processes of the clients, and if an improvement in the emotional and psychological state of the clients was visible.

5.1 Accuracy of resonance

The research indicated a high percentage of coherent resonances (96.3%) which is in line with the findings by Ruppert (2022). Although the high accuracy percentage only reflects a binary outcome, the recorded protocols showed that the resonances were exceedingly precise ("It is embarrassing, when a stranger reveals the innermost so bluntly" #19; "I see you like a friend I haven't seen in long time" #42; "I resonate fully with this" #44; "Yes, that is so true" #5; "Everything you say hits the nail on the head" #1; This is exactly how my life feels" #11; "very accurate" #4; "this describes my situation too good" #30). These confirmations demonstrate that the resonances were not only coherent but highly precise.

In congruence with the theoretical framework (Broughton, 2011; Ruppert, 2017), suppressed feelings that the client was unaware of were revealed by the resonators ("Someone is knocking on my stomach and genitals. I am too young to know what is going on." Client: "I do not have the exact memory but I trust you fully" #3; "I can feel his penis in my mouth" #15). This highlights that resonances are an accurate way of revealing unconscious psychological processes. This is an important step in psychotherapy because with the intention method the unconscious is now directly accessible.

Confirming the assumption of prenatal traumas (Ruppert, 2018; Merchant, 2015), even traumatic experiences before or during birth were revealed by resonators ("I am calling from the uterus but no one talks back." Client: "I totally resonate with this. I sent signals but nothing came back."#43; "I feel like I am in the womb, and I am impacted" #20; "…it feels like I am in the womb" #4, "I am burning hot right now. There is nowhere to go." #13; "[I am] in utero, almost born" #22). These resonances confirm that traumas can occur before birth and that the psychological well-being of the individual is negatively affected (Bail, 2007; Merchant, 2015; Wolynn, 2017). Psychotherapy needs to include prenatal traumata for holistic healing (Ruppert, 2018).

In every self-encounter, a psychological or physical symptom has led the way toward trauma. This is in line with current trauma literature suggesting that the traumatic experience is stored in the somatic memory (Bauer, 2014; Levine, 2010; van der Kolk, 2014). As AliceMiller (1979) proposed: "The body is the guardian of truth" (p.23). Most self-encounters started with resonators expressing the current psychological or physical symptoms of the client. This is in line with Levine (2010) who proposed that the body is a guide toward the traumatic experience. During the self-encounters, the body guided the clients toward their suppressed parts ("There is no obvious problem but my body tells me something is really bad" #33; "My body is getting sick" #28; My body is feeling goosebumps all over my heart" #15). This is crucial as listening to the body enabled the client to access blocked feelings the mind could access.

A low but considerable amount of resonances (*N*=9; 3.7%) were noted as incoherent with the subjective inner states and objective information of the client. Even a single incoherent resonance can have damaging consequences for the client (Bauer, 2019). The aim is to develop a pure sense of one's identity (Broughton, 2011). Incoherent information distorts the real identity, and regression would be made. Therefore, a closer look upon incoherent resonances is stringently required. Unfortunately, it was impossible to clearly differentiate between a factual wrong resonance and a resistance of the client to accept a part of the self.

A possible explanation for incoherent resonances is the cognitive interference of the resonators with the resonance process. As mentioned above, resonance cannot be changed or manipulated (Rosa, 2016). When a resonator cognitively thinks that some sentence or action would improve the situation s/he manipulates the purity of resonance and opens the window for errors (Rosa, 2016). Pure resonance is free from cognitions or evaluations. It is difficult for the psychotherapist to spot a resonator who overrides the resonance and starts to do what s/he thinks would help. Here lies a great danger of IoPT therapy because this leaves room for errors that are hard to discern.

Another possible explanation is that incoherent resonances are defense mechanisms denying reality (Broughton, 2011). This assumption is supported by two "incoherent" resonances that are likely to be survival strategies preventing the client from feeling the underlying pain. In self-encounter 50, one resonator said that she does "not like reading. It distracts you from yourself" which was denied by the client. The client probably likes to read, yet she uses reading to not feel upcoming emotions. The same applies to the resonance disconfirmation where a client denied that it might be "dangerous to express [her] sexuality" (#1). It is likely that feeling would be too much for the psyche

to bear and therefore, it denies reality (Ruppert, 2012). This assumption is supported because the client contradicted herself directly after her disconfirmation as she said that she is “paralyzed from shock” when men try to approach her in a sexual way. The defense mechanisms were too strong to overcome. Ruppert (2019) confirms that trauma victims are not able to process sexual traumatizations before the trauma of identity is resolved.

Survival strategies build an important part of the self-encounter. They indicate where the client is resisting the feelings s/he has successfully avoided because “it is too painful to feel” (#7). Denying reality is one alternative for the victim to escape the fact that one’s parents have been perpetrators (Ruppert, 2018). Many different survival strategies were visible during the self-encounters. Clients trivialized or belittled the traumatic experience (“[being raped] didn’t hurt that much” #34; “My feelings are not a big deal” #23); ignored the expressions of the traumatized parts (#1); protected the perpetrators (“she [the mother] was not able to do this” #6); blamed themselves (“I was too much […] I took too much from [my mother]” #12); intellectualized (“My intellect is a safe place” #6); talked about irrelevant stories (#26); hurt themselves (“I want to punch my own face” #34); identified with the perceptions of the perpetrators (“I am luggage [and] passed around like a sickness” #4); clung to an illusion (“An Illusion is more safe to hold on” #22); or dissociated (#15). It is important for therapists to spot the survival strategies and direct the focus onto the traumatic feelings that are covered by these strategies. Once the client is feeling the underlying pain, the survival strategies lose their function and dissolve.

Concluding, the vast majority of resonances were highly accurate. The clients could see themselves accurately reflected by the resonators. Even though the vast majority of resonances were coherent, the results do not prove that all resonances are fully trustworthy. It could not be finally clarified if the incoherent resonances were wrong or a resistance to feeling. If the incoherent resonances have nothing to do with the life experience of the client s/he runs danger to deteriorate her/his self-concept including something that is not part of his/her identity. Because of the possibility of cognitive interference in the resonance process, incoherent resonances should be interpreted with caution.

5.2 Impact of resonances

Due to the accurate portrayal of the physical symptoms, feelings and perceptions by the resonators, the clients were able to connect with their suppressed feelings and needs most of the time. During the observations and analysis of the protocols, it was found that especially the genuine expression of

neglected needs had a positive effect on the outcome of the self-encounter. When children were not allowed to express their needs, they have difficulty recognizing them as an adult (Rosenberg, 2016). Experiencing what their needs are enabled the clients to feel what they have been missing during their childhood. Traumatized parents are triggered by their own traumas, and thus are unable to provide their children with the needs that have not been met for them by their parents (More, 2013).

In congruence with the findings of Bowlby (1969) and Ainsworth (1978), the most essential need for the healthy psychological development of a child is the secure attachment. Children need parents to fulfill their needs ("I want to lay in my mother and feel her and be safe" #14). Frequently expressed needs were the need to be safe and protected, the need to be lovingly cared for, including warmth and physical touch without sexual intention, and the need to be seen as an individual self with individual feelings and sentiments. Purely physical nurturance is not enough. Connecting to their unmet needs brought suppressed feelings up for the client ("I just wanted to be the boy who is liked and not who is punched" Client begins to cry #18). Being able to say it out loud and feel the sadness, the client connected with his split off parts ("I have so much connection to you. I feel warmth" #18). Genuinely expressing the needs that have not been met by their parents enabled the clients to then, meet their needs by themselves ("I don't need a Mama anymore, I want to do it with you"# 30). Only as an adult does the client have the opportunity to reintegrate the traumas and not be overwhelmed by them.

Self-encounter 30 ("I must be on distance so I don't hurt myself and others") is a textbook example of a successful self-encounter. When the client needed love and affection from her mother, her mother's trauma was triggered. The more a child seeks the warmth and closeness, the more the mother feels threatened and her survival strategies take over (Ruppert, 2022). The mother rejected the client's love transferring her own trauma of love onto her daughter. In the beginning of the process, the client clung to her survival strategies, intellectualizing her feelings or taking on the guilt of not being loved. She gained a false sense of control when blaming herself. ("I want to be guilty. Then I have the control. When I am not guilty, I am a poor pig that cannot do anything." #30) When the client was able to say that she is a normal child with normal needs, the resistance was given up and she started to cry. Her parts felt relieved, strengthened and secured. The lack of love could now be replaced with inner wealth and abundance.

A similar dynamic was visible in self-encounters 11 and 24. The pain of being neither wanted nor loved is unbearable. Consequently, the child blames itself. The fault of the parents for not meeting the needs of the child is disregarded. Because a child identifies with the feelings and perceptions of

the mother, it perceives itself as ugly or not being worthy of love (Bauer, 2019). In the mind of a small child, the rejection is not the inevitable consequence of an irritated mother or father but the fault of an "ugly" (#11), "disgusting" (#24) or "bothering" (#8) child. By including these external attributions into the self-concept, the child can survive a hopeless situation. In extreme cases, self-loathing can turn into self-harming behavior ("I want to die. This is the solution" #15).

If a trauma victim is able to let the traumatic feelings flow through the whole body, a somatic experience of healing occurs where the original physical symptoms subside, and an emotional improvement takes place (Levine, 2010; Van der Kolk, 2014). This was visible during many self-encounters ("When you said you are the victim […] the burning sensation stopped" #13; when you felt, I feel more calm and relaxed" #24; "the tension is gone" #49). This form of healing is different than a cognitive insight, since it can be felt in the body as sensory-perceptual-affective knowing ("It feels like a sense of completion. I feel like I am my own person" #39) (Merchant, 2015). Another form of somatic healing was visible in self-encounter 14 where the client was able to express her anger and burst into uncontrollable and random movements. This is in line with Levine (2010) who proposes that the movements that are stuck in response to trauma need to be finalized.

In self-encounter 12 ("I vulnerability") the dramatic consequences of sexual violence could be observed and how the IoPT process facilitated the release of stuck emotions from the body. The client was physically violated by her mother and sexually abused by her father. She could not trust them, and as a consequence did not trust herself anymore. Because parts of herself were still stuck in the *past*, she was whispering so as not to disturb her parents. This underlines that victims of trauma cannot differentiate between what is past and what is present (Unfried, 2013). As she expressed the truth of how violent and terrifying her childhood had been, intense crying began. She realized that "being vulnerable" was a survival strategy to secure the attachment to her mother, and that "being hurt" brought her closer to her identity. She "feel[s] this in [her] body" which confirms the assumption that cognitive understanding is different from experiencing the change. In the end, she enjoyed the presence of her parts and they were happily dancing in front of their cameras.

The primary purpose of the intention method is to experience the feelings that were too painful to feel as a child and consequently, release stuck emotions and heal physical or psychological symptoms, because the survival strategies actively attempt to prevent the clients from feeling. Even though real transformation takes place during heartfelt emotions the first step towards a better connection could be cognitively (Schore, 2012). Understanding the cause of one's own inner

psychological conflicts paves the way to connecting with feelings. A self-encounter with no feelings is not futile, but often a necessary first step.

The self-encounter with the intention “I -close relationships- dad” (#1) is a vivid example of an insightful process without emotional improvement. It was stated how the father energetically invaded the self of the client. The client’s father had a stereotypical image of how women should be. He forced these traits onto his daughter, *s*uppressing her own traits. Her “I” expressed how angry she is at him (“I want to beat him up.”; “[I’m] fucking angry” #1). In congruence with Bauer (2019), the free development of an “I” is not possible when there is no safe supportive space. The permanent confrontation with harmful resonances leads to self-abandonment (Bauer, 2019). The father overtook the disempowered self of his daughter, filling it with his unwanted self-fragments. This led to a trauma of identity, where the self-fragments of the perpetrator control the victim from the inside (Ruppert, 2022). Protecting the attachment with her father, the client suppressed her true impulses, identifying with her father’s image of an ideal woman. Even though she was unable to feel her traumatized part, she gained a deeper understanding of her inner psychological conflict. This cognitive understanding lays the foundation for future processes where the client might be able to feel the hurt that was caused by this invasion by her father.

In conclusion, the qualitative data proves that the IoPT is an effective tool to understanding the inner psychological processes of the client better. In congruence with Bauer (2019), it was seen that if the clients were able to resonate with the expressed feelings of the resonator an improvement was visible. Surprisingly, the findings indicated that the body plays a central role in the reconstruction and reintegration of trauma. The body holds the fragments, and guides the victims to their traumatized parts. Then, clients were able to express their pain, sorrow and sadness about their traumatic life experiences. Due to the resistance of the survival strategies some clients were unable to create a genuine connection with themselves, yet every self-encounter provided some cognitive insight for the client.

5.3. Strengths and limitations

One major strength of the study is its diversity. This study included clients from 16 different nations with widely differing political systems, cultural norms, religious beliefs, social structures and educational styles. It can be concluded that resonance is a universal phenomenon that works independently of these factors. Another advantage of the study is that 4 clients had no prior personal

experience with a self-encounter. Therefore, I was able to witness and observe 4 processes where the clients had no expectations or experiences that might deviate results.

Although the study tried to assess the accuracy and the truthfulness of the resonances, the validity of the results is limited. Because most of the resonances were subjective (*N*=219), a definite answer about the accuracy cannot be obtained. It is difficult to prove in accordance with current empirical measures if a person truly resonated with what was being expressed. Even more difficult is to find hard evidence that suppressed feelings and events are truly a part of the clients' life experiences. Adding to this, this study was reactive. I noted only resonances when the client either confirmed or disconfirmed what was expressed. When clients did not react to a resonance it was not evaluated at all. This might have led to biased results.

Another limitation that this study did not address is the psychological process that happened after the self-encounter. Sometimes, clients refuse to accept certain information during the self-encounter, but after a week or two, they come to realize the truth of the resonance after letting the self-encounter sink in (Ruppert, 2022).

The checklist turned out to be unnecessary for my analysis. There was no need to have a register of possible resonances. Writing down the resonances in the protocol was precise enough. The resonances could have been categorized after extracting them from the protocols.

5.4. Future research

Future research should use a longitudinal design where a certain number of clients is followed over several self-encounters. Observing the accuracy and the impact of resonances over a longer period of time might lead to new insights and a stronger claim for their effectiveness. The aim of psychotherapy is to improve emotional well-being and psychological stability. It might be fruitful if the focus is directed more intensively on the emotional well-being and psychological health of the clients. Because the accuracy of resonance is not finally answered, future research should administer a questionnaire after two weeks and specifically focus on objective resonances. Verifiable objective resonances can provide a final answer to the question if the resonances are coherent or incoherent without any doubt. An additional questionnaire that directly measures the well-being of the clients before and after the self-encounter might yield insightful results.

5.5. Conclusion

As it becomes increasingly central to focus on the unconscious in psychotherapy it is essential to find a reliable psychotherapeutic technique that accurately reveals unconscious psychological processes. Practical experience has shown that the intention method is able to retrieve suppressed feelings through resonance, yet there has been no empirical evidence that proves the accuracy of the resonances.

The results of the study have shown that most resonances were coherent with the life experiences of the clients. Yet, a final proof could not be obtained due to the subjectivity of feelings. The findings have shown that resonances triggered heavy emotional reactions when the clients did not resist them. This strengthens the claim that the intention method can access unconscious phenomena through resonance. Seeing the emotional improvement after a self-encounter verifies the effectiveness of the treatment. During every self-encounter, the clients learned something new about themselves and often were able to process traumatic wounds. Noteworthy too is that the theoretical background is robust and withstands practical assessment. In conclusion, working with resonances might be the needed tool to consciously work with the unconscious.

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7. Appendices

Appendix A (Checklist)

Subjective aspect: 51 Sj	*Coherent (Yes)*	*Incoherent (No)*
Trauma of Identity		
- I was not wanted as a child		
- I feel like I was tried to be killed		
- I only survive (not live)		
- I am afraid to die		
- I don't want to live / want to disappear		
- My needs autonomy were/are not		
- My needs symbiosis were/are not met		
- Internalized Attribution		
- Birth Trauma (conception)		
Trauma of Love		
- My needs for love were/are not met		
- I am identified with the traumatic feelings of my parents		
- I feel like I dont need love in my life		
Trauma of Sexuality / Violence		
- I feel raped/abused		
- I feel I am separated from my body		
- My need for protection was (not) met		
Trauma of Perpetration		
- I feel like I made a mistake / did not want this		
- I am afraid of social condemnation		
- I want to hurt others		
In General		
- This is what I think, interpret, perceive, wish		
- I have trust issues		
- No connection seperated		

Feelings	*Coherent (Yes)*	*Incoherent (No)*
- I feel **solitude** (alone / no connection / lonley…)		
- I feel **disgust** (nauseaous / disgusted…)		
- I feel **shame** (embarressed / humiliated / uncomfortable…)		
- I feel **powerless (**overwhelmed / helpless / little…)		
- I feel **indifference** (numb / emotionless, tired…)		
- I feel **fright** (shocked / aroused / alert…)		
- I feel **anger** (angry / sour / rage…)		
- I feel **anxiety** (stressed / anxious / shy…)		
- I feel **sadness** (empty / depressed / disappointed…)		
- I feel **frustration** (discouraged / desperate / resignated…)		
- I feel **confused** (undecisive / disorientated / dissocative…)		
- I feel **hurt** (suffering / aggrieved…)		
- I feel **guilt** (conscience / responsible…)		
- Feelings **Other**		
Bodily signals		
- I am cold / warm		
- I feel I cant breath		
- This is what my body does		
- Currently: I experience these Symptoms		
Important Attachment figures		
- My mother experienced this/behaved like this		
- My father experienced this/behaved like this		
- My relatives experienced this/behaved like this		
Survivl Strategies		
- Offender protection (trivialize)		
- pain avoidance (e.g. fixiation on how others feel)		
- I distract myself		
- I numb my feelings with (drugs..)		
- I hurt myself		

	Coherent (Yes)	***Incoherent (No)***

General

- This is what I think interpret want
- I have trust issues
- No connection / feel seperated

- Not assignable



Facts / Objective Truths

Trauma of Identity	*Coherent (Yes)*	*Incoherent (No)*
- I know I was not wanted		
- During pregnancy, this happened		
- My parents have tried to abort me		
- My birth proceeded like this		
- I was in an incubator after my birth		
- My parents have tried to kill me		
- My parents gave me away		
Trauma of Love		
- I have lost an important attachment figure		
- My parents told me that they do not love me		
Trauma of Sexuality / Violence		
- I was raped/abused		
- I experienced psychological violence		
- I experienced physical violence		
- I have problems with sex		
- He/she was the perpetrator		
Trauma of Perpetration		
- I hurt others (eg: mobbing, violence, insults)		
- I have aborted a chidl		
- I tried to kill my child		
Important Attachment figures		
- My mother experienced this/behaved like this		
- My father experienced this/behaved like this		
- My relatives experienced this/behaved like this		
Body signals		
- This is what my body does		
- Currently: I experience these Symptoms		
- ***Not assignable***		
Vague Resonances		
- Saliences		
- Other		

Appendix B (Rules)

Self-induced rules for resonance (dis)confirmations

1) When do I need to draw a line in the coherent field

- It has to

a) be clearly communicated by the client that the resonated information was coherent by saying something similar to:

- „this is coherent“, „that fits“, „this is how I am“, I know this behavior/thinking from myself“.

OR:

b) a strong physical reaction needs to be visible. The reaction needs to indicate that feelings were triggered

- client begins to cry, is visibly agitated (e.g. starts shaking), starts to scream **OR:**

c) a personal memory of the client was expressed that confirms what the resonators have said.

2) When a line is drawn it needs to be noted:

1. What the confirmation of resonance was (RC = resonance confirmation). It has to be apparent why a line was drawn.

2. If applicable: What feelings or reactions did the resonated information elicit?

3) What information is insufficient to draw a line?

- a nod or an acknowledgement of the information

- vague or a subjunctive formulation („this could be“, „this might be the case“)

4) When do I need to draw a line in the **incoherent** field?

a) the clients need to communicate that the resonated information is wrong/incoherent

- „No, this is unfamiliar to me“, „This does not resonate with me“, „this is wrong/false“

–» Caution! Often resonated information show suppressed experiences or feelings that are outside of the consciousness of the client. If resistance towards this information is present that does not necessarily mean that the resonated information is incoherent with the life experiences of the client. Resistance should not be evaluated as incoherent information but as an observer, I am not able to differentiate between resistance and incoherent resonance. Therefore, I will write down the resonances and analyze them afterward in the context of the whole self-encounter with the attending therapist.

Vague (disconfirmation)

If I evaluate a resonance as (in)coherent but the resonance fails to meet the criteria I will list it under vague resonance (dis)confirmation.

Categorization

The categorization serves the purpose of orientation. I can allocate the information into appropriate subcategories which helps me to better evaluate the resonance and put it into a context.

Appendix C (Short Questionnaire)

Demographic Questionnaire:

What gender are you?:

How old are you?:

What is your nationality?:

How long have you been working with the IoPT?:

Appendix D (Example Protocole)

I delted the example protocole due to privacy concerns. There were no names to identify the client, yet I still felt that providing a full description of an self-encounter would be too personal.

Appendix E (Informational Letter)

Informational Letter

Dear Participant,

My name is Niklas Müller and I am a graduate student at Leiden University. For my master thesis project, I am observing IoPT online sessions. Because you are currently working with the IoPT, I am inviting you to participate in this research study by letting me protocol your process in written form and fill out a short questionnaire. The questionnaire will require approximately 1 minute to complete. There is no compensation for responding nor is there any known risk. All information will remain confidential. Participation is strictly voluntary and you may refuse to participate at any time. If you refuse to participate or withdraw your consent the treatment will go on as usual. Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information regarding the accuracy and usefulness of resonance in a therapeutic setting. The data will be treated completely anonymously.

If you require additional information or have questions, please contact me at the number listed below. You may report (anonymously if you so choose) any complaints to the Leiden University Data Protection officer: privacy@bb.leidenuniv.nl.

Sincerely,

Niklas Müller

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Supervisor:
Franz Ruppert
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Appendix F (Informed Consent Form)

Informed consent form

'I hereby declare to have been informed in a way that was understandable to me, on the nature and method of the research, as was also laid out in the information sheet 'Informational Letter'. My questions have been answered satisfactory.

I voluntarily agree to participate in this research. I obtain the right to withdraw this consent at any time, without having to provide a reason for this. When my data has been fully anonymized, it is no longer traceable to me. It is therefore no longer possible to withdraw this data. If my data will be used in scientific publications, or are published any other way, this will be done fully anonymized. My personal data will not be accessible by third parties without my consent.

If I would like to receive further information on the research, now or in the future, I can turn to

Niklas Müller

telephone number: 0176/42998304

e-mail: 1mueller@posteo.de

address: Grafschafterstraße 107c

47199 Duisburg, Germany

If I have any complaints about this research, I can turn to the secretary of the Ethics Committee of the Faculty of Humanities of Leiden University, Sanne Kleijn (ethics@hum.leidenuniv.nl/ telephone number: +31 715 273870).

Due to the nature of the study, a signature is not possible. I give my consent by saying that agree to participate in this study.

Researcher:

'I have provided information on the research. I hereby declare myself willing to, now or in the future, answer any questions on the research to the best of my ability. '

Niklas Müller 

(Name of researcher) Signature